

<Insert Purchaser Name>

<Insert Date>

Request for Information

# High-Value Maternity Network

INSTRUCTIONS TO PURCHASER

(Delete this page prior to sending to respondents)

This Request for Information (RFI) provides a template of questions for employers and other health care purchasers to pose to hospitals and health systems, for the purpose of curating a high-value maternity network (HVMN). Information and best practices on how to deploy, manage and evaluate RFI responses can be found in the accompanying *High Value Maternity Network How-to Guide,* included in your toolkit.

The RFI is designed to be customized by the purchaser sponsoring the RFI. Prior to sending the RFI, it is recommended that purchasers take the following steps:

1. Use the find/replace function in MS Word to replace the following placeholders fields with your organization’s information. Copy these terms exactly, including the brackets:

|  |  |
| --- | --- |
| **Placeholder Field** | **Replace with** |
| <Purchaser> | Purchaser organization name |
| <Market(s)> | The primary markets where purchaser intends to launch the HVMN |
| <Health Plan> | Purchaser’s health plan or third-party administrator (TPA) |

1. There are other placeholders in the document for you to customize with information about your organization. These placeholders are marked in **Red Text**, and instructions are provided. Delete or replace the red text prior to sending to RFI respondents.
2. In the introductory Section, the sub-section section called [“Data Snapshot for <Purchaser>‘s Recent Births”](#_<Purchaser>‘s_Expectations_for) contains a table which you should populate using data from your plan participant population. Instructions for procuring this information are included in the *Baseline Assessment Tool,* in the HVMN Toolkit.

1. Questions 14, 18, 23, 27, 29, 31, 32, and 34-36 require RFI respondents to submit data within the *Maternity RFI Attachment* Excel file. This file should be sent to candidate hospitals along with this RFI.

**

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# Section I – Introduction

## Introduction

According to the Centers for Disease Control and Prevention (CDC), more than 50,000 American women are harmed giving birth each year. Over 700 women die, and half of these deaths are preventable. Although many developed countries have enacted change effectively to reduce maternal mortality, maternal death rates in the United States continue to increase. The lack of adherence to safety measures, excessive use of C-sections, and inappropriate early elective deliveries lead to harmful complications for both mothers and babies.

With national rates of maternal morbidity and mortality on a consistent rise, **<Purchaser>** is paying close attention to the maternity care our health plan members receive.

|  |  |  |
| --- | --- | --- |
| **Indicator** | **United States** | **11-Nation Mean** |
| Maternal mortality per 100,000 live births | 26.4 | 8.4 |
| Neonatal mortality per 1,000 live births | 4.0 | 2.6 |
| Infant mortality per 1,000 live births | 5.8 | 3.6 |
| Cesarean rate | 33% | 25% |
| Low birth weight rate | 8.1% | 6.6% |

*Source:* Papanicolas et al. (2018). Health care spending in the United States and other high-income countries. JAMA 319(10) 1024-1029.

These alarming rates have prompted **<Purchaser>** to take a proactive and collaborative stance toward improving maternal care and outcomes for our health plan members. **<Purchaser>** is proceeding with the development of a High Value Maternity Network in **<Market(s)>** to increase quality, plan member service, and overall value for inpatient care for labor and delivery, as well as postpartum care. The High Value Maternity Network will be composed of select local hospitals and their affiliated providers who are committed to partnering with **<Purchaser>** to increase the quality and safety of maternity care.

**<Purchaser>** pays for approximately <insert #>births per year in **<Market(s)>**, and maternity remains a significant cost driver. As a result, we are seeking partners that are committed to improving maternal outcomes, while helping **<Purchaser>** manage the cost of care for its plan participants.

Through this Request for Information (RFI), hospitals are invited to provide information to **<Purchaser>** for consideration to participate in the High Value Maternity Network.

## About <Purchaser>

***Insert information about purchaser, including the following:***

* Company mission
* Types of health plan members
* Number of covered lives
* Number of covered lives in primary market
* Information about current network, TPA and/or benefit design

Data Snapshot for **<Purchaser>‘s** Recent Births

**<Purchaser>** has analyzed the incidence of severe maternal morbidity (SMM) and episiotomy rates associated with our members. SMM classifies unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health. Episiotomies are directly linked to a variety of maternal complications and, according to the American College of Obstetricians and Gynecologists, should be used only in a narrow set of cases.[[1]](#footnote-1) In 2015, The Leapfrog Group established a target rate for episiotomies at 5% of all births.

