Colorado Hospital Quality Incentive Payment Program and Maternity Bundled Payment Program

Colorado established two value-based payment arrangements with the goal of improving maternity care for Medicaid enrollees. The Hospital Quality Incentive Payment (HQIP) Program is a voluntary payment arrangement for hospitals providing services to Medicaid enrollees (CHASE 2019b).[1] It offers incentive payments to hospitals if they meet certain quality measures, which include measures on maternal health and perinatal care. In November 2020, Colorado launched the Maternity Bundled Payment Program (CHASE 2020a).[2] This voluntary model creates a payment incentive for obstetrics providers for performance on cost and quality metrics. Once fully implemented, providers will be financially penalized if they have high costs (i.e., costs above what the state consider to be acceptable) and financially rewarded if they have low costs (i.e., costs below what the state considers to be commendable).

Under contract with MACPAC, RTI International conducted interviews and examined five states (Arkansas, Connecticut, Colorado, North Carolina, and Tennessee) implementing value-based payment initiatives to improve maternity care in Medicaid. This case study includes an overview of the Colorado HQIP and maternity bundled payment program, details how each model is defined, describes the payment methodologies, and summarizes the available research on the models' effects on cost and quality.[3] MACPAC has also published case studies for the other study states, as well as an issue brief summarizing the key findings (MACPAC 2021a–e).

Hospital Quality Incentive Payment: Overview

HQIP established a value-based payment arrangement for hospitals that provide services to Medicaid enrollees and launched a maternal health and perinatal care measure set in 2018 (CHASE 2019b). The goal of the HQIP Program is to promote quality and reduce costs (CHASE 2019a). The program operates solely in the Medicaid market and participation is voluntary (COHI 2018).

Under HQIP, participating hospitals may receive bonus payments in addition to fee-for-service (FFS) payments for Medicaid services. Each quality measure has a point value and points are summed and divided into five tiers based on hospital performance. Dollar amounts per hospital discharge are assigned to each tier to allow larger rewards for hospitals in higher tiers. The bonus payments are based on performance across quality measures, adjusted for the total number of Medicaid-funded discharges, times the dollar multiplier for that tier. There are no financial penalties for low performance and scores are not adjusted for patient risk.

Design Parameters

The HQIP bonus payment is calculated using Medicaid discharges, as the target population comprises Medicaid enrollees receiving services at hospitals participating in HQIP. However, many of the HQIP

measures require hospitals to implement initiatives that could affect all of their relevant patients (CHASE 2019a).

Market participation. Colorado Medicaid is the sole payer in this model.

Provider participation. Hospital participation in HQIP is voluntary. During federal fiscal year (FFY) 2018—2019, 76 hospitals received HQIP payments (CHASE 2020a). In 2020, 54 out of 56 labor and delivery hospitals participated (Haynes 2020).

Patient population and attribution. There is no patient attribution. All Medicaid discharges from a hospital may factor into the payment.

Exclusions. There are no patient exclusions for HQIP.

Payment Methodology

Participating hospitals continue to receive FFS payments for deliveries but are also eligible for bonus payments. These payments are calculated based on performance across a set of measures and the Medicaid volume for each hospital. The methodology does not include risk adjustment for patient factors (CHASE 2019a).

Quality measures

HQIP bonus payments are based on 13 measures in three groups: maternal health and perinatal care, patient safety, and patient experience. The maternal health and perinatal care measure group includes six measures, the patient safety group includes three measures, and patient experience includes four measures (CHASE 2020a). A fourth group of maintenance measures are not assigned points for bonus payments. Maintenance measures are considered important to quality of care and patient safety but have little room for improvement over current statewide performance levels (CHASE 2020b).

As of 2020, seven performance and maintenance measures pertain to maternal health and perinatal care (Table 1). Six are assigned points and tied to payment as part of the maternal health and perinatal care measures set. The seventh measure, early elective deliveries, is part of the maintenance measure group and is not tied to payment. A measure to reduce racial and ethnic disparities in peripartum outcomes was added to the patient safety group for 2020; however, data collection was postponed due to COVID-19 (CHASE 2020b). Additional information on the points associated with the quality measures is presented in Table A-1.

