Transforming Maternity Care Blueprint for Action
Payment Reform to Align Incentives with Quality

This document presents the content of the Transforming Maternity Care Blueprint for Action that addresses one of eleven critical focus areas. The complete Blueprint for Action can be accessed at http://transform.childbirthconnection.org/blueprint

Problems

Poor return on investment
The United States spends far more than all other countries on health care, yet lags behind many on currently available global maternal and newborn indicators. Maternal and newborn hospital charges ($86 billion in 2006) far exceed those of any other hospital condition. When applied to 4.3 million births annually, care that is of poor value especially impacts employers and private insurers, who paid for 50% of births in 2006, and taxpayers and Medicaid programs, who paid for 42%.

Negative and perverse incentives
The current global fee maternity care payment system creates incentives that are poorly aligned with overall quality and value. Perverse financial incentives discourage coordination of services and encourage clinicians and hospitals to overuse some interventions. For example, rather than focusing on the goal of an overall optimal outcome of maternity care across the full episode, the current reimbursement system incents each individual provider caring for a woman to seek opportunities to get paid for discrete, specific services that can be charged outside of global fees. Simultaneously, the system has inadequate incentives for important aspects of maternity care that do not generate significant reimbursement. These include many safe and effective lower cost interventions that address widespread concerns but are reimbursed at lower rates or are not covered at all, such as smoking cessation help for pregnant women and breastfeeding support. Reforming payment systems has the potential to improve practice, reduce morbidity, and save lives of mothers and babies, while simultaneously improving value.

Misalignment of payment system with maternity care goals
Volume-driven reimbursement increases cost without improving health outcomes. Providing more services than are needed does not improve health and increases the risk of harm, while driving up spending. Supportive, preventive care to avoid problems along with early detection and appropriate intervention when they occur promotes wellness and carries least risk of harm. However, there is no alignment between caregivers and institutions to coordinate care and share expenses and revenue for desired outcomes; in fact, legislative hurdles prevent cost sharing among facilities and providers.

These problems also adversely impact health professions education. In current educational settings, new professionals learn to value and provide acute, hospital-based care to a primarily healthy population. Faculty practice plans with productivity formulas incentivize service volume and discourage teaching time.
Many women assume that widely used interventions are in their best interest. Women are generally not aware that they may be exposed to avoidable and potentially harmful interventions at present because of a lack of transparent comparative performance data to guide decisions and limited access to some effective high-value alternatives. Thus, those most affected by systemic misaligned incentives are not well-positioned to advocate for system change.

System Goals
- All women have comprehensive coverage over the full episode of maternity care.
- Payment systems are designed to support and not undermine the goals of care.
- Payment redesign is accompanied by redesign of maternity care delivery systems and standard content of care.
- Payment reform starts with regional pilots and demonstration projects with national support that are carefully evaluated and refined to ensure they meet intended objectives.

Major Recommendations and Action Steps
1. Advance efforts toward comprehensive payment reform through a restructured payment model that bundles payment for the full episode of maternity care for women and newborns.
   - Design a model maternity care payment system, adapting the generic bundled payment system described in From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs to Maternity Care (Miller, 2008).
   - Ensure the following features for piloting and assessment:
     - Capitated payments to entities encompassing providers and facilities for the full episode of combined maternal and newborn care.
     - Maternity care teams that foster high-quality, high-value care and desired outcomes.
     - Risk adjustment of payments (e.g., for age, marital status, race, ethnicity, socioeconomic status, and language).
     - Basic payment for the vast majority of episodes, as 95% of births, including those with minor complications, have largely homogenous costs aside from mode of birth (Schmitt, Sneed, & Phibbs, 2006).
     - Exclusion of outliers with extreme variance or very high costs (e.g., extreme prematurity or congenital anomalies that require major surgery) to minimize need for caps and/or secondary insurance and enable participation of small hospitals, clinician groups, and birth centers.
     - Bonuses for attaining or progressing toward maternal and newborn outcome targets.
     - Bonuses for priority components of postpartum care that may not be incentivized, such as lactation support, or screening and treatment of maternal depression.
     - Mechanism for cost and revenue sharing among caregivers and facilities.
     - Shifting of some of any savings realized to beneficial care that has not been uniformly covered.
   - To provide the clinical content for the reformed payment structure, develop an essential package of evidence-based maternity services focused on prevention and wellness, plus indications for additional services as needed. (See the Blueprint section on Scope of Covered Services for Maternity Care.)
• Coordinate care and services through implementation of a Woman- and Family-Centered Maternity Care Home model that fosters continuity of care, gives priority to prevention and health promotion, promotes accountability for outcomes, and offers high value for purchasers. (See the Blueprint section on Coordination of Maternity Care Across Time, Settings, and Disciplines.)