The below exhibit provides a high-level summary of information on **<Purchaser>‘s** <insert year> deliveries:

|  |  |
| --- | --- |
| **Metric** | **<Purchaser>’s Maternity Baseline Data in <Market>** |
| **Number of Births** |  |
| **Total Labor & Delivery Costs** |  |
| **Episiotomy Rate (%)** |  |
| **C-section rate** |  |
| **SMM Rate Per 10,000 Births** |  |
| **Average Age of Women Giving Birth** |  |

<NOTE TO PURCHASERS: Instructions for aggregating and collecting this information is provided in the Maternity Baseline Assessment Tool, included in the HVMN Toolkit.

To contain growth in benefit costs and to ensure that plan members can identify and utilize high quality providers, **<Purchaser>** seeks to develop clinical partnerships and direct contracts with high-performing maternity providers. Through this partnership, **<Purchaser>** will direct health plan members to participating providers by:

* Directly advertising the partnerships to its plan members through…

< insert purchaser’s strategy for advertising health plan partners; potential examples include: advertising through purchaser’s call center, network directory, direct mail, website and social media>

* Encouraging use of preferred clinical providers through…

<insert preferred benefit design strategy, such as: zero copays or other incentives for using preferred providers>

## <Purchaser>‘s Expectations for High Value Maternity Network

Through this RFI, **<Purchaser>** will identify hospitals and clinicians for its High Value Maternity Network. Partner hospitals must be committed to improving the quality and safety of maternity care and reducing the cost for that care.

Hospitals in the High Value Maternity Network will be expected to identify high-quality obstetricians and midwives to provide clinical services during the prenatal, labor and delivery and postpartum periods. Both the individual providers and the hospitals will be featured in **<Purchaser>‘s** communications to its plan participants.

In Phase 1 of the High Value Maternity Network, selected hospitals will sign a participation agreement with **<Purchaser>** and will commit to achieving a mutually developed set of goals for inpatient labor and delivery services. Hospitals and their providers will be paid for services as stipulated in **<Health Plan>** contract, as applicable.

***Optional***

In Phase 2 of the High Value Maternity Network, **<Purchaser>** expects to contract with hospitals in the High Value Maternity Network for a bundled rate for labor and delivery services. In consultation with partners in the High Value Maternity Network, **<Purchaser>** may opt to explore the inclusion of prenatal and postpartum services in the bundled rate. The structure of the bundled payment will be developed during Phase 1, in consultation with providers in the High Value Maternity Network.

## Minimum criteria for participation:

For a hospital to be eligible to respond to this RFI, the hospital must meet ALL of the following minimum criteria. Hospitals that do not meet these criteria will not be eligible for participation in the High Value Maternity Network.

1. The hospital must participate in the **<Health Plan>** network.
2. Hospital system must have at least one hospital applying for participation in the High Value Maternity Network that is designated as <insert highest level of perinatal designation in **<Market(s)>**
3. Each hospital that a system recommends for participation in the High Value Maternity Network must have performed at least 1,800 annual deliveries based on the most recent state published data. If the hospital performed fewer than 1,800 annual deliveries, the hospital must meet the following criteria to be eligible:
   1. Be designated as <insert highest level of perinatal designation> in **<Market(s)>**
   2. Receive a score of ‘Fully Meets the Standard’ in the majority of applicable performance measures within the Leapfrog Hospital Survey on Maternity Care
   3. Receive a score higher than ‘Willing to Report’ (lowest ranking level) in all performance measures within the Leapfrog Hospital Survey on Maternity Care
4. The hospital should have a NTSV Cesarean Section rate of under 23.9% or an explicit plan to achieve this target.[[2]](#footnote-2)
5. Providers recommended for participation must also participate in the **<Health Plan>** network. ***Optional* <Purchaser>** will allow midwives that are currently not participating in the **<Health Plan>** network to be recommended for participation in the High Value Maternity Network if the midwives will accept the in-network rate as payment in full for their services.
6. Ensure that all labor, anesthesia and delivery services, including Neonatal Intensive Care Unit (NICU) care, are delivered by providers who participate in the **<Health Plan>** network or are professionals who do not bill “out-of-network” for their services.
7. For each of the following applicable reporting entities, be willing annually to provide **<Purchaser>** with all measures for the most recent reporting period:
   1. The Leapfrog’s Hospital Survey on Maternity Care and
   2. For **<Market(s)>**: <insert any state data collection activities related to maternity care>
8. Allow **<Purchaser>** to share hospital and provider level maternity quality information with its plan participants in a format designed by **<Purchaser>.**
9. Make available to **<Purchaser>** a single point of contact (POC) to serve as a liaison between the health system, its relevant clinicians and staff, and **<Purchaser>**. The POC must have the authority to address any hospital and provider billing issues that **<Purchaser>‘s** plan participants experience, related to the contracted episode of care, as well as the authority to improve the quality of customer service that plan participants receive for the episode of care.
10. Responses to the RFI must be submitted by an individual who has authority to enter into contracts with self-insured health plans.
11. Agree not to release any data provided by **<Purchaser>** without **<Purchaser>‘s** written consent.

