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RECOMMENDATIONS OF THE ILLINOIS MATERNITY CARE PAYMENT SUMMIT November 29, 2011

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I. Background

On November 29, 2011, the Midwest Business Group on Health, Quality Quest for Health of Illinois, and the Illinois Chapter of the March of Dimes convened a group of employers, government agencies, health plans, hospitals, physicians, and other healthcare providers to discuss how to change healthcare payment systems and health plan benefit designs to achieve better outcomes in maternity care. The Payment Summit was designed to build on the efforts of MBGH, Quest, and the March of Dimes to reduce the number of non-medically related early deliveries in Illinois as well as to support a broader range of quality improvements in maternity care. Funding for the Summit was provided under a grant program to promote community improvements sponsored by the National Business Coalition on Health and United Health Foundation.

The participants in the Summit worked collaboratively through the day to develop a consensus on the kinds of payment systems and health plan benefits for maternity care that Illinois should have in place within five years (i.e., by 2016) and to identify the steps that would be needed to transition to those improved structures.

II. What Payment Systems and Benefit Designs for Maternity Care Should Look Like in Illinois in Five Years

A. Bundled Payments for Labor, Delivery, and Neonatal Care

Instead of paying hospitals, birth centers, physicians, and certified nurse midwives separately for labor and delivery services, a single, prospectively-defined amount should be paid to cover the expected cost of both hospital care and the services of all physicians, midwives, and other professionals involved in a mother's care during and immediately following labor and delivery.

In addition, instead of paying separately for neonatal care of the infant, the single payment should also cover the expected cost of neonatal care of the infant, including any neonatal intensive care (NICU) services.

The amount of the payment should be adjusted based on maternal risk factors and complications associated with the pregnancy in order to reflect the fact that more complicated pregnancies and fetal problems will require more complex care, and to discourage providers from "cherry-picking" lower-risk cases. Also, additional (outlier) payments should be made to cover all or part of the extra costs of care for mothers or infants who require an unusually high number of hospital or physician services. However, the payment would not be increased to cover additional services that are provided for discretionary reasons or for services that are required as a result of elective procedures, such as non-medically indicated early term deliveries.

The risk factors used to adjust payment levels should be based on objective factors about a mother or baby that experts agree make it likely that additional services will be needed in order

to delivery high quality care. The risk factors attributed to specific patients should be monitored by an independent, neutral organization to encourage accurate coding.

Special outlier payments or other payment adjustments may be needed to help the providers receiving the bundled payment to manage costs when certain services can only be provided by other providers that are “out of network” or that charge high prices for specialized care (e.g., transfers for NICU care).

Hospitals, birth centers, physicians, and nurse midwives will need to select or form an appropriate entity which can contract with payers to accept the single payment and divide it among the participating providers.

B. Warrantied Payments for Labor and Delivery

No additional payment should be made to maternity care providers for services needed to address a preventable adverse event that occurs during labor and delivery. However, the amount of the payment for labor, delivery, and neonatal care should be set at a level which is adequate to cover both (1) the cost of problem-free labor and delivery and (2) the costs of treating achievable low rates of preventable adverse events for mothers and infants who have similar risk factors and pregnancy complications.

If physicians who were not involved in the labor and delivery are needed to treat the result of a preventable adverse event, or if the mother or infant need to be transferred to a different facility to deal with a preventable adverse event, those physicians or facilities should still be paid, but the amount they are paid should be deducted from the payment made to the primary maternity care providers.

The maternity care providers should not be permitted to bill the patient for any unreimbursed costs associated with the preventable adverse events.

Maternity care providers and payers should reach agreement on the specific situations which would be defined as “preventable adverse events.” The list of preventable adverse events covered by the warranty may start with a small number of situations and then expand over time to cover additional situations.

The rates of all preventable adverse events should be measured by all maternity care providers and publicly reported.

C. Limited Payment Differentials Based on Delivery Method

In general, the amount paid for labor and delivery should not vary based on the method of delivery used, i.e., for women with any particular combination of risk factors and complications, the payment should be the same regardless of whether vaginal delivery or Cesarean section is used. The payment amount should be based on a weighted average of the costs of C-sections and vaginal deliveries, with the weighting based on best practice benchmarks for the appropriate rate

of C-sections, and with the weighting and costs risk-adjusted based on characteristics of the mother and baby.