TABLE 1. Hospital Quality Incentive Payment Program: Maternity Care Performance Measures, 2019

Quality measure	Measure type	Scoring method
Exclusive breast feeding	Structure	Pay for reporting and points depending on activity
Cesarean-section	Outcome	Peer-comparison ranking method – scoring is based on relative performance to other participating hospitals.
Perinatal depression and anxiety	Structure	Pay for reporting – scoring tiered depending on number of elements in place

Maternal emergencies	Structure	Pay for reporting – points awarded on an all or nothing basis
Reproductive life and family planning	Structure	Pay for reporting – points awarded on an all or nothing basis
Incidence of episiotomy	Outcome	Peer-comparison ranking method – scoring in based on relative performance to other participating hospitals
Early elective deliveries	Outcome	N/A
Reduction in peripartum racial and ethnic disparities	Structure	N/A

Notes: N/A is not applicable. The early elective measure is not tied to payment and is not scored. The measure pertaining to racial and ethnic disparities was originally planned for implementation in the 2020 HQIP program year. However, due to the COVID-19 global pandemic, it was not added until 2021.
Source: CHASE 2019a.

Payment calculation

HQIP bonus payments are determined by hospital performance on quality measures and Medicaid patient volume. During federal fiscal years 2018-19, HQIP payments totaled $90.4 million with 76 hospitals receiving payments (CHASE 2020a).

Quality points. Hospitals received up to five points per measure for a potential total of 65 points (Table 2). Points are assigned through a combination of reporting requirements and the performance thresholds unique to each measure and are summed across measures to obtain a total quality score for the hospital (CHASE 2020a). Data to assess performance are obtained from a variety of sources, including hospital reports to the Medicaid agency, Medicaid claims data, and Hospital Compare data from the Colorado Hospital Report Card (CHASE 2019a).

Performance threshold. To assign points for the next performance year, the HQIP subcommittee retrospectively evaluates statewide performance on each measure relative to national or state averages. For example, for the perinatal depression and anxiety criteria, hospitals can receive one, three, or five points, with the first point awarded for reporting only (Table A-1). Performance thresholds vary and maybe an absolute target or relative to other participating hospitals.

Tiers. Hospitals are grouped into tiers based on the total number of points they earn across all measures (Table 2). Hospitals that earn more points are assigned to higher tiers and a higher dollar multiplier (defined as the dollars per discharge point) (CHASE 2020a).

TABLE 2. Hospital Quality Incentive Payment Program: Bonus Dollars per Adjusted Discharge Point, FY 2018-2019

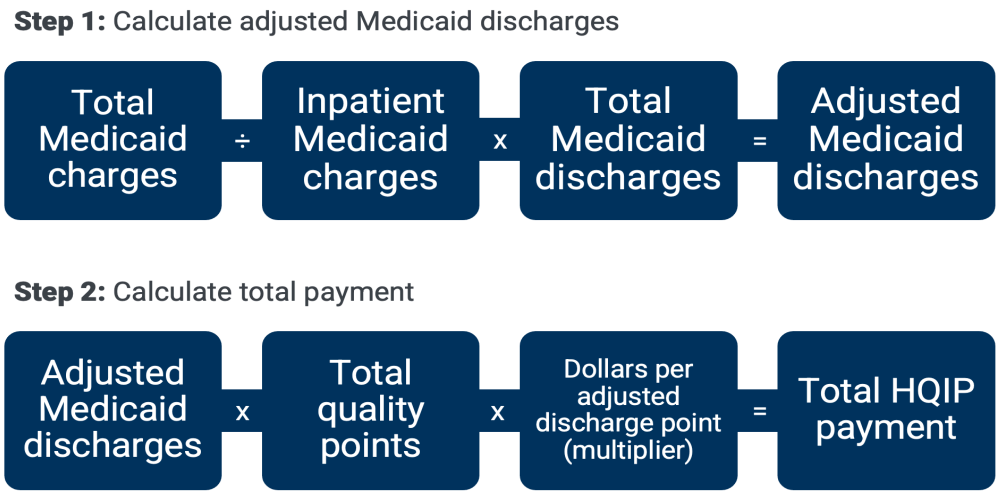
Tier	Quality points awarded	Dollars per adjusted discharge point (multiplier)
0	0—19	$0.00
1	20—35	3.13
2	36—50	6.26
3	51—65	9.39
4	66—80*	12.52

Notes: FY is fiscal year. In 2019, hospitals could earn a maximum of 80 quality points tied to 16 measures. In 2020, a hospital could earn a total of 65 points tied to 13 measures; the four performance tiers will be adjusted to reflect this maximum point allowance.
Source: CHASE 2020a.