# Section II: General Instructions

This document is for use in replying to this Request for Information (RFI). Please send the completed intent to bid to **<Purchaser POC Name, Title>**, at **<Email>**, by **<Date>**, indicating whether your organization plans to submit a response to this RFI. If you intend to respond, we also require that you confirm adherence to ALL of the criteria outlined in the “minimum criteria for participation” in the introduction to the RFI. If you do not intend to respond, please check the appropriate box on the “intent to respond” and destroy this document.

**<Purchaser>** reserves the right to contract with your organization based on the information provided in your response and any other information obtained by **<Purchaser>**. If your health system includes multiple hospitals, **<Purchaser>** also reserves the right to accept this offer for some, all or none of the hospitals that you propose for the High Value Maternity Network. **<Purchaser>** reserves the right to add additional hospitals and hospital systems to the High Value Maternity Network at any time, and to remove hospitals and hospital systems from the High Value Maternity Network at any time.

## Costs Incurred by Providers

**<Purchaser>** will not be liable for any costs you may incur in responding to this RFI, regardless of whether **<Purchaser>**accepts your organization for inclusion in the High Value Maternity Network, decides not to go forward with the proposed High Value Maternity Network, cancels this RFI for any reason or develops the High Value Maternity Network through some other process or by issuing another RFI.

## Proposal Format and Submission

Each proposal must respond to every request for information in this document whether the request requires a simple "yes" or "no" or requires an explanation. All rates/fees should be provided as requested in the RFI and any additional costs should be clearly explained. You should respond to questions as completely as possible or explain why the question cannot be answered or does not apply.

Responses should be submitted in a separate document and responses should be clearly labeled with the appropriate question number. Please abide by the specified word limits. Separate attachments (such as Excel files for the requested outcomes reporting) should be submitted along with your written responses. Be sure that any documentation includes the relevant question number from this RFI.

You will have the opportunity to submit questions to **<Purchaser>** at **<Insert Email>** regarding this RFI and **<Purchaser>** will answer those questions as completely as possible during the Bidders’ Conference. Please refer to the Calendar of Events for specific details.

For the hospitals that you wish to include in the High Value Maternity Network, please respond by hospital and in aggregate for your hospital system where indicated. The first chart in the questionnaire requires listing the name of each hospital and the location in the respective rows. This format and order should be maintained throughout the additional charts. Please add and remove columns in your response as needed to include all hospitals that you propose to include in the High Value Maternity Network. If you are responding in long-form to a specific question for a hospital, please clearly title the response with the hospital’s name.

All proposal responses must be provided by **<Date/Time>** by electronic submission to:

**<Purchaser POC Name, Title>**, at **<Email>**

No hard copy submissions will be accepted.

## Calendar of Events

The schedule of events is below. While the schedule may change at any time, please be prepared to meet the deadlines as currently outlined.

Any failure to meet a deadline may result in **<Purchaser>** delaying review of your proposal, or refusing to consider it.

|  |  |
| --- | --- |
| **Key Dates** | **Event** |
| 6.5 months before program Effective Date (**DATE)** | Request for Information (RFI) distributed |
| 6 Months before **DATE** | Intent to Bid due back to **<Purchaser>** |
| 6 Months before **DATE** | Questions about RFI due from bidders to **<Purchaser>** |
| 5.5 Months before **DATE** | Bidder Conference |
| 5 Months before **DATE** | RFI responses due |
| 4 Months before **DATE** | Conduct finalist interviews with selected finalists |
| 3 Months before **DATE** | Providers notified of final decision |
| 6 weeks before **DATE** | Signed participation agreements due back to **<Purchaser>** |

# Section III – Intent to Respond

This is to notify you that it is [insert hospital system’s name] present intent to [submit or not submit\*\*] a proposal in response to **<Purchaser>‘s** High Value Maternity Network RFI. The individual to whom information regarding this RFI should be transmitted is identified below.

|  |  |
| --- | --- |
| **Organization** |  |
| **Contact Name** |  |
| **Title** |  |
| **Address** |  |
| **Phone number** |  |
| **Email Address** |  |

In order for a hospital to be eligible to respond to this RFI, the hospital must meet ALL of the minimum criteria set forth on pages 6-7.