However, it may be desirable to explicitly increase the payment amount for Vaginal Births After C-Section (VBACs), i.e., second and subsequent births to mothers who have previously delivered by C-section, in order to encourage greater use of VBACs. It may also be desirable to explicitly reduce the payment for non-medically indicated C-sections in order to discourage their use.

D. Reduced Payment for Elective Early-Term and Pre-Term Deliveries

The payment for labor and delivery should be reduced significantly for elective (i.e., non-medically indicated) early-term and pre-term deliveries, whether they are vaginal or by C-section.

Although some stakeholders feel that no payment at all should be made for such deliveries because of the potential for harm to the baby, complete non-payment may conflict with the obligations of health plans to pay for labor and delivery, and non-payment will also likely make decisions about what is “elective” more contentious. It is important to note that even if no explicit reduction in payment is made for elective early deliveries, the bundling of neonatal care costs into the labor and delivery payment will significantly disincent such early deliveries because of the high likelihood that early-term and pre-term babies will require an expensive NICU stay with no increase in payment to cover the extra cost.

The maternity care providers should not be permitted to bill the patient for any unreimbursed costs associated with elective early deliveries.

E. Unbundled Payment for Prenatal Care Services

Physicians and certified nurse midwives should be paid fees for prenatal care services separately from payment for labor and delivery and post-partum care, in order to encourage and support the delivery of high-quality prenatal care. (This means that the current- “global fee” that covers both prenatal care and labor and delivery would be discontinued.) Pay-for-performance bonuses and penalties should also be paid based on whether early prenatal care is provided and based on the rates at which evidence-based processes are used during prenatal care.

Consideration should be given to paying for “community navigators” to help low-income women access prenatal care and other services needed to support good pregnancy outcomes. Efforts should also be made to connect and coordinate maternity care and more general health and wellness programs, both during and prior to pregnancy. A coordinated, regional approach will be needed to effectively manage the care of women with high-risk pregnancies.

Pregnancy outcomes, e.g., the rate of premature delivery, low-birthweight babies, etc. should be publicly reported in order to evaluate the effectiveness of prenatal care processes and encourage greater compliance with proven processes. Small maternity care providers may need some funding support to help them cover the cost of the necessary data collection.

F. Benefit Changes for Mothers to Improve Maternity Care Outcomes

Copayments should be reduced or eliminated for visits that pregnant women make to their maternity care provider. If copayments are not eliminated for such visits, they should be further reduced for women who use maternity care providers that provide a full range of coordinated services (i.e., a “maternity care medical home”).

Copayments should also be reduced for medications and other treatments that maternity care providers prescribe to help mothers manage their pregnancy.

Pregnant women should receive financial incentives to encourage them to improve their health and adhere to prenatal care plans developed with their maternity care provider. In addition, all women of child-bearing age should receive incentives to complete an education program about pregnancy, ideally before conception and again during pregnancy. For commercially insured women, the incentive could be a reduction in their insurance premium; for women covered by the Medicaid program, the incentive could be a cash payment.

G. Encouraging Use of High Quality/Low-Cost Maternity Care Providers

Pregnant women should be given information on the quality and cost of different maternity care providers to help them select the highest-value providers. However, teaching hospitals should not be disadvantaged in price comparisons simply because of their need to cover the additional costs of medical education through their payments for labor and delivery.

Copayments should be reduced or eliminated for low-income women (and potentially for all women) if they choose providers that deliver high-quality, low-cost maternity care.

H. Determination of Payment Amounts for Maternity Care

Maternity care providers should propose appropriate payment levels for the bundled, warranted maternity care payments, and then negotiate the final payment levels with health insurance plans and other payers. Payers may then choose to assign providers to different cost “tiers” based on these prices for use in the education and incentive programs for mothers described above.

The payment levels should differ for mothers with different levels of risk or pregnancy complications. An independent, objective method of verifying a woman’s risk level needs to be established in order to assure payers that risk levels and payment amounts are being determined accurately.

III. How Illinois Should Transition to the Desired Payment Systems and Benefit Designs

A. Build Stakeholder Support for the Changes

It will be important to clearly communicate to all stakeholders the goals of the proposed payment changes and how they can benefit mothers, physicians, midwives, and payers.

