HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

American Academy of Family Physicians

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

May 23, 2016

Lew Sandy, MD
Work Group Chair, Clinical Episode Payment
Health Care Payment Learning & Action Network (LAN)
Submitted electronically through HCP LAN website

Dear Dr. Sandy,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the draft white paper titled. "Accelerating and Aligning Clinical Episode Payment Models: Maternity Care" as released on April 21, 2016.

The AAFP agrees that the overarching goal of clinical episode payments for maternity care is to improve the value of maternity care by reducing costs and improving outcomes, as well as the experience of care, for the woman and her baby.

According to the most recent AAFP member census, approximately 17 percent of members deliver maternity care, but 75 percent deliver care to infants and children. The proposed episode payment encompasses the first thirty days of a newborn's life. The only routine care mentioned for the baby during this time was "ensuring a link from birth to pediatric care." Typically, a baby will have a two-day or fourteen-day follow up with a provider, often times both. There are also infants born that require higher levels of care at birth that exceed the thirty day window.

The AAFP is concerned about how the payment would flow back to physicians providing services to infants within the thirty day window. To reduce confusion and payment complications, we strongly believe it would be best to exclude newborn care from this episode.

We thank you for the opportunity to provide input to the Accelerating and Aligning Clinical Episode Payment Models: Maternity Care White Paper. Please do not hesitate to call upon the AAFP for assistance. For additional information, please contact Amy Mullins, MD, Medical Director, Quality Improvement (913) 906-6000 extension 4120 or amullins@aafp.org.

Sincerely,

Robert L. Wergin, MD, FAAFP
Board Chair

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American Association of Birth Centers

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America's Birth Center Resource

3123 Gottschall Road - Perkiomenville, PA 18074 - Tel: 215-234-8068 - Fax: 215-234-8829 - aabc@birthcenters.org - www.birthcenters.org

AABC Comments on Maternity Episode of Care White Paper

The American Association of Birth Centers (AABC) applauds the work of the HCP-LAN to take steps to improve the way maternity care is paid for. Improving payment models will improve the quality of care if it also incentivizes or includes payment for cost effective care that produces good outcomes rather than simply rewarding the quantity of interventions provided.

AABC finds much positive information in the Maternity Episode of care White Paper. The goals of increasing rates of healthy vaginal births that occur at full-term with babies of appropriate weights would improve quality indicators that are not where they should be in the US. Achieving these goals could potentially impact existing disparities among some populations for maternal and infant health. At the same time, changes in how care is paid for, with incentives available for provision of more effective care delivery, would lead to significant cost savings in maternity care.

Although the white paper's title suggests that it addresses all maternity episodes of care, most of the discussion of improvements in costs, quality and patient satisfaction seem to be confined to women experiencing low risk births. While there is specific discussion of the definition of low risk pregnancy—full-term, singleton, vertex—the paper does not say that alternative payment should focus only on these pregnancies, and encourages a broad use of the term low risk. It is important to recognize that enhanced prenatal care improves outcomes and helps women *achieve* a low risk status. For example, some women may not reach full term unless they have experienced enhanced prenatal care services, along with education concerning their choices, such as avoiding elective induction. However, for women who are truly high risk and remain so, it may be prudent to consider a separate Episode definition and payment mechanism.

While AABC finds much of a positive nature in the Draft White Paper, there are some points that could be enhanced or clarified to improve the paper and its purpose. A list of these items and comments follows:

- On Page 8, statement that: "For women who choose a midwife and a birth center for their primary care provider and birth setting, respectively, the costs are significantly less than in a hospital. Of course, part of this is due to the fact that birth centers do not provide cesarean section procedures."

    - In Stapleton et al. (2013), the cost saving model takes into account all women who are eligible to be admitted in labor to a birth center and the cost for those who have

cesarean births at the hospital is included in the calculation of savings. In this cost model using Medicare rates, savings per birth center admission in labor were $2558. So even when cesarean births for birth center clients are included, significant savings are possible when more women utilize birth center care (Stapleton, S. R., Osborne, C. and Illuzzi, J. (2013), Outcomes of Care in Birth Centers: Demonstration of a Durable Model. Journal of Midwifery & Women's Health, 58: 3–14. doi: 10.1111/jmwh.12003)

- Also, on page 8 in the discussion of cesarean rate variation, the average national total cesarean rate is given, and the goal for low risk women is given as a cesarean rate of 23.9%. The current rate for low risk cesareans, 26.9%, should be added here for comparison. (Osterman & Martin, Trends in low-risk cesarean delivery in the US, 1990-2013, 2014).
- Design Elements (p. 12)
    - Episode Definition - postpartum services need to be defined more broadly; the continued close attention and care of new mothers and newborns leads to continued success with breastfeeding and avoiding complications before they occur. The white paper is in agreement with this point, stating that "postpartum care that supports the new mother in breastfeeding, baby care, contraceptive care, mental health and self-recovery can have a lifelong impact on the health of both the woman and her baby". But the paper is not clear that postpartum care that provides all these services takes more than just the 1-day postpartum visit and the visit at 6 weeks postpartum. At least one other visit at 10 days to 2 weeks postpartum is beneficial, and most birth centers follow their clients even more closely in order to achieve the best results for mom and baby. Home visits should be considered. Reimbursement should include funding for a program of care that keeps rigorous track of moms and babies during this period, and provides support when needed, perhaps including phone check-ins.
    - Episode Timing - 40 weeks prior to delivery as the beginning of the episode of pregnancy is not accurate for every pregnancy. Some women carry their pregnancy beyond 40 weeks gestation to 42 or more weeks, and those who deliver prematurely would not even be pregnant 40 weeks prior to delivery. Using a definition such as a positive pregnancy confirmation until 60 days postpartum, or from initial visit through postpartum may be more helpful.
    - Services – Birth centers provide enhanced services throughout the episode of care. Enhanced services include: time intensive prenatal visits in the midwifery model that include individualized health education and support as needed, care coordination for other services needed, breastfeeding education and support, preparation for childbirth, doula care, and postpartum support services. These time-intensive services limit the volume of clients that a midwife can serve. Midwife providers in birth centers typically see only about 1/3 - ½ of the number of women per day than in standard prenatal care in order to produce the better outcomes for low-risk women. Data from Washington

State Medicaid recipients demonstrate the inverse relationship between time spent with the client and success on both cost containment and outcome measures for both mom and baby (Cawthon, Laurie: First Steps Data Base Live Births 2012-2013, State of Washington Health Care Authority, 2015)

- Patient Engagement – This section would benefit from more emphasis on choices for women. What would motivate a primary care physician to talk to women about birth centers? Health care plans should also offer choices with comparative data to the newly pregnant woman so that she may make an informed choice. Birth centers should be listed prominently in provider directories.
    - Requirements that providers use the Patient Activation Management (PAM) tool or similar proprietary tools to track patient engagement would add cost to the Episode, so this cost would need to be included in the base payment.
- Accountable Entity - there was no OBGYN solo or small practice model in the table in Appendix D. This could assist in understanding implementation models.

- Episode Price Considerations p. 24
    - The white paper states that: "Research increasingly reveals that births managed by midwives and births in birth centers are not only less expensive than hospital births but also often lead to the same, if not better, outcomes."
        - Savings in the birth center model are linked to the use of fewer medical procedures, elective inductions, cesarean births, and other improved outcomes resulting from the model of care.
        - Costs of the birth center model vary due to the time spent in prenatal care with education and support preparing women to have low risk pregnancies and births and to be more confident parents.
        - This time intensive care actually ***increases*** the cost of the office visit portion of prenatal care. The savings occur in the labor and birth portion, when fewer costly medical procedures and avoidance of complications are seen for low risk women. Midwives see fewer clients per day in the office, and face-to-face visits with the midwife last from 30 minutes to 1 hour, so more midwives are needed by birth centers to care for the same number of clients seen by the average obstetrician.
    - AABC proposes that enhanced prenatal and postpartum care be incentivized, which will sustain birth centers providing this care and lead to improved outcomes.
- Patient population and quality metrics p. 26

- Birth centers already collect most of the quality metrics proposed in the draft White Paper, so baseline data are available.
- Birth center quality metrics far exceed national benchmarks for low risk women. For example, in a population of 6888 Medicaid beneficiaries in birth center care: elective inductions < 39 weeks 0.13%, preterm birth rate 4.75% (US 9.6%), low birthrate 3.2% (US 8%), primary cesarean rate 8.4% (US 21.5%), and NTSV cesarean 13.9% (US 26.9%), exclusive breastfeeding 86%. AABC proposes that upside payments be calculated on regional averages for low-risk women, so that birth centers will start receiving extra compensation for the extra work they do to produce the improved outcomes.
- The widely held belief that all birth centers clients are very low risk is not borne out in the data. Women in the above group of birth center clients had a risk profile that was assessed to be comparable to the US childbearing women's social and medical risk profile for the same time period. [Jolles, D. Stapleton, S., Langford, R. (2016). The Birth Center Model of Care and Childbearing Medicaid Beneficiaries: A comparison of national benchmarks and variations in care and quality. Manuscript submitted for publication].
- The patient population in the birth center setting includes women with risk factors that do not preclude birth center care, such as previous preterm birth, current depression, obesity with BMI 30-35, and poor social support, so low risk should be interpreted broadly for eligibility in this model of care.

Other considerations

AABC recommends that bundling plans do include coverage of high-value pregnancy and birth services that are currently not covered by health plans or Medicaid, such as care coordination, shared decision making, group prenatal care, doulas for birth support, and breastfeeding support.

AABC recommends that payment is adequate to support the midwifery model of care, because the increased time spent with each woman means that fewer visits can be scheduled per provider each day.

AABC recommends that groups implementing the Episode of Care approach to maternity care be encouraged to help women understand that their choice of provider and birth setting – due to highly variable practices from one type of provider to another – could greatly impact the care they receive and their outcomes. Women and families need to have easy access to quality outcome data for decision-making about their choice of providers and birth settings in their local area.

Pregnancy is an opportunity for educating and empowering women and their partners to be more confident, better prepared parents. The education and shared decision-making that are integrated into midwifery prenatal visits at birth centers are vital to this process.

Current barriers to choice of all options for maternity care

Currently, many barriers still exist for women to access birth center care. State regulations limit birth centers by requiring physician medical directors, certificates of need, and written transfer agreements with hospitals. Physicians and hospitals may not wish to be affiliated in these ways with birth centers, thus preventing birth centers from operating in these areas.

Efforts to increase access to the birth center model can be a positive opportunity for improvement. Transfers of care between birth center and hospital when a different level of care is needed will be safer and more seamless, if hospitals and birth centers can make plans for these transfers in advance. Birth centers should have transfer policies in place that are known by local hospitals, placing the woman and her family at the center of care planning. Communication between hospitals and birth centers should be improved overall to make these plans work as well as possible.

Some health plans refuse to include birth centers in their networks, choosing high volume providers over smaller community based birth centers. When birth centers are included in health plans, they are not always included in provider directories, nor are these services effectively marketed to health plan consumers. With better knowledge of the benefits of offering birth center care, health plans can do a better job of promoting this option.

Birth center care is a high quality choice for maternity care that meets the Triple Aim of better health for mothers and babies, high rates of client satisfaction with care, and cost savings. Women should be educated as to this option for care both before and during pregnancy.

5.23.2016

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2nd comment

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AABC Proposal for Alternative Payment Models

Introduction

Maternity care is in dire need of substantial improvement to meet the goals of the Triple Aim in healthcare.[1,2] Medicaid funds nearly half of all births each year and spends over $54 billion in facility charges for mothers and newborns, making pregnancy and newborn care the largest Medicaid budget expenditure.[2,3] For commercial payers, whose enrollees include the Medicare population, maternity care is also a considerable expenditure. Despite these expenditures, according to the World Health Organization, outcomes for both mothers and newborns in the United States rank the lowest of any developed country.[4] Particularly worrisome is the increasing rate of maternal mortality.[5] In addition to concerns about high financial costs and suboptimal outcomes, women have voiced dissatisfaction with their experiences of care in traditional care models.[6,7]

The freestanding birth center (FSBC) is an innovation in maternity care that fits well in an alternative payment model framework. With a 45-year history of demonstrating high-quality care, better outcomes and cost savings for low-risk women, as well as excellent patient satisfaction, the FSBC should be accessible to more women in the US.[8,9,10,11] While the majority of women in the US experience medically low-risk pregnancies, the existing maternity care system is poorly designed to provide women sufficient access to the FSBC, an evidence-based care model that is supportive of physiologic birth processes.[7,8,11] Encouraging low-risk women to choose birth center care would reduce cesarean rates and improve other outcomes, important goals in improving maternal outcomes immediately and in subsequent pregnancies.[12,13]

Recently, the ACOG/SMFM Obstetric Care Consensus Statement "Levels of Maternal Care" recognized the freestanding birth center as an appropriate level of basic maternity care in the US.[14] Studies of processes and outcomes of FSBC care clearly support that birth centers are a safe model of care for low-risk women when associated with a health system able to provide hospital care.[7,10,11]

Background

The freestanding birth center offers women a home-like, comfortable setting where they can receive maternity care with appropriate levels of intervention.[7,10,11] Relationship, continuity of care, and increased time spent with clients are core components of birth center care.[7,8,10,11] The model is defined by the American Association of Birth Centers (AABC) Standards, that include criteria for planning, organization, safety, staffing, quality assurance and quality improvement.[15] Multiple studies demonstrate that birth center care is safe, cost-effective, and leads to excellent outcomes when care is provided according to AABC Standards.[7,8,10,11] Continuous risk screening is a key component of birth center care. Women are screened for risk status throughout pregnancy care, labor, and birth to ensure they are appropriate for the birth center setting.[7]