2. Pilot the model payment reform strategy through regional demonstration projects funded through competitive Request for Funding Proposals, and disseminate successful strategies for replication and widespread uptake.
   • Create regional payment pilot projects involving health systems and all payors in a region to pilot payment systems that align quality and value.
   • Encourage state Medicaid payors to coordinate implementation of the bundling payment strategy, given that they are the primary payor of maternity care for a large segment of the childbearing population and have policy levers that can be mobilized in public programs.
   • Form regional quality collaboratives including state or regional Medicaid agencies and private insurers along with providers and managed care organizations to decide on indicators and targets. Design appropriate incentives (e.g., sharing of cost savings with providers) and/or disincentives to help providers meet them, and test the outcomes of alternative payment models based on these determinants.
   • Encourage hospitals and health systems leaders to propose value-based reimbursement initiatives based on their clinical experience that can be implemented promptly and that will enhance safety and quality, decrease waste, and promote cost containment.
   • Identify effective maternity services that are not being reliably delivered and incentivize provision of these services through Medicaid and private insurance programs. Implement value-based purchasing initiatives within managed care programs to improve access to preventive prenatal services with proven effectiveness such as first trimester care, smoking cessation and other behavioral interventions, and dental care.
   • Within hospitals and health systems, use personnel policies to remove incentives for overuse of unnecessary interventions and encourage appropriate care, e.g., hiring salaried maternity care providers or redistributing savings from quality/value initiatives to providers through bonuses for meeting benchmarks or revenue sharing.
   • Inform childbearing families about higher and lower value options for maternity care, and implement cost-sharing policies when they select higher value care.

3. While working toward comprehensive payment reform, implement selected policies immediately to address some severe misalignments in the current payment system.
   • Medicaid and private insurers should develop an approach for maternity services similar to the Medicare “Do Not Pay List” strategy enacted by CMS. Payment systems should not reimburse for errors or avoidable adverse events, or pay for overuse of procedures with higher costs and poorer maternal and newborn outcomes than alternatives (Miller, 2007).
   • Adjust the differential in payment between cesarean section and vaginal birth to providers and hospitals to remove potential economic incentive for cesarean deliveries.
   • Redesign reimbursement strategies to promote and support hospitals and providers who safely offer VBAC. Engage measure developers to define
indicators for VBAC attempt and enhanced VBAC surveillance, and then pay all payors a 10% to 15% increment for enhanced surveillance when a woman with a previous cesarean labors. Track the proportion of women with a vaginal birth among women planning VBAC, and report provider and hospital performance to Medicaid and private insurers, caregivers, and the public.

- Eliminate financial rewards for inappropriate newborn care, e.g., term infants requiring nonintensive care phototherapy services, or infants born at less than 32 weeks or weighing less than 1,500 grams who are born in hospitals without adequate nursery level or without adequate delivery volume, when they are located in densely populated areas.
- Modify maternity-related billing codes to enable collection of more meaningful quality information through claims data, to be used in value-based purchasing and pay for performance (P4P): 1) unbundle CPT codes for prenatal visits or create an option to bill for a single visit so that payors can use this information for quality assurance of the timing, number, and content of prenatal visits; 2) separate codes for scheduled cesarean sections, emergency cesarean sections, and cesarean sections after inductions; 3) separate codes for spontaneous and induced vaginal births; 4) identify codes for indicating trimester of pregnancy in which prenatal visits occur, and gestational age of the newborn at delivery for intrapartum and/or newborn care.
- Develop mechanisms to encourage early initiation of prenatal care, such as paying more for first trimester prenatal visits. Remove or reduce financial barriers to prenatal and postpartum care (e.g., co-pays, coinsurance, deductibles). As high-quality evidence emerges, develop evidence-based guidelines and billing codes for effective preconception care practices.

4. Develop critical enabling factors and conditions for payment reform in concert with payment reform efforts.

- Engage nationally recognized organizations to launch an effective public awareness campaign using conventional and new media to raise public awareness of the problems of overuse and under-use in maternity care and the need to eliminate perverse incentives that favor lower quality, more costly options in the current system.
- Reach out to members of Congress and administration leaders involved with health care reform, key federal agencies, and leading national organizations about the need to rectify perverse financial incentives in maternity care payment.
- Ensure that major national health care reform legislation removes current barriers to access to comprehensive maternity services through the private health insurance market. These include lack of maternity coverage owing to preexisting conditions or to obtaining benefits through small business employers, inadequate level of coverage, and surcharges.
- Promote the use of health IT systems that connect outpatient and inpatient care settings to foster care coordination, value-based reimbursement decision making, and data-driven quality improvement. Pay particular attention to ensure equitable distribution of health IT to safety net providers who care for low-income women and their newborns. (For details on this crucial tool for payment reform and efficient provision of quality care, see the Blueprint section on Development and Use of Health Information Technology.)
- Align the payment system for health professions education to national goals for high-quality, high-value care and workforce development based on outcomes and performance data. Unlink health professions education funding from Medicare
and from case payments and expand it to include all cadres of qualified maternity care providers. (See the Blueprint section on Scope, Availability and Content of Health Professions Education.)

Lead Responsibilities
Payment reform should be based on collaborative multi-stakeholder efforts and support. Leadership for payment reform should come from diverse stakeholders, including Congress, CMS, the Agency for Healthcare Research and Quality (AHRQ), private insurers, private foundations, and health care quality organizations and collaboratives. The analytic and advisory role of the Medicaid and CHIP Payment and Access Commission (MACPAC) should encompass maternity care owing to Medicaid’s considerable responsibility for this care. To address resistance to change, entities that authorize and pilot payment reform should engage a broad coalition of supporters of such reform, including consumers and their advocates, maternity professional organizations, and quality organizations, highlighting potential gains and the consequences of failure to improve care.

References