Payment calculation. HQIP bonus payments are calculated using both quality metrics and Medicaid patient volume. To account for Medicaid volume at a given hospital, adjusted Medicaid discharges are calculated. This number is meant to represent the total Medicaid inpatient and outpatient volume combined (step 1 in Figure 1) (CHASE 2019a).

Next, the adjusted Medicaid discharges is multiplied by the total quality points earned. This number, referred to as total discharge points, is then multiplied by the hospital's tier-specific dollar multiplier to arrive at the bonus payment (step 2 in Figure 1) (CHASE 2020a). Hospitals that have total point scores in Tier 0 are assigned a multiplier of zero and receive no bonus payment (CHASE 2019a).

FIGURE 1. Bonus Payment Calculation



Source: CHASE 2019b.

The experience of two different hospitals demonstrates how HQIP bonus payments are affected by both quality points and hospital volume (Figures 2 and 3). Avista Adventist Hospital received 58 quality points. As a Tier 3 hospital, its multiplier was $9.39 per adjusted discharge point. With 2,009 Medicaid discharges, it received a $1,094,142 HQIP payment (CHASE 2020a). While Avista Adventist had fewer quality points and was in a lower tier than Kit Carson County Memorial Hospital, the much larger patient volume (2,009 adjusted Medicaid discharges compared to 181) resulted in a much larger total HQIP payment.

FIGURE 2. Bonus Payment for Avista Adventist Hospital

Source: CHASE 2020a.

Kit Carson received 67 quality points. As a Tier 4 hospital, its multiplier was $12.52 per adjusted discharge point. Kit Carson had 181 Medicaid discharges and thus received a $154,830 payment (CHASE 2020a). While Kit Carson had relatively few discharges compared Avista Adventist, it received a proportionately larger bonus per discharge. Kit Carson had more quality points and received a larger bonus per point (by being in a higher tier) for each discharge. The bonus payment per adjusted Medicaid discharge for Avista Adventist was $544.62 compared to $855.41 for Kit Carson.

FIGURE 3. Bonus Payment for Kit Carson Hospital

Source: CHASE 2020a.

Model Effects

The HQIP annual report includes the total points earned by each hospital as well as adjusted discharges and total payments. However, the report does not include information on specific performance measures or payments. Cost savings are not measured as part of HQIP. Information on changes in maternal or birth health outcomes is not available (CHASE 2020a).

The Maternity Bundled Payment Program: Overview

The Maternity Bundled Payment Program launched in November 2020 as part of an additional set of alternative payment models in Colorado Medicaid. It started with an initial cohort of three practices, representing approximately 20 percent of all Medicaid births in the state. The goal is to promote continuity of care and health outcomes for mothers and their babies while controlling costs. This model also seeks to address the needs of mothers with substance use disorders (SUD) (CO DHCPF 2020b, 2020c). Medicaid is the sole payer and participation among Medicaid providers is voluntary (CO DHCPF 2020a, 2020c).

Under the model, the accountable provider is held financially accountable for the episode's cost and quality.[4] In the first year of participation, the accountable provider receives credit for reporting on a set of quality measures; in the second and subsequent years, they are subject to gainsharing and risk-sharing payments based on cost and quality. Payments are made retrospectively, within 90 days of the end of a performance

period. Provider performance is assessed relative to individual provider performance in previous years and is not compared to other providers (CO DHCPF 2020a).

Design Parameters

Duration. The perinatal episode covers three windows: prenatal (280 days before delivery), delivery (10 days surrounding delivery), and postpartum (60 days after delivery). If no inpatient hospitalization occurs within 60 days of delivery, the postpartum window closes and the episode ends. It extends beyond 60 days if an inpatient hospitalization began during this period (CO DHCPF 2020b).

Market participation. Colorado Medicaid is the sole payer in this model. The commercial market does not participate.

Provider participation. Provider participation is voluntary. Providers or health systems are eligible to participate if they have at least 500 Medicaid-covered births each year for the last two complete fiscal years (2017-2018 and 2018-2019). Physicians and nurse midwives are eligible to participate in the program (CO DHCPF 2020a).

The accountable provider for the episode is defined by the state as the provider with the greatest ability to influence the episode's cost and quality of care. Colorado Medicaid allows practices to elect the accountable provider based on either labor and delivery or prenatal care claims. An episode must include prenatal care and delivery services by the same participating obstetric group or health system, although not necessarily the same provider (CO DHCPF 2020b).