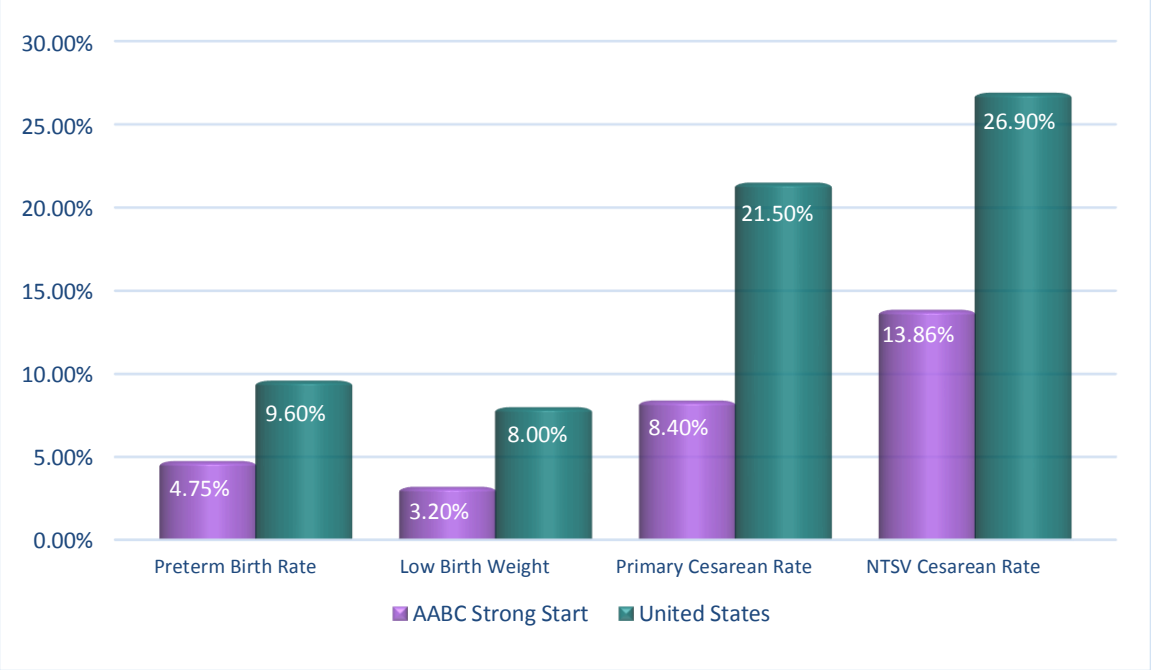
Birth center care leads to improved health outcomes, cost savings, and increased patient satisfaction when compared to hospital-based maternity care for women with similar risk status.[7,8,9,10,11] Key outcomes of birth center care include an average 6-9% cesarean birth rate (compared to national rate of 24% for low-risk women), low rates of costly medical interventions, reductions in preterm and low birth weight infants, and a 95% successful breastfeeding rate.[7,11,16] Women are highly satisfied with care received at birth centers, with 94.4% reporting they are very satisfied or extremely satisfied in a survey of Medicaid beneficiaries in birth center care.[7,10,16] Though the percentage of women who currently give birth in birth centers is low, it is increasing[17,18,19] and a quarter of women who gave birth in hospitals stated in a national survey that they would consider a birth center for their next delivery.[6]

Midwives are the care providers in the majority of birth centers. Relationship-building and time-intensive prenatal care reduces the volume of patients that are able to be seen by one midwife in FSBCs. The care model leads to a positive egalitarian relationship with person-centered care and emphasizes patient engagement and shared decision-making.[7,11]

Freestanding birth center care is one of the enhanced care models being studied in the Strong Start for Mothers and Newborn Initiative sponsored by the Center for Medicare and Medicaid Innovation. AABC convened a group of 45 birth centers around the US to provide enhanced prenatal care services to Medicaid beneficiaries enrolled in the program. Preliminary data from the Strong Start initiative show that the population in the birth center sample exhibits a similar sociodemographic and medical risk profile to national data. However, Strong Start participants experience decreased

treatment intensity while exceeding national benchmarks for nationally endorsed quality measures.[16,20] Preliminary data show that AABC Strong Start participants enrolled in the study experienced a preterm birth rate of 4.75%, a low birth weight rate of 3.2%, and a primary cesarean rate of 8.4% for the first 4700 births.[16] National rates for these indicators are 9.6% for preterm birth, 8% for low birth weight, and 21.5% for primary cesareans 21.5%.[17]

Comparisons of Preterm Birth, Cesarean, and Low Birth Weight Rates [16,18,21,22]



At present, the freestanding birth center is underutilized in the United States, with only 18,219 births or .5% of all US births occurring in birth centers in 2014.[23] However, this number represents an increase of 75% in the past ten years.[24] According to the AABC, there are only 315 birth centers in the United States, limited in part by regulatory barriers and inadequate reimbursement or due to denials of coverage and contracting by Medicaid, Medicaid Managed Care Plans, TRICARE and other health plans, as well as a general lack of knowledge of the birth center model of care.

Alternative Payment Models in Freestanding Birth Centers

FSBCs have the demonstrated ability to reduce unnecessary medical interventions and the cost of maternity care for women who are medically low-risk, even if they have low socioeconomic risk status and a lack of social support. The birth center model of care meets the Triple Aim of quality healthcare, greater client satisfaction and cost savings.[25] The birth center care model should be integrated into APM planning to the fullest extent possible. AABC believes in a risk stratification of women eligible for low-risk care, with eligibility screening by the birth center or other low-risk midwifery provider at the beginning and throughout care. Birth centers operating under the AABC Standards utilize risk criteria that determine at the outset of care whether a woman is eligible for birth center care or not, and her risk status is tracked in AABC's Perinatal Data Registry (PDR) throughout the pregnancy. Because many birth centers are small, initial alternative payment arrangements need to focus on upside incentivized payments for the improved outcomes (and therefore lower costs) documented above, while greater volume birth centers would include upside and downside risk factors.

Episode of Care. The episode of care (EOC) for mom and baby commences upon confirmation of pregnancy at mom's initial visit to her provider or 270 days prior to her date of delivery when she is accepted as low-risk into midwifery care at the Birth Center and continues through her prenatal care, labor and delivery and including her 6-week postpartum care visit. The newborn's EOC continues through 28 days of life. The site of the delivery in the EOC could be either the birth center or hospital and the delivery supported by either a midwife or a physician. It should be noted that some women transfer care into or out of birth center care partway through pregnancy due to events of relocating, change in employment or insurance coverage, or if they learn about the option of FSBC later in pregnancy.

Women accepted as low-risk, and who continue their prenatal care under the midwifery model of care, in accordance with the standards adopted by American Association of Birth Centers, are deemed eligible for a birth center delivery so long as they are healthy, full term, with a single fetus in vertex position; these are estimated at 70-85% of pregnant women[26] In either event of a delivery at the birth center or hospital, the birth center is the accountable provider for the EOC.

If certain high-risk complications occur during pregnancy, such as severe preeclampsia, clotting disorders or gestational diabetes requiring insulin, leading to the need for transfer of care to an Ob/Gyn

or maternal-fetal medicine specialist, then the birth center part of the episode of care would end, unless the mother was approved to return to the care of the providers at the birth center. In the event of transfer of care at any time during the EOC to an Ob/Gyn or maternal-fetal medicine specialist for said high-risk complications which are considered exclusions from the EOC, then the provider who delivers the mother at the hospital will be the provider accountable for the EOC.

Clinical Episode of Care. The objectives of the clinical episode of care would be outcomes of increasing vaginal births, increased full term births, decreasing cesarean sections, decreasing pre-term babies, decreasing unnecessary medical interventions and complications resulting therefrom, providing support for women to choose their care providers and site of delivery, coordinating maternity care among providers in all settings, and creating a safe and comfortable environment for women to birth that is family-centric.

Included Services. Services provided in this low-risk episode of care would include personalized comprehensive enhanced prenatal care that is time-intensive and based on relationships developed between clients and their midwives, as well as ancillary staff.[7] Services would include enhanced prenatal care, discussion of options for birth, nutrition, patient navigation, care coordination, childbirth and parenting preparation education, doula services, prenatal and postpartum lactation consultation, prenatal and postpartum depression and mental health screening, social support, smoking and drug abuse cessation education, and support to avoid preventable complications. Bilingual staff would be hired if there is a significant need in the population served. Women with risk factors or emerging risk status would receive consultation by a collaborating obstetrician or maternal-fetal medicine specialist. Ultrasound for dating of pregnancy and level II study may or may not be included in the services provided in the EOC depending on local factors. Lab testing for normal prenatal care may or may not be included, depending on factors such as ability to contract with labs to accept capitated or discounted payment as similarly reimbursed by health plans.

Engaging Clients. In most studies of birth center care, women have chosen the birth center as both their care site and their birth site. Part of the high satisfaction with FSBC care results directly from women having their choice of care provider and setting.[7] Many women are not aware that they are appropriate for birth center care, so low-risk healthy women require education and encouragement to consider the birth center option. When primary care providers are the practitioners who confirm that a

healthy woman is pregnant and that she meets low-risk criteria for birth center delivery, then she could be advised of enhanced prenatal care and an alternative childbirth experience at a birth center. There is a high level of satisfaction by women choosing a birth center model of care because it promotes shared decision-making, open access to medical records, and discussion of her birth plan.

Episode of Care Payment to Accountable Entity and Risk. FSBCs are typically small facilities and will vary in their tolerance of risk based on size and the population served, whether self-paying, commercially insured, Medicaid, or Medicaid Managed Care. Small birth centers might include fewer than 100 births per year or a majority of its patients are Medicaid beneficiaries, and therefore it would not be feasible to accept downside risk. These centers would benefit from incentivized payment for improved costs, better outcomes and confident, prepared, and satisfied parents (HCP-LAN Category 2c or 3a).[27] In the current payment system, effective care measures such as: 1) prenatal education; 2) enhanced prenatal care; 3) doulas; 4) peer counselors and 5) continuous support during labor and birth are not reimbursed. Although these are precisely the services that are effective, their time-intensity reduces the number of clients that birth center providers can serve. Ideally, the base reimbursement for the EOC in each region would be sufficient to cover the costs of these enhanced services, the facility fee for the mother and newborn at the birth center, and care during the postpartum period. If the base reimbursement is not inclusive of the costs for these enhanced services, then there needs to be an incentive based on the improved outcome historical data so that results are rewarded continuously for providing and coordinating high quality services.

Small birth centers would receive an upfront incentivized payment at the commencement of pregnancy care for the enhanced prenatal services. The base reimbursement for birth center care would be paid at the end of the EOC and should be sufficient to support services provided and to include adequate numbers of midwives and support staff. Like other facilities, FSBC operating costs vary in different regions of the US depending on rents and overhead, liability insurance and cost of living for staff.

Large volume FSBCs will be able to accept upside and downside risk (Category 3 or 4) and would design its bundled payment to additionally include basic imaging, routine lab tests, consults with obstetricians or maternal-fetal medicine specialists, and professional services of the delivering provider, whether midwife or obstetrician at either the birth center or hospital. Included in the bundled payment

would be home visits and pediatric services for well-baby visits through Day 28. All facility fees for the birth center would be payable within the bundled payment, excluding any facility, technical or professional fees charged by the hospital.

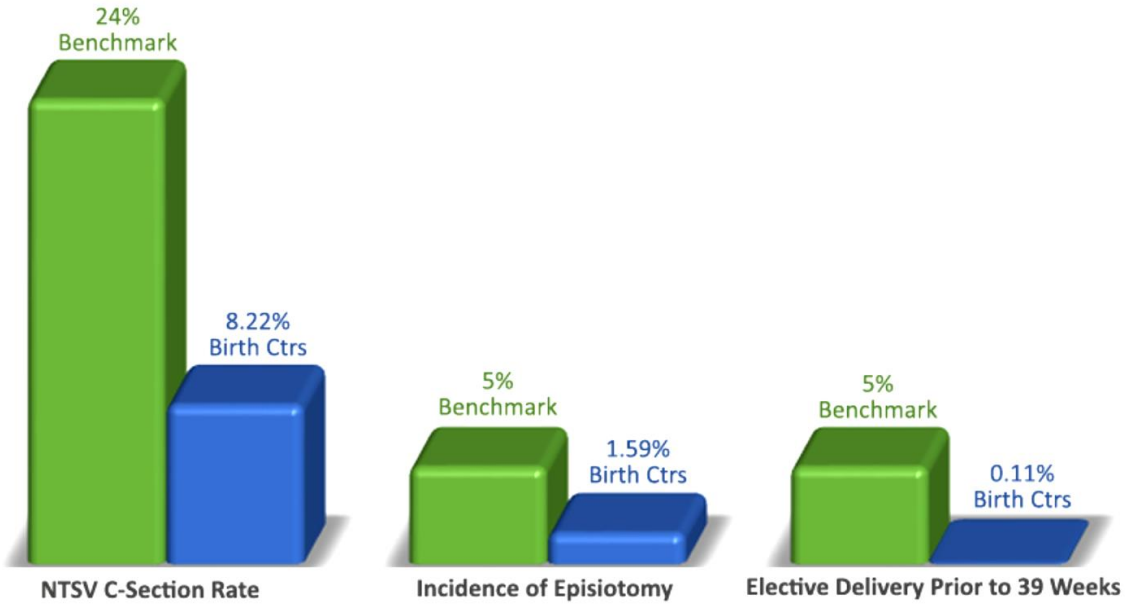
Bundled payment would flow to larger birth centers as the Accountable Entity for their acceptance of risk for an episode of care of low-risk women and newborns for the entire pregnancy, labor and delivery, and postpartum care, including the professional fee to the delivering provider whether at the birth center or hospital. The bundled payment would be set based on a negotiated price or formula to include costs of the EOC to achieve its goals and pay prospectively for its historical outcomes of decreased rates of cesarean sections, increased rates of full term babies, and other quality metrics.

There would be a set of high-risk complications and exclusions during which the EOC would cease or suspend unless the complication resolves and prenatal care resumes at the birth center. In some cases, care may resume during pregnancy, and in other cases, care would not resume until postpartum care, or not at all. However, exclusions would need to be carved out of the bundle or risk adjusted, such as hospital admissions, testing and ultrasounds performed in the care of an obstetrician or perinatologist for high-risk pregnancy, as well as admissions for increased length of stay and readmissions to the hospital for high-risk complications in pregnancy or birth. In regard to the newborn, exclusions would include admission to NICU and hospital admissions for complications arising in the postpartum 28 days.