* I/We confirm that the hospitals and affiliated providers that we propose to include in the High Value Maternity Network for **<Purchaser>** meet all of the Minimum Criteria for Participation as set forth in this RFI.

Signed by:

|  |  |
| --- | --- |
| **Name (signature)** |  |
| **Date** |  |
| **Typed Name and Title of Representative** |  |
| **Typed Name of Organization** |  |

\*\*If declining to respond, please state reason(s) why:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section IV – Questionnaire

Before completing the questionnaire, please review the Proposal Format and Submission section in the General Instructions. Each proposal must respond to every question in this document. All rates/fees should be provided as requested in the RFI and any additional costs should be clearly explained. For the hospitals that you will include in the High Value Maternity Network, please respond by hospital and in aggregate for your hospital system where indicated. Please add and remove columns in your response as needed. Responses should be submitted in a separate document, be clearly labeled with the appropriate question number and abide by the specified word limits. Separate attachments also should be submitted along with your written responses. All responses should be submitted electronically; no hard copies are required or will be accepted.

## General information and Experience

1. Please provide the contact name, title, address, phone number and email for the contact person at your organization for this RFI.

|  |  |
| --- | --- |
| **Organization** |  |
| **Contact Name** |  |
| **Title** |  |
| **Address** |  |
| **Phone number** |  |
| **Email Address** |  |

1. Please affirm that you meet all of the Minimum Criteria for Participation as described on pages 6-7. Provide an explanation if you cannot fully meet any of the criteria. (250 word max)

[] Yes [] No, please explain

1. Provide an overview of how your hospital system directly contracts with employers or health plans for Centers of Excellence, High Performing or High Value Networks and other clinical services. Please describe your experience working directly with employers or health plans on maternity and delivery as well as in any other clinical areas. (250 words max)

## Hospital Selection

1. **<Purchaser>** believes that it is essential that the hospitals included in the High Value Maternity Network provide superior care to their population. **<Purchaser>** is looking for health systems to recommend hospitals for inclusion in the High Value Maternity Network. If you have more than one hospital in your health system, please provide the criteria that you will utilize to select the hospitals to be included in the High Value Maternity Network. (250 word max)
2. Based upon the criteria outlined in the previous question, please complete the table below for the hospitals within your health system that you propose be included in **<Purchaser>‘s** High Value Maternity Network.

|  |  |  |
| --- | --- | --- |
|  | **Hospital Name** | **Hospital Address** |
| Hospital #1 |  |  |
| Hospital #2 |  |  |
| Hospital #3 |  |  |
| Hospital #4 |  |  |
| Hospital #5 |  |  |

*Add more rows as needed*

1. Please provide a description of services offered by your health system with respect to the following: (1,000 word max)

* Pre-natal care through your provider network, including the use of obstetricians, midwives and doulas
* Labor and Delivery, including care provided by obstetricians, midwives, doulas, lactation consultants and other staff
* Newborn Care, including Neonatal Intensive Care Unit (NICU) levels available
* Postpartum care provided within the hospital
* Postpartum care upon discharge, including services offered by obstetricians, midwives, lactation consultants and doulas that participate in the Empire POS or Horizon PPO network or do not otherwise bill for services
* Birthing classes and other educational classes (i.e., infant first-aid & CPR, parenting courses, etc.) offered by providers that participate in the **<Health Plan>** network or do not otherwise bill for services
* Incentives or giveaways offered by your hospital system to encourage healthy pre and/or post-natal practices (i.e., transportation, supplies, educational material, baby boxes, etc.)

1. To the extent that the maternity-related services described in the previous question differ among the hospitals that you propose be included as part of the High Value Maternity Network, please provide an overview of those differences. (250 word max per hospital)
2. Please provide an overview of your labor and delivery staffing model and approach. Is there a laborist available 24/7? Are there some obstetricians or midwives who do not use a laborist? If this model varies by hospital, please provide an overview for each hospital that you propose be included in **<Purchaser>‘s** High Value Maternity Network. (250 word max per hospital)
3. Please indicate whether there is an in-house anesthesiologist(s) that participates in **<Health Plan>** network. If yes, is the anesthesiologist(s) available 24/7? If yes, is the anesthesiologist(s) dedicated to the obstetrics floor? (100 word max per hospital)
4. It is extremely important that all providers treating **<Purchaser>‘s** population during their hospital stays participate in the **<Health Plan>** network, which is the network for **<Purchaser>**. Please explain how you will ensure that all providers who administer care to **<Purchaser>‘s** population during their hospital stays are participating in **<Health Plan>** network. If available, please provide the number and specialty of providers who do not participate in **<Health Plan>** network and what portion of maternity patients they treated in the past year. (250 word max)
5. Describe how you will educate participating hospitals and hospital staff about **<Purchaser>‘s** High Value Maternity Network. (250 word max)
6. Do any of the hospitals that you propose for the High Value Maternity Network, place limits on women’s health services, including, but not limited to, sterilization and contraception services? If yes, please explain these limitations. (250 word max per hospital)