Patient population and attribution. The model serves Medicaid-covered pregnant enrollees, including high-risk patients. Patients are only attributed to the model if their provider elects to participate and is deemed the accountable provider.

Exclusions. Episodes may be excluded if they meet one of the following criteria:

- the patient is dually eligible for Medicaid and Medicare,
- there is third-party liability on the attribution claim,
- no prenatal services were supplied by the accountable provider or group practice,
- the patient died,
- there are incomplete episode claims,
- there is no professional claim for delivery,
- the episode is a high-cost outlier (exceeding the 95th percentile), or
- the patient is an emergency Medicaid recipient (CO DHCPF 2020a).

Payment Methodology

Accountable providers receive FFS payments for care provided during the perinatal episode. In the first year of program participation, providers report on quality measures to establish a performance baseline and only gainsharing payments will be available; in the second and subsequent years of participation, quality measures are tied to payment and providers are subject to both gainsharing and risk sharing (CO DHCPF

2020b). Payments are made retrospectively, within 90 days of the end of a performance period. Provider performance is assessed relative to individual performance in previous years.

Cost thresholds

The model includes two cost thresholds – a commendable and acceptable level. Accountable providers may fall into one of three categories based on average episode costs relative to these thresholds:

- The provider has commendable performance if costs are lower than the commendable threshold, which makes them eligible for a gainsharing payment.
- The provider has risk-sharing performance if costs are above the acceptable threshold, subjecting them to a risk-sharing payment.
- The provider has acceptable performance if costs fall between the thresholds, resulting in no payment change.

The acceptable cost threshold is calculated by averaging the cost for all qualifying maternal episodes over the past two years for each accountable provider. The commendable cost threshold is calculated by applying a minimum savings rate to the acceptable threshold (Table 3).[5]

TABLE 3. Maternity Bundled Payment Program: Incentive Payment Thresholds Example

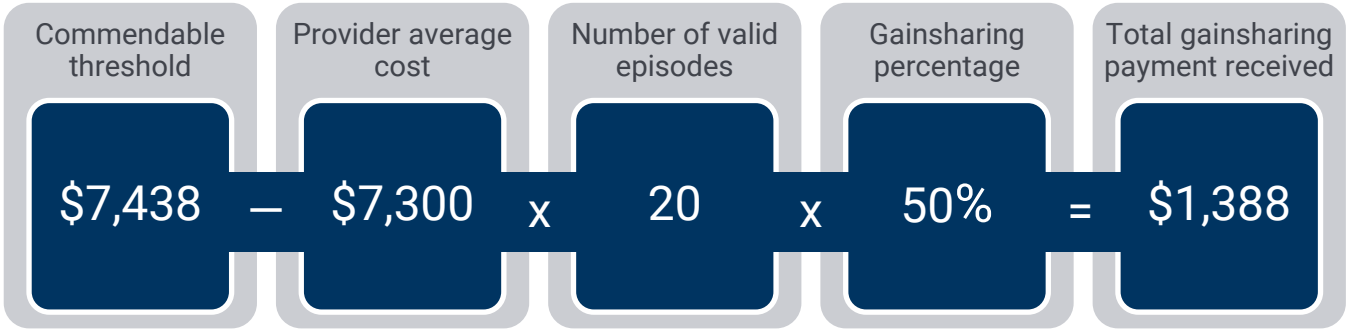
Threshold category	Value
Non-SUD acceptable threshold	$7,652.03
Non-SUD commendable threshold	$7,438.79
SUD acceptable threshold	$8,131.20
SUD commendable threshold	$7,791.41
Gainsharing percentage (non-SUD and SUD)	50%
Risk-sharing percentage (non-SUD and SUD)	50%

Notes: SUD is substance use disorder.
Source: CO DHCPF n.d.

The Colorado episode model differs from other Medicaid episode or bundled payment models in two key ways. First, the cost thresholds are based on each individual provider's past performance rather than the statewide average.[6] Second, cost thresholds are calculated separately for patients with SUD diagnoses.[7] Colorado Medicaid uses two years of individual provider claims to calculate the cost thresholds. Both thresholds (for patients with and without SUD) are recalculated every two years for each accountable provider (CO DHCPF 2020a, 2020b).