Quality Metrics. Quality measures for maternity care include number of prenatal visits, cesarean birth rate, elective delivery before 39 weeks, preterm birth and low birth weight rates, breastfeeding initiation and continuation, NICU admissions, readmissions, perineal integrity, and completion of the 6-week postpartum visit. Participating birth centers would track process and outcome data by entering data prospectively in the Perinatal Data Registry or other comparable data set. See figure below for an example of quality benchmark data from the Strong Start data set.[16]

Adding birth centers to networks of hospital midwifery providers and other maternity providers will improve the overall quality measure profile and lower costs of care. If low-risk women are educated and encouraged to choose the FSBC, significant savings will result.[7, 8,9,11,16]

Birth Centers Exceed Quality Benchmarks [11,28, 29]



Example Models of Freestanding Birth Center APMs

1) Incentivized payment for enhanced care services and quality outcomes in recognition of increased provider time in providing enhanced care. Low-risk women are informed and encouraged to choose the birth center option. Birth center tracks processes of care and outcomes in Perinatal Data Registry and reports to health plan on quarterly basis. Base reimbursement for facility fees of birth center when EOC includes birth center delivery.
2) Bundled payment where FSBC is Principal Accountable Provider (PAP) (Accountable Entity/AE) managing EOC beginning at 270 days prior to delivery. Women are eligible for birth center care if they meet low-risk criteria at beginning of care and throughout care at birth center for entire pregnancy, labor and delivery, and postpartum care for 54 days for the mom and 28 days for the newborn. FSBC contracts with referral providers and the birth center is the PAP/AE even when women require transfer to hospital. Professional services of midwives and physicians are covered in EOC. Hospital charges are excluded from EOC.

3) Demonstration projects with Medicaid MCOs (MMCOs). Pilot MMCO models of incentivized payments to birth centers for providing enhanced prenatal care and achieving quality outcomes such as lower cesarean rates, preterm birth, perinatal integrity, and elective delivery before 39 weeks. Quality measures would be tracked by birth center in the PDR and submitted to the MMCO quarterly or annually.

Example of Pennsylvania freestanding birth center that receives bundled payment for all professional services and birth center facility services--commercial payers:

"Our global contracts are for most of our commercial payers that we contract with. Our Medical Assistance contract is not a global contract. The services for the majority of the global contracts include prenatal visits, delivery, home visit, postpartum visit, initial newborn care and the facility service fee. If the client transfers to a hospital for delivery there are additional hospital charges. Services that are billed outside of global are for services that vary based on the clients (e.g., NST, ultrasounds, labs, and circumcisions). Reimbursement varies based on the contract; some contracts pay a reduced rate for a direct hospital admit and other contracts are specific to the type of delivery, SVD vs. cesarean. The range can be anywhere from $4,000-7,000.

The global begins with the Initial OB; there may be services for confirmation of pregnancy prior to the initial visit. Also if a client changes insurance, transfers out of our care or has an SAB, we would bill those services 'outside of global.' Clients that are high-risk would be transferred to a physician; they would no longer be our client."

Example of incentive payments for high quality care

One birth center received a lump sum "historical quality incentive payment" from one of their largest volume payers. In addition to this payment, they also received an incentive increase to all contracted rates for professional and service facility fees for both commercial and Medicaid products.

American Association of Birth Centers

AABC is a national membership association composed not only of birth centers, but also individuals and organizations, including physicians, midwives, consumers, owners and several educational institutions, which support the birth center concept. AABC is the only national trade

organization for freestanding birth centers. The birth center is a home-like facility existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth. Birth centers are guided by principles of prevention, cultural sensitivity, safety, appropriate interventions only, and cost effectiveness. Birth centers provide family-centered and client-centered care for healthy women before, during, and after pregnancy, labor, and birth. Membership in AABC includes birth centers that are staffed by certified nurse-midwives (CNMs), certified midwives (CMs), certified professional midwives (CPMs) and other licensed midwives. Currently there are 315 birth centers in the US and the number is growing rapidly.

AABC sets the Standards for Birth Centers and their operation, like other trade organizations. As the nation's most comprehensive resource on freestanding birth centers, AABC works on multiple levels to provide a national forum for birth center issues, to conduct ongoing research on normal birth and care in birth centers, to promote and maintain the nationally recognized *AABC Standards for Birth Centers*, and to develop and promote quality assurance systems for birth centers.

Commission for the Accreditation of Birth Centers

National accreditation based on the *AABC Standards for Birth Centers* is provided by the Commission for the Accreditation of Birth Centers (CABC). The CABC is the only accrediting organization dedicated exclusively to the quality of the operation and services of all birth centers regardless of ownership, primary care provider, location, or population served. When a birth center seeks accreditation by the CABC, they are measured against the rigorous, national *AABC Standards for Birth Centers*. There are currently 104 CABC accredited birth centers.

5.18.16

[1] Pfuntner A, Wier LM, Stocks C. *Most frequent procedures performed in U.S. hospitals, 2010.* Rockville, MD: HCUP Statistical Brief #149, Agency for Healthcare Research and Quality; 2013.
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HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

American Association of Nurse

Anesthetists

May 23, 2016

Submitted via https://hcp-lan.org/maternity-comments/

Clinical Episode Payment Work Group

RE: Accelerating and Aligning Clinical Episode Payment Models: Maternity Care Draft White Paper

To Whom It May Concern:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this white paper entitled "Accelerating and Aligning Clinical Episode Payment Models: Maternity Care." The AANA makes the following comments and requests in the following areas:

- Clarify the role of anesthesia and anesthesia professionals such as CRNAs in the design elements
- Recommendations on design elements should encourage cost efficient anesthesia delivery models when anesthesia is used

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes more than 49,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 40 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNA services include providing a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration,

administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[1] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[2] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.[3]

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the principal anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[4] Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

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[1] Paul F. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169.

[2] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475.

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[4] U.S. Government Accountability Office (GAO). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO-07-463. July 2007;15. http://www.gao.gov/new.items/d07463.pdf.

AANA Request: Clarify the Role of Anesthesia and Anesthesia Professionals Such as CRNAs in the Design Elements

The AANA is concerned that the roles of anesthesia and that of anesthesia professionals, such as CRNAs, are missing from the draft white paper. Because anesthesia services and CRNAs are critical to labor and delivery, we recommend that the final white paper should recognize and incorporate anesthesia services and CRNA care. We offer our professional organization as a resource to the LAN in helping to complete this task.

As CRNAs personally administer more than 40 million anesthetics to patients each year in the United States, including for labor and delivery, CRNA services contribute extensively to the successful development and implementation of the maternity payment episode of care. Anesthesia contributes to a maternity episode through multimodal pain management that allows the parturient to be comfortable, yet able to engage in activities related to labor, delivery, neonate bonding and personal recovery.[5] Further, anesthesia professionals, such as CRNAs, play an integral role in these episodes of care as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and ultimately in cost savings.[6] Yet, neither anesthesia nor CRNAs are mentioned in this draft white paper.

We request clarification on how anesthesia fits into the model as it is not apparent in this white paper. More to the point, the healthcare professionals who contribute to the success of an episode of care should be included not only in reimbursement discussions, but more importantly in the design of care and outcome measures to identify successes and opportunity to improve across transitions of care. Additionally, the metrics should reflect the elements of care that allow the team, including the patient, to improve outcomes.

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[5] See for example Ding T et al. Epidural labor analgesia is associated with a decreased risk of postpartum depression: a prospective cohort study. Anesth Analg. 2014 Aug;119(2):383-92.

[6] See for example Rice AN, Muckler VC, Miller WR, Vacchiano CA. Fast-tracking ambulatory surgery patients following anesthesia. J Perianesth Nurs. Apr 2015;30(2):124-133 and Kimbrough CW et al. Improved Operating Room Efficiency via Constraint Management: Experience of a Tertiary-Care Academic Medical Center. *Journal of the American College of Surgeons* 2015; 221: 154-162.

AANA Request: Recommendations on Design Elements Should Encourage Cost Efficient Anesthesia Delivery Models When Anesthesia is Used

For the maternity episodes of care that do involve the use of anesthesia services, the Clinical Episode Payment (CEP) Work Group has an interest in patient safety and access to anesthesia care as well as its cost-efficient delivery. Where anesthesia services are involved in labor and delivery, in most instances they are analgesia services such as placement of epidural analgesia, though in some instances additional services including general anesthesia are required. While all models of anesthesia delivery are equally safe according to extensive published research, the most cost-effective anesthesia care delivery model is the CRNA non-medically directed model.[7] Therefore, the white paper should encourage the adoption of safe and cost-efficient anesthesia delivery models for the reasons outlined below.

In demonstrating the costs of various modes of anesthesia delivery, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by an anesthesia care team where a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by an anesthesia care team where CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA[8] and $540,314 for the anesthesiologist[9]. Under the Medicare program, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable.

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[7] Paul F. Hogan et. al, op cit.

[8] AANA member survey, 2014

[9] MGMA Physician Compensation and Production Survey, 2014. www.mgma.com

However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals $170,000 per year. For case (b), it is ($170,000 + (0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. Finally, for case (d), the annualized cost equals $540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	$170,000
(b) Medical Direction 1:4	1.25	$305,079
(c) Medical Direction 1:2	1.50	$440,157
(d) Anesthesiologist Only	1.00	$540,314
Anesthesiologist mean annual pay	*$540,314*	*MGMA, 2014*
CRNA mean annual pay	*$170,000*	*AANA, 2014*

Under the more costly anesthesia models, hospitals and other facilities are bearing the additional costs. Hospitals and other facilities should be able to choose how much cost they are willing to incur with respect to how they provide their anesthesia care.

Therefore, we recommend that the white paper promote safe and cost-efficient anesthesia delivery models, such as non-medically directed CRNA services. Furthermore, we recommend that the development clinical episode payment models not include any policy or requirement in this payment model that would result in different payment for the anesthesia service when furnished by a CRNA, an anesthesiologist, or both working together, except in the instance of medical necessity for more than one anesthesia professional in a case.

We thank you for the opportunity to comment on this draft white paper. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Juan F. Quintana, DNP, MHS, CRNA
AANA President

cc: Wanda O. Wilson, PhD, MSN, CRNA, AANA Executive Director
Frank J. Purcell, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy

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Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

American College of Nurse-Midwives

AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

May 20, 2016

To: Health Care Payment Learning & Action Network
From: American College of Nurse-Midwives
Letter via Email to: paymentnetwork@mitre.org

RE: Maternity Care Draft White Paper

To Whom It May Concern:

On behalf of the American College of Nurse-Midwives (ACNM) I am pleased to submit these comments in response to the Maternity Care Draft White Paper issued by the Health Care Payment Learning & Action Network on April 22, 2016. We hope you find our comments helpful and look forward to your response in the final document.

COMMENTS

Below are our comments on the specific recommendations and questions raised by the draft document. We have numbered them as they appear in the document.

Recommendation 1. Episode Definition

We appreciate the recommendation that low-risk be defined broadly so as to capture larger groups of women. We believe that the types of quality improvement efforts likely to arise from a bundled payment arrangement would be beneficial to many, if not all women, not just those falling into a narrowly defined low-risk category. We support this recommendation.

The goals that a given organization seeks to address should inform the way in which the episode is defined. For example, if a payer wishes to improve the delivery of prenatal care, a bundled payment arrangement may be restricted to that aspect of maternity care. We recommend acknowledging that where a payer wishes to focus improvement on a specific aspect of maternity care, the episode may be defined more narrowly to accomplish that goal.

Recommendation 2. Episode Timing

We appreciate and support the variation in the episode timing for the mother and the infant. As drafted, the recommended timing for the mother ends 60 days post-discharge. Currently approximately one-third of women give birth via cesarean section, a major surgery that entails a significant recovery time, other women may have conditions such as hypertension or postpartum depression that persist beyond the 60 day window. We recommend that the draft acknowledge

that for these women, the episode timing may need to be extended to as far as 120 days post-discharge.

Recommendation 3. Patient Population

As noted above, we support the recommendation that the patient population be defined broadly to include as many women as possible. We anticipate that provider organizations agreeing to accept episode-based payments are likely to implement a range of activities that will benefit many women, even those with conditions that would increase their risk and we would want to see as many women as possible benefit from those activities. We believe that sufficient recognition of increased costs associated with higher risk pregnancies should be built into the payment methodology, to encourage providers to include such women in their programs. This is particularly important for provider organizations caring for smaller numbers of women where a small number of patients with outlier costs could offset savings generated with the rest of their patient pool.

4. Services

We strongly support the recommendation that the episode be defined and priced in a way that includes high-value support services that may be less commonly used. Further, as evidence emerges about the value of these types of services or practices evolve to include them, the episode should be revised to reflect that change.

6. Accountable Entity

The draft document indicates that the Work Group "favors clinicians as the preferred accountable entity," and acknowledges that in some cases the interests of clinicians and facilities may diverge. However, the draft then goes on to say that "optimally, accountability would be shared among all involved providers" and that "accountability should be shared between the clinicians and the facility."

We recommend that the draft emphasize the importance of shared accountability among clinicians and facilities. Hospital administration may impact whether certain evidence based clinical practices are allowed in the facility, such as the provision of nitrous oxide during labor, access to vaginal birth after a prior cesarean delivery, or facilitating intermittent auscultation instead of routine continuous fetal monitoring. Clinicians may desire to implement such practices in an effort to improve quality or reduce costs, while the facility may be motivated by liability concerns or the expense associated with staffing or infrastructure changes necessary for their provision. Shared accountability for outcomes and costs should help these two groups find common ground and we recommend that the draft be revised to emphasize the importance of such cooperation. Ideally, accountable entities would be selected based on their ability to engineer real change in how care is delivered, focusing on quality improvement, not just cost savings.

We caution that it can be very difficult for multiple clinician and facility organizations to come together and form the legal structure necessary to accept joint accountability for an entire episode

of care. The challenges in creating these structures, with the potential need to proceed in incremental steps, should be acknowledged in the White Paper.

We believe that the White Paper should encourage payers and the accountable entities to consider structuring care delivery so that the most appropriate provider is available for a given patient. Specifically, accountable entities should be encouraged to discuss the option of midwifery care and birth centers with women who are capable of normal physiologic birth, while simultaneously making sure that smooth transfers of care to higher acuity settings can take place when necessary.