## Obstetrician and Midwife Provider Selection

1. **<Purchaser>** believes that it is essential that the providers included in the High Value Maternity Network provide superior care to their population. **<Purchaser>** is looking for hospital systems to select the obstetricians and midwives for inclusion in the High Value Maternity Network. Please provide the criteria that you will utilize to select the obstetricians and midwives for inclusion in the High Value Maternity Network. (250 word max)
2. To the extent possible and based on the criteria described in the previous question, please provide a complete list of the obstetricians and midwives and their practices that you anticipate including in the High Value Maternity Network in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 14. Please list providers regardless of current participation status with **<Health Plan>**.

## Lactation Consultant and Doula Selection

Research indicates that, on discharge, rates of exclusive breastfeeding and any breastfeeding are higher among women who have delivered their babies in hospitals with International Board Certified Lactation Consultants (IBCLCs) on staff than in those without these professionals. As a result, providing access to IBCLCs during the hospital stay and postpartum is important to **<Purchaser>**.

1. Please provide an overview of the lactation services available to **<Purchaser>‘s** population during their hospital stays. To the extent that these services vary by hospital, please describe the differences. (250 word max, 100 word max per hospital per difference)
2. **<Purchaser>** would like lactation services to be available to its population during the postpartum period. Please describe the availability of IBCLCs in the hospital (hours and days available), and post discharge (250 word max)
3. **<Purchaser>** does not want its plan participants to pay out-of-pocket for lactation services. Please describe how lactation consultants are compensated. (250 word max)
4. To the extent possible and based on the criteria described in question 16, please provide a listing of the IBCLCs that you anticipate including in the High Value Maternity Network in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 18.

Providing access to certified doulas during pregnancy, labor and delivery and postpartum can reduce C-section rates and improve clinical outcomes (i.e., reducing incidences of low birth weight and reducing complications). **<Purchaser>** is interested in partnering with hospitals that provide doulas to its patients during pregnancy, delivery and postpartum – or at a minimum, have experience working with Doulas during labor and delivery and would be willing to partner with them.

1. Does your hospital provide certified Doulas during pregnancy, labor and delivery and potpartum? If so, please describe your Doula services, the criteria you use to select them, and their availability to patients. If not, please describe your policy toward and experience working with Doulas that patients hire privately. (250 word max)
2. Please provide the percentage of births at each hospital at which a doula is present. How do hospitals decide to allocate doula resources? (150 word max)

|  |  |  |
| --- | --- | --- |
|  | **Hospital Name** | **% Births with Doula Present** |
| Hospital #1 |  |  |
| Hospital #2 |  |  |
| Hospital #3 |  |  |
| Hospital #4 |  |  |
| Hospital #5 |  |  |

*Add more rows as needed*

1. Please provide your best estimate of the number of doulas that you propose be available to **<Purchaser>** plan participants at each hospital that you propose for the High Value Maternity Network and explain why this is an appropriate number. If possible, please provide information on the number and percentage of doulas that are DONA certified. (100 word max)
2. **<Purchaser>** does not want its plan participants to pay out-of-pocket for doula services. Please describe how doulas are compensated. (250 word max)
3. Please complete the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 23 for the providers and other professionals that you would like propose to include in **<Purchaser>‘s** High Value Maternity Network. The data reporting period should be calendar year <Insert Year>.

## Quality Reporting

1. **<Purchaser>** expects that the selected clinical partners are transparent with purchasers and patients about their record on quality and safety. Clinical partners participating in the High Value Maternity Network will be required to provide annual reporting on a comprehensive set of mutually agreed upon maternity care measures for hospitals and providers included in the High Value Maternity Network, and some or all of these measures will be shared with **<Purchaser>‘s** plan participants. Please confirm your willingness to provide such measures. If not, please explain. (250 word max)
2. Provide an overview of the maternity care measures that you routinely measure and report on today and any planned future expansions to your reporting. Please list all agencies or other entities to which you currently submit regular quality metrics. (500 word max)
3. Confirm that your organization is willing to provide **<Purchaser>** with Leapfrog Hospital Survey Maternity Care outcomes on an annual basis for each hospital included in the High Value Maternity Network. Please also confirm whether your organization is able to provide this information summarized by patient race/ethnicity group and payor type (commercial, Medicaid, Medicare)..