Commendable performance. Accountable providers can earn 50 percent of their realized savings if their average episode cost is less than their commendable threshold and they meet quality measure reporting requirements. As an example of a gainsharing calculation, an accountable provider averages $7,300 in costs per perinatal episode, which is $138.79 lower than her commendable threshold of $7,438.79. During the performance year, this provider was the accountable provider for 20 episodes resulting in $2,775.80 in costs lower than the commendable threshold. The provider is eligible to receive 50 percent of the savings resulting in a gainsharing payment of $1,387.90. Gainsharing is contingent upon meeting quality measurement benchmarks (Figure 4).

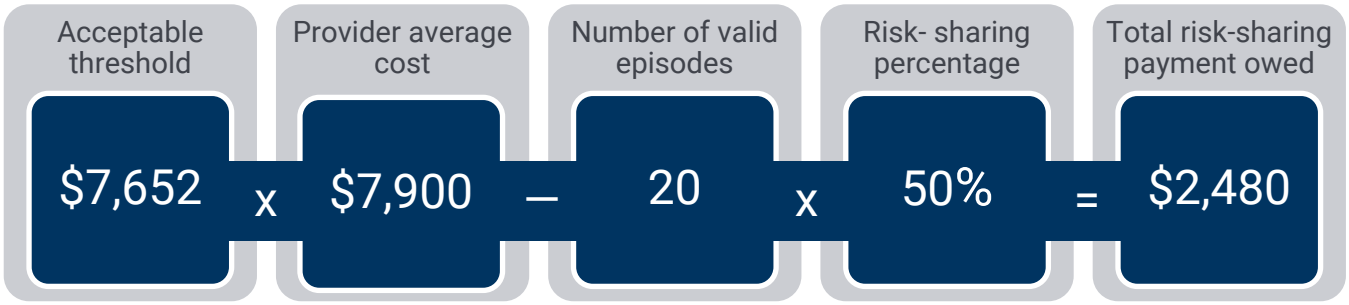
FIGURE 4. Maternity Bundled Payment Program: Gainsharing Example



Source: RTI 2021.

Risk-sharing performance. In the second and subsequent years of participation, providers are subject to risk-sharing payments if their average episode cost exceeds their acceptable threshold. As an example, a provider averages $7,900 in risk -adjusted costs per episode, which is $247.97 higher than the provider's acceptable threshold of $7,652.03. During the performance year, this provider was the accountable provider for 20 episodes resulting in $4,959.40 in costs above the threshold. The provider is accountable for 50 percent of the cost above the threshold resulting in a risk-sharing payment of $2,479.70 (Figure 5).

FIGURE 5. The Maternity Bundled Payment Program, Risk-Sharing Example



Source: RTI 2021.

Acceptable performance. If the provider's average cost is between the acceptable and commendable levels, the provider will not receive a gainsharing payment or be subject to a risk-sharing payment. As such, there will be no change in payment (CO DHCPF 2020a).

Quality measures

Performance thresholds have yet to be determined and will be based on historical performance of participating practices. In the first year of program participation, quality metrics are used to establish a practice's performance baseline (CO DHCPF 2020b).

Five quality measures will be tied to payment beginning in the second year of participation for practices participating since rollout (November 1, 2021 through October 31, 2022): prenatal behavioral risk assessment, postpartum depression screening, cesarean birth, postpartum contraceptive care, and elective

deliveries (Table 4). Quality benchmarks for these measures will be established using the data from the first-year reporting (CO DHCPF 2020b). Seven quality measures will be tracked but will not be tied to payment.

TABLE 4. The Maternity Bundled Payment Program: Quality Measures

Measure	Expected direction
Measures tied to payment (beginning in year 2 of implementation)	
Prenatal behavioral risk assessment	Higher rates are indicative of better performance
Postpartum depression screening	Higher rates are indicative of better performance
Cesarean birth	Lower rates are indicative of better performance
Postpartum contraceptive care	Higher rates are indicative of better performance
Elective delivery	Lower rates are indicative of better performance
Measures for reporting only	
Prenatal HIV screening	Higher rates are indicative of better performance
Screenings: group B Streptococcus, gestational diabetes, hepatitis B	Higher rates are indicative of better performance
Prenatal immunization status	Higher rates are indicative of better performance
Prenatal and postpartum care	Higher rates are indicative of better performance
Unexpected complications in term newborns	Lower rates are indicative of better performance
Percentage of low birthweight babies	Lower rates are indicative of better performance
Exclusive breastmilk feeding	Higher rates are indicative of better performance

Source: CO DHCPF 2020b.