Communications with consumer advocacy groups should clearly convey that the goal is to save money by achieving better outcomes for mothers and babies, not by cutting necessary services or benefits.

The support of medical specialty societies is most likely to be obtained if strong physician champions can be convinced to play a leadership role in the initiative.

B. Document the Business Case for Maternity Care Payment Reform

Before implementation efforts can begin, more and better data on the cost and quality of maternity care need to be collected and analyzed in order to clearly define the business case for the new payment system and benefit design, i.e., how it can benefit both payers and providers as well as mothers and babies.

A neutral, trusted organization will be needed to assemble and analyze the data in ways that support the needs of both providers and purchasers/payers. Funding will be needed to support the data collection and analysis process. It will likely be easiest to collect data, particularly a combination of claims and clinical data, from providers and payers which are committed to supporting development and implementation of improved payment model.

C. Develop and Adopt Guidelines for Better Quality, Lower Cost Care

The payment reforms will only be successful if maternity care providers implement changes that improve the quality and reduce the cost of care. Continued/expanded efforts should be made to develop guidelines and care processes that reduce or eliminate elective early-term and pre-term inductions, reduce infections and birth injuries, improve prenatal care, etc.

These types of guidelines should also help to reduce concerns about malpractice claims when physicians change the way they practice, since the guidelines will demonstrate that the changes are being made to improve care, not just to save money.

D. Recruit Leaders to Pilot Test the Payment Reforms

Since there are many details about the payment changes that will need to be resolved, and since there is the potential for unintended consequences in implementing any significant change in payment systems or benefit designs, the desired payment system and benefit structure should

be pilot-tested with selected maternity care providers in different regions of the state and evaluated before being implemented statewide.

Physicians and hospitals who are leaders in maternity care should be asked to make a formal commitment to serve as pilot sites. Payers – both commercial health plans and the state Medicaid program – should be asked to commit to testing the payment and benefit designs with these providers. It is likely that if some providers and payers agree to “go first,” others will follow. Purchasers could encourage providers to step forward by offering more favorable contracts to those providers who “go first.” The Medicaid risk-based payment model could also be used to encourage providers to participate.

Providers will be more likely to volunteer to participate if payers do not demand large amounts of savings in the initial year of implementation. Multi-year contracts that phase in savings over time will be easier for providers to implement while still “bending the cost trend” for purchasers.

Also, both providers and payers will be more likely to participate in pilot projects if it is clear that there is broad consensus that the payment changes to be used are the desired direction for the future, rather than merely experiments or demonstration projects that may not be continued or expanded.

Other interested organizations should be invited to participate in the planning and transition process if they can help increase the potential for success. For example, providers which agree to pilot test the new payment systems will likely benefit from technical assistance in restructuring their care processes from organizations with expertise in quality improvement techniques. Early successes will help to reinforce the commitment of participants to continue and will likely help to attract additional participants.

E. Facilitate Collaboration Among Purchasers/Payers and Providers

Even if the business case is attractive and both payers and providers are willing to participate, a neutral organization will be needed to facilitate discussions among multiple stakeholders in order to resolve the many details required for implementation. In particular:

- As many health plans and other payers (e.g., Medicaid) as possible will need to participate and agree to pay in similar ways so that providers will have a critical mass of patients covered by the new payment model.
- As many self-insured employers as possible will need to support the payment and benefit changes to enable health plans to make the changes for all of the patients they cover.
- Multiple physicians and other maternity care providers will need to participate in order to make it worthwhile for payers to change their payment systems and to have enough patients participating to accurately evaluate the results.
- Physicians, midwives, and hospitals will need to agree on how to divide bundled payments and how to cover the costs of adverse events covered by the warranty.

IV. Other Issues

A series of additional issues were identified that will need further exploration in the future:

- Whether and how the payment model and transition process should be modified to work effectively in both urban and rural communities;
- How to address cases in which mothers change insurance coverage during their pregnancy, and where the mother and baby are covered under different insurance plans;
- The way that services from nocturnists should be covered by the payment models;
- How to create incentives for maternity care providers to care for Medicaid patients; and
- How to avoid having bundled payments to hospitals and physicians encourage the creation of larger provider organizations which raise prices for maternity care.