If “not confirmed” for any section below, please explain why. (50 word max)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Hospital #1** | **Hospital #2** | **Hospital #3** | **Hospital #4** | **Aggregate** |
| 1. Did you complete the [Leapfrog Hospital Survey on Maternity Care](https://www.leapfroggroup.org/ratings-reports/maternity-care) in <previous calendar year>? | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed |
| 1. Confirm that you will provide annual reporting of [Leapfrog Hospital Survey on Maternity Care](https://www.leapfroggroup.org/ratings-reports/maternity-care) outcomes to **<Purchaser>** for all patients | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed |
| 1. Confirm that you will provide **<Purchaser>** with annual reporting of [Leapfrog Hospital Survey on Maternity Care](https://www.leapfroggroup.org/ratings-reports/maternity-care) outcomes broken out by race/ethnicity & payor type | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed |

1. Complete the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 27 for each hospital within your hospital system that you propose be included in **<Purchaser>‘s** High Value Maternity Network for the most recent year that data is available. Note that these questions are from the Leapfrog Hospital Survey on Maternity Care. If you are unable to provide any of the information, please list “N/A” and explain. (50 word max per metric per hospital)
2. Severe maternal morbidity (SMM) classifies unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health. The CDC maintains a list of SMM indicators that use administrative hospital discharge data and diagnosis and procedure codes to identify delivery hospitalizations with SMM. For all of the hospitals that you propose to include in the High Value Maternity Network, please confirm that you are willing and able to provide on an annual basis the total number of delivery hospitalizations with SMM based on the [CDC’s most recent list of SMM indicators](https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm), summarized by SMM indicator.

Please also confirm whether your organization is able to provide this information summarized by patient race/ethnicity group and payor type (commercial, Medicaid, Medicare).

If “not confirmed” for any section below, please explain why. (50 word max)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Hospital #1** | **Hospital #2** | **Hospital #3** | **Hospital #4** | **Aggregate** |
| 1. Confirm that you will provide **<Purchaser>** with annual reporting of the total number of delivery hospitalizations with SMM based on the CDC’s most recent list of SMM indicators | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed |
| 1. Confirm that you will provide **<Purchaser>** with annual reporting of the total number of delivery hospitalizations with SMM based on the CDC’s most recent list of SMM indicators, broken out by race/ethnicity & payor type | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed | Confirmed/Not Confirmed |

1. Provide the total number of delivery hospitalizations with severe maternal mobility (SMM) by race, ethnicity, and payor type based on the CDC’s most recent list of SMM indicators in the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 29 for each hospital within your hospital system that you propose be included in **<Purchaser>‘s** High Value Maternity Network for the most recent year that data is available. If you are unable to provide any of the information, please list “N/A” and explain. (50 word max per metric per hospital)
2. **<Market(s)>** require thateach hospital provide a selection of information about its childbirth practices and procedures. For all of the hospitals you propose to include in the High Value Maternity Network, please confirm that you can provide this information for all patients, summarized by patient race/ethnicity and payor type (commercial, Medicaid, Medicare) on an annual basis. If no, please explain why and what you will provide. (100 words max)
3. For **<Market(s)>** hospitals, please complete the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 31 with the selection of information from the state’s required information about hospital childbirth practices and procedures.
4. **<Purchaser>** is interested in including providers and facilities in the High Value Maternity Network that adhere to clinical guidelines as recommended by the American College of Obstetricians and Gynecologists (ACOG). Please provide an overview of how you ensure that your hospitals, providers, midwives and staff adhere to these guidelines. (250 word max)
5. Please confirm the following:
   1. What percentage of women are screened for postpartum depression by 6 weeks postpartum using the [Edinburgh Postnatal Depression Scale](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/practicing-safety/Documents/Postnatal%20Depression%20Scale.pdf)?
   2. What percentage of women eligible for progesterone receive an injection on a weekly basis?
   3. What percentage of women receive a cervical length screening at the mid-third-trimester ultrasound?
   4. What percentage of women with a history of pre-eclampsia take an appropriate medication on a daily basis?
6. Please complete the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 34 on the use of early elective delivery and audits related to inductions. If this information is not available, please explain why. (50 word max per hospital)
7. Other important information. Please complete the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 35. Please refer [to ACOG’s Obstetric Care Consensus Severe Maternal Morbidity: Screening and Review](https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2016/09/severe-maternal-morbidity-screening-and-review) when responding to question 35.
8. Additional NICU information. Please complete the table in the Excel file: Maternity\_RFI\_Excel\_Attachments.xlsx, tab: Question 36. For Question 36c within the attachment, please refer to [Specifications Manual for Joint Commission National Quality Measures PC-06](https://manual.jointcommission.org/releases/TJC2018B/MIF0393.html).
9. Please confirm that co-located nurseries are available in all hospitals that are included in the High Value Maternity Network. If there is a hospital that does not have a co-located nursery, please explain why and where babies go if there is no nursery. (100 word max)