Model Effects

As the maternity bundled payment is in its first year of implementation, there are no evaluations or data on its effectiveness.

Endnotes

[1] The HQIP Program is administered by the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board, a government-owned business that operates within HCPF. The Board is composed of five hospital members, one statewide hospital organization member, one health insurance organization or carrier member, one health care industry member, two consumers, one health insurance member, and two Department members. The CHASE Board is tasked with recommending reforms related to hospital reimbursement and quality incentive payments to increase accountability, performance, and reporting.

[2] The terms bundled payments and episode of care payments are often used interchangeably. While Colorado refers to its program as a bundled payment, this summary will refer to the bundled payment as an episode of care or episode.

[3] MACPAC developed this case study based on the results from RTI International's interviews and unpublished state profiles. Colorado Medicaid reviewed the unpublished profile for accuracy.

[4] In Colorado, the accountable provider is referred to as the Principal Accountable Provider (PAP).

[5] The minimum savings rate is based on the distribution of a provider's episodes to ensure that savings are a result of performance improvements; however, additional information on the minimum savings rate was not available.

[6] Practices interested in participating in the model are able to view their predicted acceptable and commendable cost thresholds before electing to formally participate.

[7] Patients with a qualifying SUD claim or diagnosis that occurs between six months before the episode and six months following the episode will be included in the SUD payment thresholds (CO Dept. of Health Care Policy and Financing 2020a).

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Appendix: Colorado Hospital Quality Incentive Payment Program

TABLE A-1. Hospital Quality Incentive Payment Program: Maternity Care Measures

Quality measure	Measure type	Measure subcomponents and scoring	Scoring method
Exclusive breast feeding	Structure	Maximum points: 5 points	Pay for reporting and points depending on activity
		Possible point values: 3 points, 4 points, or 5 points	
		Scoring:	
		Hospitals earn 1 point for reporting rate of exclusive breast milk feeding and must also complete one of the following activities:	
		+ 2 points: written breastfeeding policies for hospitals not officially on the pathway to Baby-Friendly designations including implementation of all five of the Ten Steps to Successful Breastfeeding and a copy of the policy and how staff are trained	
		+ 3 points: 4-D Pathway to Baby-Friendly Designation by moving from discovery to development phase, development to dissemination phase, or dissemination phase to designation phase	
		+ 4 points: receiving or maintaining Baby-Friendly Designation	
Cesarean-section	Outcome	Maximum points: 5 points	Peer-comparison ranking method – scoring is based on relative performance to other participating hospitals.
		Possible point values: 1 point, 3 points, or 5 points	
		Scoring:	
		Requirements include describing the process for notifying physicians of their respective cesarean delivery rates compared to other physicians and the hospital average via regular reports as well as executive meetings.	
		The report must be uploaded and include at a minimum	
		1) Physician's cesarean delivery rate	
		2) Individual rates of other physicians for peer-to-peer comparison, and	
		3) The hospitals average cesarean delivery rate.	
		Hospitals meeting the reporting criteria will be eligible to earn points which are assigned based on relative performance. Hospitals performing worse than minimum standard 23.9% (Healthy People, 2020) receive no points and the remaining divided into terciles.	

Quality measure	Measure type	Measure subcomponents and scoring	Scoring method
Perinatal depression and anxiety	Structure	Maximum points: 5 points	Pay for reporting – scoring tiered depending on number of elements in place
		Possible point values: 1 point, 3 points, or 5 points	
		Scoring:	
		Hospitals report the requested information and documentation that addresses each of the 4 R's (Readiness, Recognition and Prevention, Response, Reporting/Systems Learning). Screening rates under the Reporting/Systems Learning category must be greater than 0 in order to receive points.	
		Hospitals earn 1 point for submitting complete information on at least 2 of the 4 R's. They may earn additional points for submitting complete information on additional R's as follows:	
		+ 2 points: Submitting complete information on 3 R's, OR	
		+ 4 points: Submitting complete information on 4 R's	
Maternal emergencies	Structure	Maximum Points: 5 points	Pay for reporting – points awarded on an all or nothing basis
		Possible Point Values: 5 points	
		Scoring:	
		Hospitals report on the structure and process measures through attestation, narratives that describe processes and provide supporting evidence. The Medicaid agency will calculate the outcome measures based on claims data and evaluate structure and process measures based on the 4 R's (Readiness, Recognition and Prevention, Response, Reporting/Systems Learning).	
		The measures include:	
		1) Hypertension and preeclampsia processes;	
		2) Obstetric-specific resources and protocols;	
		3) Systems to perform regular debriefs and system-level reviews.	
		Hospitals earn 5 points for answering structure measure 1 (regarding hypertension or preeclampsia policy), and two of three remaining structure measures.	
Reproductive life and family planning	Structure	Maximum Points: 5 points	Pay for reporting – points awarded on an all or nothing basis
		Possible Point Values: 5 points	
		Scoring:	