7. Payment Flow

We support the preference for prospective payments. We believe this allows the accountable entity more leeway in deciding how to disburse the money in a fashion that will support its efforts to improve quality and reduce costs. Further, it reduces the individual focus inherent in a fee-for-service environment, which will exist to some extent even in the presence of a methodology relying on retrospective adjustment. Fostering care coordination and group communication will be better accomplished under a prospective arrangement.

We recognize, however, that a prospective payment methodology could result in stinting of care and that it is important to have in place a range of quality measurements to ensure that inappropriate reductions in care, or exclusion of high value, less commonly used services such as doula care or group prenatal care are not excluded from the package offered by the accountable entity.

Because women frequently change providers during the course of their pregnancy, it is important that the White Paper acknowledge that payers and providers will need to come to some sort of agreement about how prospectively given payments will be adjusted when this occurs. We recommend that the draft be revised to include mention of this reality in the section on Payment Flow.

The White Paper could acknowledge that it is possible for some state Medicaid programs, which constitute the most important payer for maternity services, to provide bundled payment. When this occurs, it may be helpful to both providers and commercial payers in the state to use the same or a similar approach. For the providers, it ensures that their behavior across their entire patient population can be consistent, which eases their practice operations. For payers, it ensures that providers don't try to cost shift between them, although it may be more complicated for those payers who operate in multiple states and wish to use a single approach across their entire service area.

8. Episode Price

The draft White Paper recommends pricing the episode based on a combination of provider and region specific costs. The White Paper recognizes that there can be significant variation in these costs between regions and among providers in the same region, which argues in favor of a rate based on regional and provider specific data. We support a blended approach.

We are concerned that long term success of episode pricing based on past performance may be unsustainable. Typically in these approaches to payment, a benchmark is set based on data from a prior period of time. The accountable entity then seeks to better the benchmark during its performance period. Assuming the accountable entity continues in this arrangement, benchmarks for subsequent performance periods will be based on a *prior performance period*. Thus, the accountable entity is put in the position of perpetually attempting to best its own past performance. At some point, appreciable gains in quality or cost reduction are likely to be very minimal. If the accountable entity is held to standard of constantly improving performance, at some point participation in this arrangement becomes untenable. Payers and accountable entities seeking to enter such a reimbursement methodology for the long term should carefully and regularly review evidence and best practices to identify where they lie and how to price the episode to sustain that level of performance, rather than continuously attempting to reduce payments over time to the point where it becomes impossible to deliver optimal care.

Finally, we support the inclusion of costs for historically underused services in the episode price.

9. Type and Level of Risk

We support the inclusion of risk adjustment methodologies into the payment mechanism. Providers should be given opportunity to comment on or give input into the risk adjustment methodology used in determining their payments and should be given assistance to understand how their patient population would be scored by the selected risk adjustment methodology.

In addition to discussing approaches to risk adjustment, the draft White Paper reviews the use of upside and downside financial risk. The White Paper mentions the approach of using a transition to downside risk arrangements, however, it is not clear when such an approach may begin. It would be very helpful if the paper could point readers to situations in which the mechanism or state of affairs that triggers a transition to downside risk has been identified.

We are concerned that methodologies for determining up and downside risk may impact clinicians and facilities differently, which may create unusual dynamics and incentives. Payers and accountable entities should think carefully about how risk structures are implemented to ensure that they encourage cooperative behavior between clinicians and facilities.

10. Quality Metrics

We strongly support the use of quality metrics that have been endorsed by a nationally recognized body such as the National Quality Forum, or by large, multi-stakeholder groups.[1] We also support the recommendation that preference be given to alignment of measures across programs to reduce the reporting burden.

We strongly support the recommendation that quality information be used to communicate and engage with patients. Patients need to understand the meaning and impact of these data and be

[1] See for example, Frayne, D. J., et. al. "Consensus Statement: Health Care System Measures to Advance Preconception Wellness," *Obstetrics & Gynecology*, vol. 127, no. 5, pp. 863-872.

able to access them before making critical choices about their providers and birth setting. These data should be publicly available to prospective as well as current patients.

2. Data Infrastructure

In order to accurately attribute economic and quality performance, payers must be able to precisely determine who the rendering provider is for the services included in the episode of care. Currently, many payers reimburse certified nurse-midwives (CNMs) and certified midwives (CMs) (as well as many other provider types) at some percentage of physician rates. Because of this payment differential, the services of these providers are often frequently billed under the number of a physician or group practice because when done so, they are reimbursed at the physician rate. This practice, known as "incident to billing" is a policy of the Medicare program that has been adopted by many other payers. Incident to billing obscures the actual rendering provider. As a result, it can be impossible to use administrative data to accurately attribute performance among providers.

According to CDC data, CNMs and CMs attended 8.33% of all births during 2014. In some states, this number was over 20%, making them significant providers of maternity care. If their performance is obscured in claims data, it will not be possible to establish an accurate value-based purchasing program at the provider level.

We strongly recommend that the White Paper be revised to encourage payers to reimburse CNMs and CMs at the same level as physicians. This removes the financial incentive for incident to billing, recognizes the demonstrated professionalism of these providers and is a matter of basic fairness. Second, we recommend that payers establish billing requirements to identify the actual rendering provider so that their systems will capture this crucial data.

Moving Forward: Priorities for Supporting Maternity Care Episode Payment

We are concerned about the potential impact of episode based payments on rural settings where it can be very difficult to establish a group of accountable providers who can provide the full range of needed services. As payers seek to transition their provider networks to episode based payment, they should take into account the varying abilities of provider groups to provide the entire bundle based on the presence or absence of various specialties in their areas. It may be much easier for an urban professional to refer a patient out to a maternal fetal medicine specialist, or for a woman with a normal pregnancy to find a birth center. The absence of these provider types will curtail the ability of rural providers to render the most cost effective care. This should be taken into account when determining both the content of the episode as well as the resources made available to the accountable entity.

CONCLUSION

We thank you for the opportunity to comment on the draft White Paper. Should you have any questions regarding our comments, please reach out to me directly.

Sincerely,

/JSB/

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HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

American Congress of Obstetricians

and Gynecologists

May 23, 2016

Lewis Sandy, MD, Chair
Clinical Episode Payment Work Group
Health Care Payment Learning and Action Network
2275 Rolling Run Drive
Woodlawn, MD 21244

Dear Dr. Sandy:

On behalf of American Congress of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and the American Academy of Pediatrics (AAP), we would like to voice our shared concerns with the Health Care Payment Learning and Action Network's Clinical Episode Payment Work Group's Maternity Care Draft White Paper. As the physicians responsible for caring for the vast majority of pregnant women and babies in this country and trained to care for all pregnant women and children regardless of their medical conditions or pregnancy complications, we are dismayed that our specialties and subspecialty are only able to provide input at this point in the development of this White Paper rather than earlier in the process.

We believe that the framework should be improved upon in the following key ways to ensure that women can access high-quality maternity care, and that obstetrician-gynecologists (ob-gyns), maternal-fetal medicine subspecialists (MFMs), and pediatricians can practice within models that are aligned to incentivize the most appropriate level of maternity care. Initiation of models consisting of changes in payment possess the possibility of widespread effects on care with unintended consequences. Our organizations do believe that reforms are necessary to promote value, but should be made with adequate forethought, and the input of all involved parties, to assist in appropriate buy-in and assist in avoiding untoward outcomes from poor payment design and unrecognized incentives.

Patient Population

ACOG, SMFM, and AAP believe that the patient population for maternity care episodes should include all risk levels, not just low-risk pregnancies. We believe that limiting the patient population in maternity care episodes to "low-risk" pregnant women does not adequately capture the fluctuating risk levels that pregnant women often experience. Many women have preexisting comorbidities or develop conditions during the course of their pregnancy that put them at heightened risk for poor birth outcomes and require greater medical management by an ob-gyn or MFM. Carving out these patients in the midst of the maternity care episode or failing to consider their need for enhanced medical management will lead to unworkable, unstable maternity care episodes. The recommendations pose a real threat of heightening unintended consequences, such as the refusal to provide care to women at increased health risk because of their greater need for testing and evaluation and the desire to avoid the attendant costs. In addition, the lack of appropriate categorization of pregnancies at increased risk would unfairly punish academic, tertiary, and quartenary centers that provide more care to patients at higher levels of risk.

Further, ACOG, SMFM, and AAP believe that a more comprehensive definition of risk is needed beyond gestational age, number of fetuses, and presentation. It is unfeasible to manage and treat a pregnant woman based on a definition of low-risk that only becomes apparent at the end of pregnancy. At the initiation of prenatal care, an ob-gyn, MFM, or other maternity care provider cannot predict the gestational age at delivery or the presentation and position that the fetus will be in at term. The risk status

is only known at the completion of prenatal care and the birth process, leaving little utility to these definitions.

ACOG, SMFM, and AAP strongly agree with the Work Group's recommendation that the neonate should be included in the maternity care episode's patient population. Capturing whether a newborn is admitted to the neonatal intensive care unit (NICU) and the length of stay should be evaluated when determining the value of the maternity care a pregnant woman receives. If a payer is not able to track and attribute the neonate's costs to the mother's ob-gyn, MFM, other maternity care provider, or specific practice of neonatal care, then ACOG, SMFM, and AAP believe that the payer should not pursue a maternity episode.

A better approach to handling pregnancy risk is to create tiers of risk that account for common conditions (diagnosis-related group- (DRG) based) that develop during pregnancy, such as gestational diabetes, preeclampsia, and pregnancy-induced hypertension, and more severe complications or comorbidities, all of which require extra visits, antepartum admissions, and additional testing. Risk-stratified payment for these differing risk populations will ensure that ob-gyns and MFMs are not penalized and are appropriately compensated for taking care of higher acuity patients and those with underlying health disparities. The conditions are more prevalent in women who already have limited access to care, which will certainly become more challenging and invite unintended consequences, such as further limiting access or decreasing services if the CEP Work Group fails to address this issue and include them in any proposed plan.

Services

ACOG, SMFM, and AAP believe that the White Paper needs much greater detail on whether services that are currently separately reimbursable, such as ultrasound, genetic testing, and other fetal diagnostic testing, should be outside of an episode, carved into the episode payment, or only viewed as a resource use measure for determining appropriateness of care. These are core services to the practice of maternal-fetal medicine and are necessary to manage high-risk pregnancies. Utilizing these diagnostics can help minimize costlier acute conditions for women and their offspring.

Additionally, the White Paper should provide more detail on how episodes should handle other common services, such as anesthesia, immediate postpartum contraception, and newborn care. Anesthesia can be a high-cost service, but is frequently out of the control of providers performing the delivery. Women should not be limited in their choice of intrapartum analgesia, and physicians should not be penalized for costs that are not within their control.

Furthermore, many women desire contraception or sterilization immediately postpartum. Physicians should not be held accountable for the higher cost associated with an additional procedure, such as tubal ligation or placement of long-acting reversible contraception. Women's access to the contraceptive method of their choice is paramount and no barriers, financial or otherwise, should prevent a woman from receiving her contraceptive method of choice. Some women with high-risk pregnancies should never be exposed to the health risks associated with a subsequent pregnancy, and therefore, the most effective contraceptive method is sterilization.

As noted above, ACOG, SMFM, and AAP believe the cost of newborn care should be factored into the overall cost of maternity care to ensure a holistic approach to evaluating the value of maternity care.

However, payment for newborn care should be given directly to the pediatrician or other children's health provider.

ACOG, SMFM, and AAP also encourage the CEP Work Group to consider how a maternity care episode will deal with pregnancy loss and abortion. While it is the goal of every ob-gyn and MFM to deliver a healthy baby, this is not always possible, and not every pregnancy ends with a live birth. Some adverse fetal outcomes are unavoidable even with stellar prenatal care. The CEP Work Group must determine how to reconcile miscarriage management and elective abortion (if it is a covered service under the insurance plan) for women who have initiated prenatal care.

Accountable Entities

ACOG, SMFM, and AAP believe that individual ob-gyns, MFMs, and other maternity care providers should not be the accountable entity, but rather the entire practice should be treated as the accountable entity. By measuring quality at the practice level, measures will have sufficient-sized denominators to be meaningful and team-based care can be better incentivized. In many practices, pregnant women receive care from multiple providers within an ob-gyn's or MFM's practice during their prenatal care so they are familiar with all of the providers who may be on-call at the time of delivery. In this care delivery model, it would be difficult to accurately attribute outcomes and other quality measures to one single provider. In the case of solo practitioners or small practices with only one partner who does obstetrics or maternal-fetal medicine, evaluating costs and quality at the practice level will achieve the same results as examining the individual provider.

Additionally, facilities should also be included as accountable entities in order to align incentives. As the CEP Work Group has pointed out multiple times in the White Paper, hospital charges make up the bulk of the cost for maternity care. If this cost-driver is not addressed in the White Paper and included in future maternity care episodes, inefficiencies and high costs will remain. Hospitals must support the idea of reducing cesarean delivery rates and neonatal intensive care unit (NICU) admissions and length of stay, which are currently seen as sources of higher revenue; otherwise, ob-gyns and MFMs will remain out of alignment with hospitals. Including facilities will also better account for the care delivered by salaried hospitalists who perform births and who may not be integrated into the practice where a pregnant woman received her prenatal and postpartum care.

Thank you for the opportunity to comment at this juncture. We hope you have found our comments helpful. Should you have any questions, please contact Elizabeth Wieand, ACOG Program Director of Payment and Delivery System Policy, at ewieand@acog.org, Kathryn Schubert, SMFM Federal Affairs Director, at kschubert@dc-crd.com, or Robert Hall, AAP Associate Director of Federal Affairs, at rhall@aap.org.

Sincerely,

American Academy of Pediatrics
American Congress of Obstetricians and Gynecologists
Society for Maternal-Fetal Medicine

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Barbara Levin

Improving Maternal and Neonatal Outcomes:

Comments on the HCP/LAN Maternity Care White Paper

May 23 2016

Barbara Levin, MD, MPH

The Clinical Episode Payment (CEP) Work Group of the Health Care Payment Learning and Action Network has developed an interesting model for improving maternity care outcomes through an altered payment system. The white paper focuses on maternity care as described by pregnancy and childbirth without fully recognizing both the impact of preconception care and the importance of public health strategies to improving maternal and child health.