## Quality Improvement

1. What actions has your hospital system taken to improve maternity care and postpartum care in the last 5 years? (250 word max)
2. The [California Maternal Quality Care Collaborative](https://www.cmqcc.org/) offers [Maternity Quality Improvement Toolkits](https://www.cmqcc.org/resources-tool-kits/toolkits) that are aimed to improve the health care response to leading causes of preventable death among pregnant and postpartum women as well as to reduce harm to infants and women from overuse of obstetric procedures. These are also endorsed by the [Alliance for Improvement of Maternal Health](https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim#:~:text=AIM%20is%20a%20national%20data,patient%20safety%20bundles%2C%20found%20here.), sponsored by the American College of Obstetrics & Gynecology. Please indicate whether your hospital system uses these toolkits (Yes/No). If protocols vary by hospital, please respond by hospital. If your hospital is not using these toolkits, please describe what you are doing to address these areas of concern. (250 word max per hospital)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Hospital #1** | **Hospital #2** | **Hospital #3** | **Hospital #4** |
| [Improving Health Care Response to Obstetric Hemorrhage, Version 2.0](https://www.cmqcc.org/resource/obstetric-hemorrhage-20-toolkit) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| [Improving Health Care Response to Preeclampsia](https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| [Support Vaginal Birth and Reduce Primary Cesareans](https://www.cmqcc.org/VBirthToolkit) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| [Improving Health Care Response to Maternal Venous Thromboembolism](https://www.cmqcc.org/resources-toolkits/toolkits/improving-health-care-response-maternal-venous-thromboembolism) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| [Improving Health Care Response to Cardiovascular Disease in Pregnancy and Postpartum](https://www.cmqcc.org/resources-toolkits/toolkits/improving-health-care-response-cardiovascular-disease-pregnancy-and) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| [Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age](https://www.cmqcc.org/resources-tool-kits/toolkits/early-elective-deliveries-toolkit) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |

1. Please indicate whether your hospital system follows the CMQCC/AIM (Alliance for Innovation on Maternal Health) [patient safety bundles](https://safehealthcareforeverywoman.org/patient-safety-bundles/). If it does not, please describe your efforts in each of these areas. (250 word max per hospital)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Hospital #1** | **Hospital #2** | **Hospital #3** | **Hospital #4** |
| Maternal Mental Health: Depression and Anxiety | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Maternal Venous Thromboembolism | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Obstetric Care for Women with Opioid Use Disorder | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Obstetric Hemorrhage | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Postpartum Care Basics for Maternal Safety: From Birth to the Comprehensive Postpartum Visit | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Postpartum Care Basics for Maternal Safety: Transition from Maternity to Well-Woman Care | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Prevention of Retained Vaginal Sponges After Birth | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Reduction of Peripartum Racial/Ethnic Disparities | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Safe Reduction of Primary Cesarean Birth (+AIM) | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Severe Hypertension in Pregnancy | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Severe Maternal Morbidity Review | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| Support After a Severe Maternal Event | (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |

## Patient Experience and Satisfaction

1. Please provide an overview of the languages that are spoken by your labor and delivery staff, the language translation services available to patients during their hospital stays, and the written resources available and in what languages other than English. Please include information on the written materials that are available in Spanish. If the foreign language resources vary by hospital, please provide an overview of what is offered at each facility. (250 word max per facility)
2. How does your hospital system measure patient satisfaction for maternity care at your facilities? Does it vary by hospital? Please share any available patient satisfaction results. (250 word max)
3. Does your hospital measure patient satisfaction for individual obstetricians, midwives or doulas who provide care at your hospitals? If yes, please explain the measurement methodology used by each hospital within your system. (100 word maximum)

## Compliance

1. Please confirm that you comply with the privacy and security requirements to protect patient information as set forth in HIPAA and its applicable regulations. If you do not, please explain. (250 word max)
2. Have you had any privacy or security breaches of protected health information or any other impermissible use or disclosure of protected health information within the past 5 years? If yes, please explain. (250 work max).