Quality measure	Measure type	Measure subcomponents and scoring	Scoring method
		Hospitals earn 5 points for attesting if they have a program in place that offers counseling about all forms of postpartum contraception in a context that allows for informed decision making.	
		Additionally, LARC should be offered as an effective option for postpartum contraception. The Medicaid agency will calculate LARC insertion rates (within three days of birth) and other effective means of birth control (within three days of birth) using claims data among women ages 15 through 44 who had a live birth.	
Incidence of episiotomy	Outcome	Maximum Points: 5 points	Peer-comparison ranking method – scoring in based on relative performance to other participating hospitals.
		Possible Point Values: 1 point, 3 points, or 5 points	
		Scoring:	
		This claims-based outcome measure is the number of episiotomy procedures performed on women undergoing a vaginal delivery divided by the total number of vaginal deliveries during the same period.	
		The proposed scoring methodology is to award points for those better than the Leapfrog benchmark of five percent. Hospitals that perform below the benchmark may be awarded points based on improvement.	
		Practices earn 1 point, 3 points, or 5 points based on their performance compared to a quality threshold.	
Early elective deliveries	Outcome	There are no points or payment tied to early elective deliveries as it is a maintenance measure.	N/A
Reduction in peripartum racial and ethnic disparities	Structure	Maximum Points: 10 points	N/A
		Possible Point Values: 5 points, 6 points, 7 points, 8 points, 9 points, or 10 points	
		Scoring:	
		Hospitals earn 5 points for having all elements of “Readiness” in place. Hospitals may earn up to 5 additional points for having elements of the remaining “R” elements in place (1 additional point per element in place from Recognition and Prevention, Response, and Reporting/Systems Learning categories).	
		Readiness:	

Quality measure	Measure type	Measure subcomponents and scoring	Scoring method
		1) Does the hospital's system accurately document self-identified race, ethnicity, and primary language?	
		a) Does the hospital provide system-wide staff education and training on how to ask demographic intake questions?	
		b) How does your hospital ensure that patients understand why race, ethnicity, and language data are being collected?	
		c) Are race, ethnicity, and language data accessible in the electronic medical record?	
		d) Does the hospital evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English?	
		e) Does the hospital educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system?	
		2) Does the hospital provide staff-wide education on:	
		a) Peripartum racial and ethnic disparities and their root causes?	
		b) Best practices for shared decision making? c.	
		3) Does the hospital engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams?	
		Recognition and Prevention	
		1) Does the hospital provide staff-wide education on implicit bias?	
		2) Does the hospital provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the maternal patient, in a clear and simple format that summarizes information most pertinent to perinatal care and wellness?	
		3) Does the hospital have a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect?	
		Response	
		1) Does the hospital ensure that providers and staff engage in best practices for shared decision making?	

Quality measure	Measure type	Measure subcomponents and scoring	Scoring method
		2) Does the hospital have a process to ensure a timely and tailored response to each report of inequity or disrespect?	
		3) Does the hospital have discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider?	
		Reporting/Systems Learning	
		1) Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture?	
		2) Does the hospital have a process in place for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and ethnicity and disseminate the information internally to staff and leadership? This could take the form of a dashboard, regularly distributed reports or other reporting and monitoring tools.	
		3) Does the hospital implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes?	
		4) Does the hospital consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics?	
		Does the hospital have a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?	

Notes: LARC is long-acting reversible contraception. The racial disparities measure was originally planned for implementation in the 2020 HQIP program year. However, in response to the COVID-19 global pandemic, implementation has been postponed until 2021.
Source: CHASE 2019a.