The three areas of concern -- joint replacement, cardiac care, and maternity care – are very different in their relevance to public health. The first one is a medical concern, which is closely tied to technological development. Cardiac care clearly has a preventive aspect, but remains mostly medical in its approach. Technology is also a large part of cardiac treatment.. By contrast, technologic innovations such as fetal monitoring have not been shown to improve maternity outcomes as much as public health strategies such as improved nutrition and better access to prenatal care. Intensifying algorithms for treating risk factors and comorbid conditions for obstetrical care, such as gestational diabetes, obesity, and advanced maternal age, tend to produce increased interventions (inductions and C-sections) without commensurate benefit in improved birth outcomes.(1)(see reference list below) Rather than focus on these aspects of care, the most recent Center for Medicare and Medicaid document on improving maternity care from December 2013 highlights pre and postpartum services and increased access to community-based services. (2) Maternity care is not a medical problem, but a population health reality that needs to be addressed.

The need to alter the payments for childbirth is evident. If the fee for C-section is more lucrative than vaginal birth, the outcomes are clear. Documenting the impact of prevention is difficult, but numerous studies have shown positive changes in birth statistics achieved by improving nutrition, counseling, and social support. The recent project in Ohio which provided community health workers to high risk women has shown changes in birth weights and other outcome variables. (3) The work was significant and the Ohio legislature voted to mandate these services statewide. Over the past decades, states which have provided funding for additional services to pregnant women, such as nutritional counseling, life coach support, and drug treatment, have found that the fee for such services is more than covered in the reduced cost of high risk obstetrical and neonatal care.(2)

In addition, providing support to assure that women can receive such services in or near their local communities is important, and not addressed in this document. Studies by Tom Nesbitt et al at the University of Washington in the 1990's showed that requiring women to travel for prenatal and delivery care increased their complication rate. (5, 6, 7) The importance of easy access to prenatal care is a well-documented public health objective for improving maternal and child health services. (8)

This white paper does not address the health disparities caused by the persistent loss of perinatal services in rural areas and inner-city communities. While the issues in these different communities may vary, the impact is similar. Failure to address social disparities and dwindling care providers do affect both groups. To meet these needs, financial support and active supplements to assure that providers will deliver this care will be required.

Including public health providers in this discussion of maternity care will be useful. The staff of every health department in this country is well aware of the problems of providing high quality maternity services to the most vulnerable populations of women.(9)

References for Response to the HCP-LAN White Paper on Maternity Care

1) Kim, Catherine. Gestational diabetes: risks, management, and treatment options. Int J Womens Health. 2010; 2: 339–351.
2) https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care-quality.html
3) Redding, Sarah et al. "Pathways Community Care Coordination in Low Birth Weight Prevention". Maternal and Child Health Journal, ISSN 1092-7875DOI 10.1007/s10995-014-1554-4
4) Improving Maternal and Infant Health Outcomes CMCS Crosswalk of Current Activities and Identified Potential Strategies, December 2013 Prepared under contract# HHSM-500-2011-00086C
5) Nesbitt TS, Larson EH, Rosenblatt RA, Hart LG. Access to maternity care in rural Washington: its effect on neonatal outcomes and resource use. AJPH. 1997; 87: 85-90.
6) Sonthelmer D, Halverson LW, Bell L, Ellis M, Bunting PW. Impact of discontinued obstetrical services in rural Missouri: 1990-2002.J of Rural Health. 2008; 24: 96-98
7) Nesbitt TS, Connell FA, Hart LG, Rosenblatt RA. Access to obstetric care in rural areas": effect on birth outcomes. AJPH. 1990; 80: 814-818.
8) https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health
9) http://www.astho.org/Policy-and-Position-Statements/Improving-Birth-Outcomes/

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Bree Collaborative

DR. ROBERT BREE COLLABORATIVE

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www.breecollaborative.org

May 20, 2016

The Health Care Payment Learning and Action Network's (LAN) development and implementation of innovative payment methodologies will help move our health care system toward patient-centered, evidence-based obstetrics care.

The Bree Collaborative was established by the Washington State Legislature to convene Governor-appointed public and private health care stakeholders including health plans, providers, hospitals, employer purchasers, and quality organizations to identify specific ways to improve health care quality, outcomes, and affordability. We select health care topics based on high variability, patient safety concerns, or misalignment between poor outcomes and high cost and create recommendations for improvement for all health care stakeholders in Washington State. Due to high variability, both in cost and outcomes, our group first elected to develop goals around obstetrics care including for:

- **Elective Deliveries:** Eliminate all elective deliveries before the 39th week of pregnancy (for which there is no appropriate documentation of medical necessity).
- **Elective Inductions of Labor:** Decrease elective inductions of labor between 39 and up to 41 weeks.
- **Primary C-sections:** Decrease unsupported variation among Washington hospitals in the C-section rate for women who have never had a C-section.

The alternative payment methodologies described in the LAN white paper will work to achieve these three goals and align reimbursement with whole-person care, both for mom and baby.

In looking at other highly variable medical or surgical episodes, our Collaborative has had success developing and facilitating implementation of comprehensive bundled payment models and clinical care pathways for total knee and total joint replacement, lumbar fusion, and coronary artery bypass surgery. LAN's inclusion of prenatal, labor and birth, and postpartum phases within the episode of care coupled with robust outcome metrics, especially patient-reported outcome metrics and functional status, will move toward meeting patient safety standards and assure high-quality care. Collecting data using a clearly defined data collection process with mandatory reporting and deadlines should be included in any episode-based payment. In our other models, we have required communication and care to be managed by a clinical point-person (or accountable entity) to assure that the patient's needs and the requirements of the bundled payment model are met. This increases coordination across clinicians and care settings and reduces confusion for patients. Furthermore, episode-based payment would incentivize hospitals and clinics to support and sustain quality improvement programs.

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Shared decision making is also a key component of our bundled payment models to assure that patients are informed of their choices and aware of potential risks and benefits of their choice(s). This patient engagement is critical to building the type of health care system that ensures positive outcomes. Washington State is in the process of certifying patient decision aids, starting with maternity care, moving care toward more a more standardized patient engagement process. We anticipate this step to contribute to higher quality care and encourage LAN to offer guidance around optimal shared decision making or broader patient engagement strategies. This will help reduce variation and increase health care equity.

We have also found it helpful to be very clear as to the components included in each phase of the bundle and encourage the LAN to do the same. This helps facilitate the adoption process. Furthermore, specific language around how different health care stakeholders can use the bundle would make the pathway to adoption more clear, especially how purchasers can move forward with this type of model.

Sincerely,
Ginny Weir, MPH
Dr. Robert Bree Collaborative Program Director

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Fran Schwartz

A. Frances Schwartz
Integral Healthcare for Women, LLC

Please accept this letter of comments relative to the HCP LAN Draft White Paper on Maternity Model of Care submitted by CEP.

As a recent Executive Director and CEO of the Brooklyn Birth Center, the only licensed and accredited birth center in New York, and having executive positions in practice groups of ob/gyn and midwifery for over 20 years, I write to you now as an Independent Healthcare Consultant for providers of women's health services, especially birth centers. I have been actively involved as a Board member of the American Association of Birth Centers (AABC) in the Industry Relations, Government affairs, By-Laws and Standards Committees.

I applaud the successful efforts of the LAN work group and other contributors to this project. The Work Group strives to propose an episode payment that goes beyond lowering costs but rather creates a design that supports a more patient-centered approach to care plus achieve a standard of excellence. It is the midwifery led, free standing birth centers that realizes this entire objective.

However, birth center deliveries comprise a small segment of maternity care in this country. While it has grown significantly in the last 10 years, birth center deliveries represent only half of one percent of the babies born in the US and midwifery care is 9% of deliveries including all sites of childbirth. The movement will grow because the data collected over the years by AABC demonstrates high marks in accomplishing the Triple Aim goals. But birth centers are not on equal footing with other providers of maternity care APM models because:

- Birth centers receive low and unsustainable facility fees compared to delivery of low risk moms in the hospital;
- Birth centers provide enhanced quality services prior to and during prenatal care, such as navigating and coordination or care, childbirth and lactation education, mental health screening, nutrition, doula, shared decision making, all of which is necessary, but yet not reimbursable;
- The historical data of birth centers may penalize their opportunity for gain sharing because they already achieve quality outcomes at a lower cost with high patient satisfaction;
- Barriers and impediments of opening and developing birth centers exists due to variety of regulations in many states, fueled by anti-competitive sentiments of hospitals and the ob/gyn medical community, especially due to trends of hospital mergers and their ownership of ob/gyn practices.
- Lack of education of the birth center choice to low risk pregnant women who are likely good candidates for midwifery led birth center model of care and lack of educating physicians and hospitals about high quality, safe, and cost-effective birth center maternity care;
- Lack of inclusion in networks and exclusion in directories of insurers; and
- Difficulties in credentialing and reimbursing licensed midwives to provide maternity care in the hospital setting for transfers of birth center moms which would provide better outcomes.

A. Frances Schwartz
Integral Healthcare for Women, LLC

In regard to aspects of the Draft White Paper that need further consideration and could benefit from:

1. Clarifying that the Episode Of Care (EOC) is a low risk APM because maternity practices were developed to treat medical problems are now applied routinely to all pregnant women regardless or their risk, encouraging medically unnecessary interventions;
2. Define a uniform EOC period of commencement and termination;
3. Differentiate the different types of birth centers as free standing, independently owned, hospital owned FSBC, or inpatient hospital birth centers, since hospitals shouldn't receive the benefit of higher fees as inpatient hospital care for outpatient birth center services which achieve lower costs;
4. Standardize the quality metrics upon which the APM payment will be based;
5. List the exclusions to the low risk EOC by carving out high risk complications during prenatal care and labor, birth and postpartum for mom and baby;
6. Provide for education to women on their choice of providers and site of delivery including midwifery and birth centers with information on quality maternity care among physicians, midwives and hospitals, and transparency of costs, bundled payments and outcomes. Just as important, educating physicians and hospitals about low risk care and birth center delivery;
7. Include birth centers in wellness programs for women's health in preventive and well care visits, pre-pregnancy education, family planning and contraceptive counseling;
8. Specify a bundled or blended payment of facility costs for birth center and the professional (obstetrician or midwife) fee for labor and delivery into a single payment to align goals in reducing rates of cesarean delivery and early inductions thus improve quality of maternity care, otherwise hospitals do not have a financial lever to use with providers;
9. Encouraging credentialing and reimbursement of licensed midwives to provide maternity care in all sites of delivery;
10. Access to comparative quality data including different providers and birth settings; and
11. Include enhanced quality and individualized services for the term of post partum care with home visits, telemedicine, and appropriate follow up for lactation and parenting so that women may return to work confident in their support.

Thank you for this opportunity to comment on the Draft White Paper and I look forward to the final White Paper so that quality maternity care will be rewarded within the healthcare delivery system to the benefit of all.

Sincerely,

A. Frances Schwartz

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Health Care Transformation Task Force

May 23, 2016

VIA ELECTRONIC MAIL

Lew Sandy, MD
Chair
Clinical Episode Payment Work Group
Health Care Payment Learning and Action Network

Re: Comments on Draft White Paper: Maternity

Dear Chair Sandy:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] commends the work of the Health Care Payment Learning and Action Network's ("LAN") Clinical Episode Payment Work Group ("Work Group") on its draft White Paper on Maternity Care\ Framework ("White Paper" or "Framework"). The Task Force appreciates the opportunity to provide comments to the Work Group, and looks forward to collaborating with the LAN and all of its work groups to help facilitate widespread health care delivery transformation.

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology and data for setting target prices and the way issues such as attribution are handled. We also believe that bundled payments can promote greater transparency for patients in the evaluation and selection of health care providers. Transparency, in general, will lead to shorter cycle times to refine program designs while also creating greater confidence in the technical aspects of any bundled payment program.

[1] The HCTTF is a group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

The Task Force is supportive of the LAN's draft proposal of a maternity care payment model, and we agree that both mothers and their babies would greatly benefit from a comprehensive model that supports person-centric, interdisciplinary care across the prenatal, labor & delivery and postpartum episode. We also support models that promote vaginal births, and reduce primary Cesareans for low-risk first births and prevention of early elective deliveries that are not medically indicated.

Our recommended refinements to the Maternity Care Model design include:

Episode Timing

The Task Force advocates adjustment of the episode definition and price based on differing numbers of prenatal visits. According to the Bureau of Maternal and Child Health Bureau data in 2011, 73.7 percent of women giving birth received early prenatal care in the first trimester, while 6 percent either received first prenatal care in the third trimester or did not receive prenatal care at all.[2] In States where Medicaid has not been expanded, frequently women experience coverage continuity issues due to loss of benefit eligibility. This leads to delay in first perinatal.

Patient Population and Transparency in Episode Creation

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology for setting target prices for each hospital or participant. Data is key to fostering consensus and reaching agreement on appropriate structures to manage bundled payment programs. We believe greater transparency will lead to shorter cycle times to refine program designs while also creating greater trust in the technical aspects of any bundled payment program.

In order to ensure access to maternity care, we agree with the LAN's support of the broadest possible patient population, with risk and severity adjustment to account for maternal age, BMI, complexity and socioeconomic factors. We believe this should be acknowledged at the start, and should be considered by the LAN as a challenge to be addressed by constructing episodes that work for a broader set of patients. It is critical to include both the mother and baby in the episode so as to effectively assess the true 'quality of care' that was provided. We are in agreement that models should incorporate high-value support services, such as nutrition, mental health services, advanced practice nurse/practitioner, doula care and prenatal and parenting education.

[2] http://mchb.hrsa.gov/chusa13/health-services-utilization/p/prenatal-care-utilization.html

Services

We support the White Paper's inclusion of services that are not commonly covered but beneficial to maternity care including care provided by doulas, care navigators, group prenatal visits, and breastfeeding support. We also recommend adding home visits to these services.

Patient Engagement

Ensuring the mothers have a 'voice' in their care decisions is of primary importance regardless of the payment structure that reimburses these services. Therefore, we support notifying mothers of their involvement in a bundled model via a beneficiary notification, but we do not recommend requiring an active agreement to participate in the model.

The Importance of an Accountable Entity

In our view, episode definitions should not prescribe who can be an accountable entity in bundled payment contracting. We believe a wide range of organizations dedicated to integrating and coordinating the work of practicing physicians and health care providers across care setting may be appropriate for assuming risk and managing a bundled payment program. We urge the LAN to be inclusive, rather than exclusive, on the accountable entity question to encourage innovation and foster market-based arrangements dedicated to bundled payments.