## Labor and Delivery Payment Approaches

**<Purchaser>** may be interested in contracting directly with one or multiple hospitals and health systems as part of the High Value Maternity Network in subsequent years of the program. **<Purchaser>** wishes to maintain the current payment approach through **<Health Plan>** in Phase 1 and potentially implement a global fee with warranty (including professional and facility services) and quality-aligned payment metrics moving into Phase 2.

1. Is your hospital system currently participating in any existing contractual or incentive-based arrangements that pay for maternity related services on the following basis (select all that apply):

* Global Fee
* Episodic Payment
* Pay-for-Performance
* Other

1. Aside from maternity-related payment, is your hospital system participating in any other value-based arrangements that align payment to the efficiency and quality of care delivered? If yes, please provide a general description of the types of value-based payment arrangements your system currently participates in (100 word max).
2. If you have indicated that your hospital system currently participates in some form of alternative payment models, please indicate what resources are in place to manage relative financial and quality-related performance (100 word max).
3. ***Optional:* <Purchaser>** expects to pay a blended global payment for vaginal and C-section deliveries. Complete the table and confirm that you are willing to accept a blended global payment for vaginal and C-sections births. If not confirmed, please explain why. (100 word max)

|  |  |
| --- | --- |
| **Facility Type** | **Confirm that you are willing to accept a blended payment for vaginal and C-sections births in Phase 2** |
| Facility services | Confirmed / Not Confirmed |
| Professional services | Confirmed / Not Confirmed |

1. As described above, the High Value Maternity Network will be composed of select local hospitals and their affiliated providers who are committed to partnering with **<Purchaser>** to increase the quality and safety of maternity care while helping **<Purchaser>** manage the cost of care for its plan participants. **<Purchaser>** will be evaluating the cost of maternity care across all hospitals being considered for participation within the High Value Maternity Network. For hospitals that fall above **<Purchaser>‘s** median cost for maternity care, and to the extent that payments remain based on the current payment system, **<Purchaser>** would expect a discount in exchange for including your hospital(s) and affiliated providers in a high value, narrow network.

Please confirm that you are willing to accept a discount beyond the current discount in your **<Health Plan>** contract, as applicable, should your hospital(s) fall above **<Purchaser>‘s** median cost for maternity care.

* Confirmed
* Not confirmed

1. Please confirm that you are willing to include the following in your global fee after Phase 1. If no, please explain why. (100 word max)

|  |  |
| --- | --- |
| **Service Type** | **Included in Global Fee** |
| Professional care (obstetricians and midwives) | (Yes/No) |
| Facility (hospital) care | (Yes/No) |
| Anesthesia services | (Yes/No) |
| Ultrasound and imaging (professional and technical services) | (Yes/No) |
| Lab services | (Yes/No) |
| Doula services | (Yes/No) |
| Lactation services | (Yes/No) |

1. Please list any services that are not identified above that are billed separately. (250 word max)

## Validation

1. Your organization warrants the accuracy of information submitted and acknowledges that **<Purchaser>** will rely on this information in making its selection and contracting with the successful organization. Your organization confirms that it followed the instructions provided and identified any deviations from specifications within its response. Your organization confirms that any instructions or specifications that it thought were unclear were clarified in advance of submitting this response. During the evaluation process, identified inconsistencies may be discussed, and if necessary, an independent audit of information provided may be conducted to validate your responses. If inaccurate representations are found to exist in your response, **<Purchaser>** reserves the right to reject your proposal. Please respond Agree or Disagree. If you disagree, please explain why. (250 word max)

1. https://www.leapfroggroup.org/ratings-reports/rate-episiotomy [↑](#footnote-ref-1)
2. The NTSV C-section measure identifies pregnancies that are unlikely to need surgical intervention during labor. This measure is used by The Leapfrog Hospital Survey and is endorsed by the Joint Commission, National Quality Forum (NQF) and CMS. The measure tracks the percent of nulliparous women [women who have not borne offspring] with a term [37 completed weeks or more], singleton baby [one fetus] in a vertex [head first] position [NTSV] who deliver via cesarean section. A lower rate indicates better performance with The Leapfrog Group’s target rate being 23.9% or lower. [↑](#footnote-ref-2)