Notably, the CEP Work Group was agnostic on this issue in its EJR bundling white paper. While recognizing that the maternity bundle white paper explains why the position taken here, we believe the better course of action from a policy perspective is to have consistent positions on the accountable entities across all bundle types. Thus, the HCTTF respectfully requests that the LAN adopt the inclusive position proposed above.

Payment Flow

Initial determination of whether a mother is considered 'low risk' can be made at the first prenatal visit. However, this status can change during the course of pregnancy. For this reason, a retrospective payment model may be a better choice than a prospective payment model for maternity care.

Type and Level of Risk

As mentioned previously, initial determination of whether a woman is 'low risk' can be made at the first prenatal visit. A 'high-risk' pregnancy is one which puts the mother, the developing fetus, or both at an increased risk for complications during or after pregnancy and birth. Clinical parameters for identifying a high-risk pregnancy can include:

1. Pre-existing health conditions: diabetes, hypertension, epilepsy, HIV, liver disorders, renal disease, coagulation disorders, cardiovascular disease, cancer, obesity (BMI > 30), advanced maternal age (mother's age 35 and older), mental health condition

2. Life-style choices: cigarette smoking, alcohol use and illegal-drug use
3. Previous pregnancy complications: genetic or congenital disorder, stillborn, preterm delivery
4. Pregnancy complications (can also arise during the pregnancy): multiple gestation, oligohydramnios, polyhydramnios, fetal growth restriction, rhesus isoimmunization, prolonged premature rupture of membranes, intrauterine fetal demise (IUFD), placenta abnormality (previa, accreta, increta, percreta, previa, vasa previa and abruption)

The bundle implies fee-for-value payment, and the methodology needs to account for outlier case management much like other bundles, including Comprehensive Care for Joint Replacement (CJR) have done.

Suggested exclusions might include: NICU care for prematurity, intrauterine growth restrictions, known congenital conditions and other selected exclusions which would be paid separately from the bundle.[3]

Patient-Focused Quality Metrics

We support the use of patient-reported outcome and functional status measures. However, we recommend that providers only be subject to performance in quality metrics that have been validated by sufficient data and accepted by institutions such as the National Quality Forum or the Perinatal Core Measures. In the CJR model, patient-reported outcome measures are not mandatory and providers are only being held accountable for the collection of the information, not the measures themselves. As these tools become widespread, the LAN should review and recommend which quality metrics show actual improvement in patient lives and have a dedicated group to continuously review quality metrics and ensure that they are aligned with other value-based arrangements.

We also recommend consideration of a provider portal, likely separate from provider EHRs, where providers can access their individual average quality, costs and utilization across episodes over a given period of time. This proved to be a key component of the Arkansas Health Care Payment Initiative Perinatal Bundle.[4]

[3] "Toolkit to Support Vaginal Birth and Reduce Primary Cesareans." California Maternal Quality Care Collaborative, 2016.
[4] http://www.iha.org/sites/default/files/resources/issue-brief-maternity-bundled-payment-2013.pdf.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

Lee Sacks
EVP Chief Medical Officer
Advocate Health Care

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Farzad Mostashari
Founder & CEO
Aledade, Inc.

Shawn Martin
Senior Vice President, Advocacy, Practice Advancement and Policy
American Academy of Family Physicians

Peter Leibold
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Dana Gelb Safran, Sc.D.
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OSF HealthCare System

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Providence Health & Services

Steve Wiggins
Chairman
Remedy Partners

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SCL Health

Bill Thompson
President and Chief Executive Officer
SSM Health Care

Judy Rich
President and Chief Executive Officer
Tucson Medical Center Healthcare

Rick Gilfillan
President and Chief Executive Officer
Trinity Health

Dorothy Teeter
Director
Washington State Heath Care Authority

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Lamaze International

May 23, 2016

Lewis Sandy, MD, MBA
Chair, Clinical Episode Payment Work Group
Health Care Payment Learning & Action Network

Dear Dr. Sandy:

Lamaze International appreciates the opportunity to respond to the Health Care Payment Learning & Action Network's (LAN) Clinical Episode Payment (CEP) Work Group's draft white paper, *Accelerating and Aligning Clinical Episode Payment Models: Maternity Care.* Standardizing accessible and high quality maternity care is critical to eliminating health disparities, reducing costs, and improving the health of mothers and babies. Lamaze commends the LAN for initiating this effort.

As the nation's leading childbirth education organization, Lamaze can attest to the critical role that high-value support services, such as evidence-based childbirth education, have in consistent prenatal care. Lamaze's mission is to advance safe and healthy pregnancy, birth, and early parenting through evidence-based education and advocacy. In doing so, Lamaze's Certified Childbirth Educators (LCCE) use the latest, evidence-based curriculums to help women and their partners make informed and shared decisions regarding pregnancy, childbirth, and breastfeeding.

A comprehensive maternity care model that includes evidence-based childbirth education is critical to realizing the Work Group's goal of creating a more patient-centered approach to maternity care. Without adequate prenatal care, women and their children face many short- and long-term setbacks that contribute to life-long disadvantages. Comprehensive prenatal care goes well beyond screening, measuring bellies, and checking weights and blood pressures. Women who receive information from trusted resources such as childbirth educators are more likely to integrate healthy behaviors and make decisions based on best known practices. While medical practitioners often have limited time to explore the social, cultural, and informational variables that impact the health behaviors of pregnant women, childbirth education provides more extended opportunities to explore the benefits and risks of health decisions.

LCCE instructors see firsthand how fragmented healthcare delivery prevents many women who are pregnant from seeking and accessing quality and comprehensive childbirth education as part of their prenatal care. The lack of a robust set of standardized quality metrics that can assess the impact of childbirth education and other practices hinders efforts to evaluate best practices for comprehensive prenatal care and shared-decision making. Lamaze supports the Work Group's initiative to call upon payers to encourage their pregnant beneficiaries to assess how their values and birthing preferences align with their providers' practices and care arrangements. Lamaze encourages the Work Group to further call upon payers to include evidence-based childbirth as a covered service.

Lamaze applauds how the Work Group framed its maternity care episode and offers three recommendations to strengthen the proposed model.

1. **Explicitly Define Childbirth Education**
   Lamaze appreciates the Work Group's acknowledgement of childbirth education as a component of comprehensive prenatal care. It is critical, however, that the final model explicitly defines childbirth education in terms of content and instructor credential. Often, what counts as childbirth education is in practice an afterthought in prenatal care. A brochure that a woman receives from a nurse during a prenatal wellness visit or a tour of a hospital's labor and delivery suite is not adequate childbirth education. To optimize the role that childbirth education should have in prenatal care, Lamaze recommends that the Work Group explicitly define childbirth education as "a comprehensive, evidence-based curriculum taught by childbirth educators who are certified by a National Commission for Certifying Agencies-accredited certification body," such as Lamaze International.

2. **Develop a Plan for Measuring the Effect that Specific Interventions have within the CEP**
   Lamaze agrees that a bundled payment model will help facilitate a continuum of care for mothers and newborns, but recommends that the Work Group develop a mechanism for measuring the effect that specific interventions have within the bundle. Systematic change requires data. And while bundled episodes increase efficiency, they make it difficult to assess how each component within the model affects the process and outcome. The maternity care CEP may increase childbirth education access and utilization, but without a means to measure its value, does not safeguard its long-term or widespread implementation. Lamaze supports a plan for measuring the effects of specific interventions.

3. **Define Outcomes and Measures**
   Lamaze applauds the Work Group's intent to use the Patient-Activation Measure as a means to track patient-engagement and generate data regarding prenatal care. Although the Work Group's proposed model does not define specific quality metrics, Lamaze recommends that future metrics include "comprehensive, evidence-based childbirth education taught by childbirth educators who are certified by an National Commission for Certifying Agencies-accredited certification body," such as Lamaze International.

Lamaze appreciates the opportunity to provide feedback on the LAN's CEP for maternity care—and acknowledges the tremendous amount of work and collaboration that the Work Group has devoted to this initiative. The Work Group's commitment to transparency in developing and implementing the model episode payment is laudable and Lamaze stands by as a resource, advocate, and partner in streamlining comprehensive maternity care for all women.

Sincerely,

Maria J. Brooks

Maria Brooks, BSN, RNC-OB, LCCE, FACCE
President

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

LAN Listening Session: Opportunities & Challenges in Maternity Care Episode Payments

LAN Listening Session: Opportunities & Challenges in Maternity Care Episode Payments

Questions and Comments May 24, 2016

Discussion Questions:

1. Jennifer Darden: Is there any discussion about increasing post-partum period to 90 days?

Lew: Good point. We didn't talk specifically about that. The issue is that by that period of time, most typically the mom would have been discharged from traditional maternity care and back into primary care. We did have discussion about how much of general women's health to include in a maternity bundle particularly as so many women get primary care from their OB/GYN.

2. Julianna Hart: In terms of patient population, why are high risk mothers not included?

Lew: We wanted a broad a population, but in this one the issue is that there is so much heterogeneity in high risk. High risk can be a high risk for so many reasons. As a practical matter it could create widespread cost variances depending on what subset of high risk patients you had. Also patients become high risk at different times in the pregnancy.

Cara: we also were trying to consider what the providers would want to do—eliminate concerns about being held responsible for things outside of their control. Creating provider buy-in to the concept.

3. Deidre Gifford, National Association of Medicaid Directors: Definition of included participant question: Can you talk about decision to exclude pre-term birth from episode when main goal of the model is to increase rate of full term delivery? That seems like a real challenge. Are there other ways to approach that challenge other than excluding preterm births from the bundle?

Lew: Many things lead to preterm birth—early elective induction is different—can be caused by things not under control of provider. They tend to avoid accountability for things they don't have a lot of control over.

Cara: It's complicated. Trying to balance where we are with where we want to go. We'd like to be inclusive of all women… this is a first go. Expect this will be iterative. LAN is responsible for conceptual framework—actual providers and payers will work through details. There is room for iteration.

4. Sharon Pollack: Are your efforts being informed by particular efforts? If so, which ones?

Tanya: Appendix D lays out specific programs we have studied.

5. Cynthia Flynn: We could enhance maternity care with more emphasis on birth centers!

Cara: I agree that midwives and birth centers are a great way to increase value in maternity care.

6. Benjamin Kowitt: How do you select low-risk mothers?

Tanya: Discussions in paper defines population. (*TA opened floor to informal discussion of this topic)*

Lew: This was challenging. More a question of defining low risk. We couldn't find a standard definition of low risk pregnancy. This turned out to be surprisingly challenging. If anyone has suggestions about how to do this better…

7. Benjamin Kowitt: No. That makes sense. Singleton in absence of other risk factors… I wanted to also ask: do you consider excluding babies if they have high spend or abnormalities?

Lew: What we did was try to keep inclusion, but when there were unanticipated things like the NICU, use stop loss etc. to basically address unanticipated consequences.

8. Lauren Kennedy: Patient engagement is assumed, are there specific initiatives that make this type of engagement feasible? Are there things in pace to engage patients?

Lew: We did put some best practices in the paper. If you have more of an episode based model you create an incentive for this type of engagement.

Cara: There's a whole steam of work around patient engagement that is very active with new things being added all the time. We want to make sure metrics include patient reported outcomes or more generic patient satisfaction score to make sure concept of quality is not just provider driven.

9. Fran Schwartz: no comment

10. Anne Marie Lesch:

When you look as episode concept, was there discussion around whether this would count as a warranty?

What percent of total birth would this target?

Lew: for a, 80% of deliveries are low risk. On warranty (b), what would that look like in maternity?

Anne Marie Lesch: I don't have anything specific to share right now. The whole definition—you would build that into the metrics. That would get at getting everyone more engaged.

Lew: Thank you for that.

Cara: I am not sure if it got cited, that 80% comes from xxx data extracted from national birth certificate data. (e.g., post 37 weeks and vertex births)

11. Lauren Kennedy: Are there incentives around transparency to be talking with patients about what is in a bundle?

Lew: How do you have a robust engagement so people understand there may be differences? We did talk about that. But there is a lot of work that needs to be done.

Cara: it's tricky—to the extent that you are having conversations with individual family to help them understand how their care is paid for. We do that in birth centers extensively. For many people, a pregnancy is the first time they have had much interaction with their health plan so they are learning about co-pays, deductions and insurance. As it applies to maternity care it needs to be an individual conversation.

12. Barbara Dickens: What push-back do you anticipate from the provider community?

Lew: likely to vary by geography stages of readiness. The majority of all births are covered by Medicaid and that is a very different population, different set of arrangements between purchasers and plans. Many innovations come from state Medicaid agencies working with providers and plans to test episode payments out.

13. Tina Morey: Did the group discuss enrollment of baby in another policy?

Lew: In most commercial plans, if the mom is covered by carrier than the baby is rolled into that coverage as well. I don't know how often that happens… [*Referring to the opposite*]

14. Susan Bausch: What innovations have been identified to capture and identify the at risk pregnancy for those not seeking care until the later trimester? (i.e., fear of legal action with drug use), teen pregnancy), etc.) Would they be excluded from the outcomes?

Lew: the broader question is what can we do to get people into care as early as possible? One idea is [to use] as wide a set of lenses as possible with whole idea of reducing barriers or worries about stigma so people can get the care they need.

Cara: One of the hopes with episode payment is to leave enough room for creative design of care model to allow for things like heavier reliance on community health workers to get people into care. If the financial reward is tired to minimizing cost and maxi outcomes—things like bringing people into care as early as possible should be incentivized.

Additional Questions Submitted via Chat Window:

1. Thank you all for coordinating this. It was tremendously beneficial to me, especially just starting to understand the all-payer population's needs. Much to consider! - Phillip (Truven Health Analytics)
2. Brynne Potter: Please note my comment related to allowing accountable entities to define and include high/low risk pregnancies. Similar to the ability define other elements of the bundle.
3. Interested in your thoughts around the physician who would "own" the episode. Delivering physician? Physician who saw the patient during pregnancy?
4. Inclusion of other services within the episode bundle, such as prenatal vitamins, Lamaze classes, what to expect from pregnancy would be beneficial.
5. I have a comment/question related to Dr. Sandy's comment about "innovations" that are not adequately supported in FFS (refer to slide 13): The work group could consider adding/calling out other evidence-based care (e.g. Medical Nutrition Therapy in pregnancy, and high risk populations such as GDM) that is not supported in FFS. What is the best way that the CEP can call out the need to include innovative & value-based services more categorically and not necessarily by provider type? (E.g. doulas who may or may not be licensed providers). If you are going to list Doulas, the workgroup may want to consider adding other provider types, for example (e.g. Registered Dietitians). Thank you, Michelle Kuppich
6. Can you share what the discussions were in the workgroup around the availability of so-called "enhanced prenatal care services." such as Doulas, group prenatal care, care navigators, etc. Did the workgroup have a sense of the availability of these services; and whether this might be a challenge particularly for safety net providers? Thank you
7. Often the coverage of the baby is determined by the birthday rule.
8. I missed the webinar today

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LAN Summit Session 11A: Maternity

Questions & Answers

2016 LAN Spring Summit Session

11A: Improving the Delivery of Maternity Care via Episode Payment: Opportunities and Challenges

Detailed Q&A Notes

- Karen Love – CHC
- Maureen Corry – NPWF
- Cara Osborne – Baby+Co

Cara Osborne facilitated the Q&A:

- American College of Nurse-Midwives
    - In your White Paper, one of the models you discuss says birth centers or birth center midwives partnering with hospitals where there's a single bundle or payment provided to this group. So the care starts a lower level facility like a birth center, if the patient prefers that, and if there is a need for a transfer the providers work that out. If I was a payer, I would look at that and say it is awesome; it will save me millions of dollars. If I was a birthing center I would also say it is awesome, but if I were a hospital, I would say it is not so awesome because of market share.
- Cara Osborne
    - That depends on the hospital. That is actually part of the evolution with our Wake Med system in the research triangle in North Carolina. We started as joint venture partners in the birth center and now have now pulled their employed practice in such that we now have a pretty continuous episode of care. The midwives now have more privileges in the hospital so they can keep those transfers more to themselves, and are definitely working with the WAKE ACO group toward a flat rate that would be inclusive of facility fees in the hospital and birth center and provider fees.
- American College of Nurse-Midwives
    - How do you get the hospitals to start seeing this as something positive for them as opposed to a loss of market share?
- Cara Osborne
    - I think you have to pick the right hospital. Maternity care for the grand majority of hospitals is a lost leader. It's like candy in the checkout isles in the grocery store. They are in the maternity care business to bring families into their network who will later on need additional services like hip and joint replacements or cardiac care where they generally carry more of a margin. In some of our hospital partner examples, such as Vanderbilt in Nashville, TN, they are way overcrowded, and brought us in to sort of decant the volume at their hospital, so they would have room to take care of higher risk, regional referral cases. It the Wake Med example, it was met frankly as a volume driver and marketing hook to say "we are one of three or four hospitals in the triangle that do labor and delivery, and are one of

the centers partnered with a birthing center." The Chapel Hill center with UNC is not directly partnered. The safety issues are my priority, and also making sure the incentives are aligned in all directions. You are exactly right; a situation in which there is a flat rate regardless of ultimate provider and place of delivery is sort of the shining star to work toward.

- American College of Nurse-Midwives
    - My other question is for Karen. When you look at quality metrics produced by providers, there is a problem that has existed since the inception of Accountable Care Organizations (ACOs), that is, you are looking at performance as it is relative to a benchmark, and that benchmark is usually their own performance from some prior period. Then you have your own performance period that you have really tried to improve. You do better and get rewarded for it, and then there is your next performance period wherein your benchmark becomes your previous performance period, so you are trying to beat yourself. Then you get into this spiral and it becomes harder and harder to improve. Have you thought about this? What is a good way to respond to that?
- Karen Love
    - In our marketplace, we are a long way from getting close to that floor. So I think there is a lot of room for improvement year after year. That is what we were thinking of doing in that asymmetrical share model, so even at zero change in your quality, you still gained than you did if you had a loss. So we are awarding the quality improvement as well as the cost improvement.
- National Rural Health Association
    - In rural America, over 50 percent of rural counties do not have, whether through a primary care provider or OB/GYN, access to delivery services. In rural America, you are considered to have access if you are within a two hour drive. You do not want to deliver a baby on a road trip to delivery services. That is my big concern, and my concern with this bundle concept, as much as I love it, is that it is going to make this access to care problem worse. It is going to make these patients less desirable in these sorts of bundles. When women are 4 hours from a center and you can deliver in sort of a non-emergency way, these women have to consider taking time off of work to stay at a hotel or with family near a hospital. They consider being induced or having elective C-sections, not because they want those services, but because there is just no access to care. So I have concerns about this concept, as nearly 20% of women live in rural areas without direct access to care. What is this concept going to do address this issue?
- Cara Osborne
    - I'm from eastern Kentucky, and it doesn't really get more rural than that. As I work in northwest Arkansas, we are grateful that Mississippi exists, so we are not last to access healthcare. We can usually rely on Mississippi to help us out. It is true that some people do not have access, and when they do have access it is often something they don't want. We are the only birthing center in our area in Arkansas, and it has been an uphill fight, and I'm not sure when it will be over because we have not been able to get over a variety of the hurdles that make things hard for us in a state like Arkansas. But theoretically, should big

payers and managed Medicaid adopt this sort of bundled payment structure, it actually maternity care a more attractive business to be in. For people like me with businesses that serve to grant access to care to those without it, having an episode payment structure acknowledges that what we are doing is of significant value, rather than saying birth centers cost less to run so since it costs less we should pay you less, and or saying it is a significant decrease in expense than from hospital birth. We should consider the consolidation effect occurring across rural counties, there is a real push to bring people to the centers rather than push people out to the communities. The good news for someone like me is that it leaves a lot of opportunity for empty real estate and hospital buildings where midwifery services or in-dwelling birthing centers are a possibility. So it doesn't discourage additional maternity services; it encourages a particular sort of maternity services which we hope would be of higher value to those people.

- National Rural Health Association
    - I do appreciate that. I would like to see more of a stop gap to ensure that it doesn't further erode access issues.
- St. Louis Area Business Health Coalition
    - A couple of years ago, we tried to put together a maternity bundle. What stopped it was a lack of agreement on the quality measures. I appreciate the LAN for putting forward an outline of what that might look like. Two questions: 1) when pursuing contracting for that, how do we ensure that our independent OB/GYNs are not left out, and sort of preserving that patient choice? 2) how do we convince people of the need for doulas? Do you all have resources on that?
- Maureen Corry
    - Yes, our website Chilbirthconnection.org has an entire section on labor support. We also have the doula paper, but that is not written for consumers. I think reading these will be very helpful, as it is written for and to be accessible to women upon best evidence, and there are around 30 years of evidence. In actual care there is a 28 percent reduction in C-sections and other great things. One of the problems is the expense of doulas; in the New York area it can be as expensive as $2k for a birth, but I'm sure it ranges around $500 or less. But some hospitals are going to community centers and are offering it as a complimentary service. It is a great way to encourage women who have had babies to help other women in their communities. So that's another way to think about it.
- St. Louis Area Business Health Coalition
    - Can you talk about the contract piece?
- Karen Love
    - I do think it will be a difficult thing to do because there are things forcing smaller group practices into larger groups. If you want to make that single bundles payment to that solo entity, that provider probably doesn't have the capability of distributing that payment amongst the others who also participate in the care. So how does that provider split the cost with a neonatologist and hospital involved? I don't have a good answer for that. I don't know if that solo practice provider is ever going to have the margin to do some of the things we are talking about such as doulas. Their margins on their business is so small that it doesn't matter if I am making a payment to them. I can tell them that they can use that bundle payment to pay for whatever you'd like, like hiring a doula, but their margins are so

small that it is hard for them to bring in those resources. I am not sure if there is a good answer for the solo OB/GYN practice in this model.

- American Congress of OB/GYN
    - Thank you for this presentation and the White Paper. I was pleased to see that you insisted on including the infant's outcomes and cost. We've seen some very disturbing multi-payer initiatives in certain states that only look at the mother's cost but don't look at the infant's cost or whether NICU admissions or bad birth outcomes were avoided. I've heard from those states that they just can't make the data linkages, so Karen, can you talk about whether that was a problem for your plan or if any of you have heard that from other groups?
- Karen Love
    - I think that is more of an issue for commercial plans because we are primarily in the Medicaid business and we are doing this pilot program right now with Medicaid or CHIP perinatal moms. Those babies are automatically assigned to us so we know about them right away and we are able to use proxy numbers in the interim. I didn't know it until we got there but that has been a question for me at almost everywhere I've gone. It is not hard for us to link the mom and the baby.
- Cara Osborne
    - From an epidemiology standpoint, I would say the issue is that there is no cross-linking identifier from the mom's and baby's record, and it is not even the birth certificate. So it is difficult to see what that baby born on that birth certificate looked like or went on to do in life. That being said, I see one of the panel here is about data linkage and use, as we evolve the data warehouse and state-level data exchanges, that is something that will exist a few more years but will fade over time. It won't be a good excuse anymore.
- American Congress of OB/GYN
    - Regarding post-partum contraception, that was one of the high-value services that you recommended in the White Paper. Can you talk a little about how you handle it in your plane, Karen?
- Karen Love
    - Only for the past year has Texas Medicaid covered LARCS (Long-acting reversible contraceptives), so it is not built into the historical data and budgets. I am more than happy to include that in my bundle, so I guess the question for us as the plan is "what can we do?" We can certainly provide educational resources, Maureen and I discussed that ahead of time, trying to better educate the women in our community, working with our provider groups to ensure their education on the matter and to understand that it can be paid for, and providers may have to do a pass through add on because it is not built into the history. I would be absolutely willing to do that if there were some way to encourage it. What I don't know, to be able to do that, if education is the evidence base to support it at the time after delivery, or doing it sometime post-partum, so I need that education in order to educate our moms.
- OB/GYN - CMMI
    - I was wondering if VBAC fits into this picture, or is it part of a different picture.
- Karen Love

  - For us, built into the expected budgets, was the historical mix C-sections and vaginal births. The provider that is doing a little better is the one with vaginal births as a percentage compared to what they were historically. But I don't have a specific quality metric tied to VBAC. To the extent that that is a less costly or safer option, then that's when they would have incentives to move in that direction.
- Maureen Corry
  - I don't think there is a nationally endorsed measure of VBAC that is included in the NQF measure set or joint commission. So that is problematic and I don't know if anything will change as a result of their meetings over the next month or so. But it is important to reduce the overall number of C-sections for sure.
- OB/GYN - CMMI
  - Also, I volunteered…
- Maureen Corry
  - A survey reported in 2013 showed that among women with a prior C-section, around 60 percent seriously considered a VBAC, but were unable to. 25 percent because of provider unwillingness, and around 18 percent because of Hospital unwillingness. Women are more and more interested, and you can see it in the media, and most evidence supports most women will have a successful VBAC, so it is certainly a viable option for women. To talk about the rural health issue…
- Someone spoke: people have to travel long distances, even in major cities.
- Cara Osborne
  - In our area in Arkansas there is a de facto VBAC ban. Hospitals and OBs have come together to say that it is unreasonable to expect them to meet ACOGs statement around immediate access to emergency delivery. It always begs the question for me, what do you do about all of the other emergencies that are not a uterine rupture or when a kid has fetal distress for any other reason? Don't you still need emergency availability for emergency C-sections? But from their standpoint, they have been able to lean pretty hard on the ACOG statement, and that is their reason to just not provide the service.
- Maureen Corry
  - And of course, ACOG has updated that statement and talks about how women should have the right to make that decision, but it really has not changed too much in practice unfortunately.

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ACCELERATING AND ALIGNING
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Maternity Care

White Paper

Comments:

Linda C. Davis

Linda C. Davis – Independent Consultant
Comments on Maternity White Paper

I am an independent health care consultant with a long and extensive history consulting to employers and their health care coalitions. For the last five years, I have conducted multiple "Learning Networks" for groups of public and private purchasers including the largest employer members of the MN Health Action Group, on a variety of topics. Their Maternity Care Learning Network, conducted over 2 years ago, included meeting with numerous Minnesota based maternity care providers. It increased the employers' and my understanding and appreciation of the value of Free Standing Birth Centers (FSBCs) and the midwifery model of care.

This work led to the American Association of Birth Centers (AABC) retaining me as an independent consultant. Through my work with employers and AABC, I have discovered many barriers to increasing consumer access to these facilities and models of care, and therefore precluding dramatic improvements in the quality and value of maternity care. The opinions below are my own and do not represent positions of either the MN Health Action Group or AABC.

One fundamental barrier is employer and health plan lack of awareness of the existence of FSBCs, in part, due to their scarcity. Other barriers include State regulations, often influenced by local providers, and local competitive and market forces often played out through health plan contracting behavior. Examples include lack of inclusion in provider networks, lack of sustainable payment, exclusion from provider listings, and lack of inclusion in tiered/narrow networks. If birth centers were paid sustainable rates, they could proliferate, expand and innovate, thereby increasing consumer awareness, acceptance, and access.

Another barrier is lacking knowledge of how to evaluate and differentiate the quality among FSBCs. While there is variation in the experience, size, practices, and cultures of FSBCs, there are evidence-based methods to evaluate their safety, quality, and outcomes, that health plans and consumers can use to select high value providers. Accreditation by CABC is one of these methods.

I would like to submit the following comments and recommendations on the HCP LAN Maternity Care White Paper.

1. Re-title the document to "Low Risk" Maternity Care. The entire document applies to low risk mothers.

2. Strengthen and specify the goal of "increasing the level of coordination across providers and setting of maternity care" to "increase *collaboration* between midwives and physicians as well as birth centers and hospitals, including granting admitting privileges to qualified midwives where permitted" to communicate this is a purchaser expectation. Hospital admitting privileges should not be denied for political or financial reasons.

3. Define low risk as specifically as possible and acknowledge that risk levels can change throughout an episode, from conception to labor and delivery.

4. Address how changes in risk levels affect inclusion in the Episode Definition (1), e.g., are specific services paid outside the bundle on a fee for service basis or does the entire episode revert to FFS.

5. All references to hospitals should also include FSBCs or be changed to “site of delivery”

6. In (1) Episode Definition, address what happens to payment when patients are transferred from a birth-center to a hospital both 1) when midwives admit the patient and follow them and 2) when care is transferred to a physician. Transfers are frequent enough to warrant addressing.

7. Recognize that birth centers and their clinicians, as the Accountable Entity (6) are both involved in prenatal care, unlike hospitals.

8. Provide some parameters and guidance when describing Episode Price (8) as a “balance between provider-specific and multi-provider/regional utilization history”.

    a. What defines a region; hospital service area, MSA, county, state, other?
    b. Is the “balanced” episode price a 50/50 split between the individual provider’s price and the regional historical price? Is it based on the market share of the respective providers, e.g., a small provider with 1% market share contributes 1% to the episode price while the market represents 99%?
    c. Provider market power and its impact on pricing should not affect value-based payments. Lower priced facilities, e.g., FSBCs, that deliver equal or better outcomes should not be punished with lower payments due to lack of provider market power.
    d. Is utilization based on one, two, or three years experience?
    e. How will regional comparisons affect price?

9. The Quality Metrics (10) listed as outcomes in the white paper are intermediate outcomes; vaginal/cesarean rates, episiotomy, and early elective births. Outcomes such as post partum depression, mother-baby bonding, functional status, quality of life and other patient reported outcomes should be considered as potential quality outcome measures in the future.

10. Gathering, measuring and reporting quality metrics often involve acquisition of proprietary tools, e.g., the Patient Activation Measure (PAM), software, analytic tools, and expertise. These expenses should be considered in the episode price.

11. In Moving Forward: Priorities, transparency of both cost data and quality measurement should be available via a trusted source on a national basis as soon as possible. National payers have begun to publish episode costs, e.g., Guroo, which could be the basis for provider specific cost reporting in the future. The Leapfrog Group reports maternity quality measures of specific facilities. This could be expanded with additional data from the JCAHO, the AABC Perinatal Data Registry (PDR), and other existing registries. The data exist.

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White Paper

Comments:

Maternity Neighborhood

23 May 2016

To: Clinical Episode Payment Work Group

Re: HCP-LAN maternity white paper: Accelerating and Aligning Clinical Episode Payment Models: Maternity Care

Thank you for this thorough and well-articulated overview of the pathway to improve critically valuable service provision for mothers and babies. This paper outlines a model of care delivery that would, by design, be a vanguard for a data driven delivery system for maternity care. Engagement of the woman as the central member of the care team is an essential component for achieving good outcomes and is a critical step in system re-design. Tracking and evaluating that engagement is also vital if we are to make care relationships truly meaningful and useful to patients and their providers of care.

As a digital platform specially designed to support the maternity episode, Maternity Neighborhood (MN) stands ready to engage in new and ongoing demonstration projects of innovative care delivery that takes the "last mile" approach to coordination and connectivity. Our scalable technology platform is designed to work across care sites to directly engage patients in either a stand-alone or fully integrated health system. We engage and monitor patients (and their babies) through the entire continuum of care via a robust set of clinical workflow tools and a patient engagement process called “Care Guide”. With a partnership for measurement with The Dartmouth Institute for Health Policy and Clinical Practice, this process tracks engagement and guides women through the steps of successful communication, education and coordination around the episode of maternity care based on individualized algorithms of risk, values and preferences.

In addition to serving as the technology partner for more than half of all US birth centers, the majority of practicing Certified Professional Midwives, and most out of hospital midwifery practices, including the American Association of Birth Centers-CMMI Strong Start project, MN is also being adopted by more progressive OB practices and health systems. Our Care Guide for maternity engagement is currently powering a successful pilot at Dartmouth-Hitchcock, supporting pregnancy education, patient reported outcomes and experience enhancement for pregnant women being served at the Cheshire Medical Center. Finally, the MN platform is also being used by several perinatal community health worker and doula programs; two high value, low cost models of care that have been proven to enhance patient experience and produce better outcomes in both high and low risk settings.

In sum, our comprehensive suite of tools and the people who use them include everything a community of care needs to design, deliver, measure and code the comprehensive episode of maternity care. We would welcome opportunities to work directly with payers and purchasers ready to redefine the bundle for maternity services for more effective experience and delivery of care.

Brynne Potter
CEO and Founder, Maternity Neighborhood

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
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White Paper

Comments:

Mountain Area Health Education

Center

Comment on the White Paper: A View from the Ground

I am member of the Family Medicine Faculty at MAHEC in Asheville, NC. MAHEC is committed to supplying primary care providers to Western North Carolina. We continue to train residents in full spectrum family medicine including prenatal services and obstetrical care. I came to MAHEC after 33 years of practice in rural East Tennessee. My practice in Tennessee included obstetrical care, and also featured serving as medical backup to a midwife-run out of hospital birth center. In Tennessee I was also actively involved in perinatal systems and systems of care for indigent and Medicaid patients. The opinions I am about to express are mine and are not intended to represent MAHEC. I believe that in setting national policy, it is important to balance the bird's eye view with the view on the ground.

I was pleased to see the draft White Paper recognizes that reimbursement is an important factor in shaping services. I am very supportive of the stated goals of the draft White Paper.

I don't believe the draft addresses adequately the issue of maternity care in rural areas and inner cities. In county after rural county delivery services have disappeared, and hang by a slender thread in others. Once gone, maternity services are difficult to impossible to restore. With vanishing delivery options, prenatal care often becomes remote and less accessible. Inner city communities are beset by challenges such as poverty, violence, racial discrimination, failing schools, and food deserts. Both rural and urban communities are beset by pervasive social problems such as adverse childhood experiences and drug use. Addressing these needs comprehensively is beyond the scope of the white paper to *some* degree, but changes in reimbursement for maternity care can have potential impact in these areas as well. Imagining relevant reimbursement strategies can deliver a strong signal about the intent to address what have been called "social determinants" of health. Examples could include

- Support for care coordination services or community health workers
- Financial incentives to deliver care in rural communities (rather than paying more, for example, in urban areas based on past cost)
- Support for training programs that deliver providers to rural areas and inner cities
- Insistence that recipients of federal funds collaborate with nurse midwives, certified midwives and family physicians in the provision of care (and not just in rural areas).
- Thinking upstream: coupling programs to help our current maternity patients at risk (e.g., drug addicted moms) with support programs to increase social supports and foster quality parenting and child care for the infants being born. If we do not break the generational cycles, the desired social and health outcomes will be hard to achieve.

Wishing HCP-LAN Success in transforming the landscape for maternity care,

Joshua Gettinger
Assistant Professor
MAHEC Family Medicine Residency
Asheville, NC
May 23, 2016

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

National Association of Certified

Professional Midwives

NACPM national association of certified professional midwives

May 23, 2016

To: The HCP LAN Clinical Episode Payment (CEP) Work Group

I am writing on behalf of the National Association of Certified Professional Midwives (NACPM) to provide comments on the Maternity Care Draft White Paper, Accelerating and Aligning Clinical Episode Payment Models. NACPM greatly appreciates the HCP LAN's work to guide and drive the uptake of innovative payment models to incentivize quality maternity care and improve the health and patient experience of childbearing families in the U.S., while significantly reducing the cost of care for this population.

The draft references the important role of midwives and birth centers in improving the quality and reducing the cost of maternity care. NACPM would like to highlight another set of stakeholders: women who choose home birth and the midwives, principally CPMs, who care for them at home. Page 8 of the draft references MacDorman & Declerq's recent article on out-of-hospital birth trends as evidence of increased birth center utilization. We would further add:

- Of the 59,674 community-setting births described in the study, the majority took place *in homes* (38,094 at home, 18,219 in birth centers)
- 88% of the at-home births were planned
- The overall percentage of out-of-hospital births increased by 72%
- This total increase comprises a 71% increase in home birth (0.96% of all births in 2014) and a doubling of birth center births (0.46% of all births in 2014)

CPMs were among the providers in the study on birth centers referred to in the whitepaper, and contributed to the improved outcomes and reduced costs. CPMs are the fastest-growing segment of the midwifery workforce, and additionally contribute expert practice and policy infrastructure for community care delivery. The past several years have seen several regional and multi-state CPM-led quality initiatives focused on professional collaboration, safe transport, and inclusion criteria for community birth. We believe this expertise is critical to the success of any care episode strategy that prioritizes women's choices and promotes physiologic vaginal birth.

Research demonstrates that the care of CPMs for women choosing home birth results in high rates of successful vaginal birth, low rates of cesarean section and premature and low-birth-weight babies, decreased morbidity, high rates of successful breastfeeding, and comparable neonatal outcomes to babies born to low-risk mothers in hospital. Including these women and CPMs in system reforms designed to incentivize quality, improve health outcomes and emphasize value over volume will significantly support achievement of these goals.

A meta-analysis comparing studies of home and hospital birth (Wax et al., 2010) found that the following outcomes favored home: reduced preterm birth and low birth weight; reduced use of epidural, electronic fetal monitoring, episiotomy, operative vaginal birth, and cesarean birth; and

reduced lacerations, infection, postpartum bleeding/hemorrhage, and retained placenta. A subsequent report of nearly 17,000 planned home births reported favorable results congruent with the 2010 meta-analysis (Cheyney M, et al., 2014).

A 2007 study in Washington State found that community-based births attended by CPMs resulted in fewer low-birth weight babies and much lower cesarean section rates, while delivering substantial savings to the state budget (Health Management Associates, 2007). In one example, with just 2% of births over a two-year period, savings were just under $500,000 in prevented cesarean sections alone.

Currently, variation exists across the country for how well-positioned CPMs are to participate in payment reform models; however, there are numerous examples of states and communities where CPMs are licensed, where they own home birth practices and licensed birth centers, where they have strong consulting and collaborative relationships with Certified Nurse Midwives, physicians and hospitals, and where CPMs are enrolled in health plans and have public and private payer contracts.

CPMs and the women they serve are ripe for inclusion in clinical episode-based payment models. In-home maternity care is the safe choice of an expanding population of low-risk women in the US. The excellent outcomes and corresponding cost savings achieved by these providers and these women will contribute greatly to the success and development of these innovations.

We sincerely appreciate the opportunity to comment, and thank you for your consideration.

Sincerely,

Mary Lawlor, CPM
Executive Director, NACPM
executivedirector@nacpm.org
917-453-6780

References:

Cheyney M, Bovbjerg M, Everson C, Gordon W, Hannibal D, and Vedam, S. (2014). Outcomes for care for 16,942 planned home births in the United States: The Midwives Alliance of North

America statistics project 2004-2009. Journal of midwifery and women's health, 59: 17-27. doi: 10.1111/jmwh.12172

Health Management Associates (2007). Midwifery licensure and discipline program in Washington state: Economic costs and benefits. Self-published: Lansing, MI. Available at: http://www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf

MacDorman, M. F., & Declercq, E. (2016). Trends and Characteristics of United States Out-of-Hospital Births 2004-2014: New Information on Risk Status and Access to Care. Birth (Berkeley, Calif.), 43(2), 116-124. doi:10.1111/birt.12228

Wax JR, Lucas FL, Lamont M, Pinette MG, Cartin A, Blackstone J. (2010). Maternal and newborn outcomes in planned home birth vs planned hospital births: A meta-analysis. American Journal of Obstetrics & Gynecology.

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

National Partnership for Women &

Families

national partnership for women & families
Because actions speak louder than words.

May 23, 2016

Attn: Dr. Lew Sandy
Chair, Clinical Episode Payment (CEP) Work Group
Health Care Payment Learning and Action Network

RE: Accelerating and Aligning Clinical Episode Payment Models: Maternity Care (Draft White Paper)

Dear Chair Sandy,

The National Partnership for Women & Families appreciates the opportunity to offer comments in response to the Health Care Payment Learning and Action Network (LAN) Clinical Episode Payment (CEP) Work Group's "Accelerating and Aligning Clinical Episode Payment Models: Maternity Care Draft White Paper." The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of maternal-newborn and other health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality, and well-coordinated patient- and family-centered care.

We applaud the Obama administration for its continued commitment to shifting to value-based payment and moving away from payment models that reward volume rather than quality and value. The LAN, inclusive of its component work and affinity groups, is a critical opportunity for strengthening the delivery of care for consumers. We commend the CEP Work Group for their thoughtful approach to clinical episode payments for maternity care.

The White Paper represents a promising start toward aligning payment with the reforms needed to improve the quality and experience of care for women and babies. We appreciate the White Paper's approach to covering a broad range of issues and providing sound recommendations on how to advance clinical episode payments for maternity care. We were pleased to see the balance between what is possible and feasible today versus where we need to direct improvement in the future. The National Partnership fully supports the thorough approach to patient engagement throughout the clinical episode, which is consistent with our recognition of the importance of having women and families engaged as partners in their health and care. As the White Paper states, the entire maternity care episode is an optimal time to partner with women to become effective users of health care during their pregnancy and beyond.

However, we also have concerns about additional infrastructure and resources needed across payers and providers (including Medicaid) to support the delivery of value-based maternity care. We would like to see further attention to enabling the elements needed to collaboratively partner and engage with women throughout pregnancy, including the ability

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of members of the care team to have adequate time to support and activate women during both prenatal and postnatal visits and coordinate care across this episode with multiple care settings and teams. Medicaid pays for nearly half of the nation's births, and we encourage greater focus on the needs of providers and pregnant women in Medicaid and other safety net settings.

Before finalizing the paper, we encourage the Work Group to address ways to mitigate potential unintended consequences in this payment model, including

- Challenges for safety net providers in meeting the often greater needs of Medicaid beneficiaries within the pressure to reduce costs, given that total maternal-newborn Medicaid payments have been roughly half the amount of total commercial payments;
- Stinting on, rather than enriching, prenatal and postpartum care given pressure to reduce cost of the overall episode (and limits on use of performance measures for improving these phases of care given the growing focus on a parsimonious set of aligned measures);
- Physician discontent in the transition to value-based payments that could exacerbate growing maternity care workforce shortages: many obstetrician-gynecologists are retiring early as providers of maternity services, and family physician provision of maternity care (either prenatal and postpartum office visits alone or full scope) has been declining;
- Increased elective induction, a costly and unwarranted practice, given accountable parties' interest in having greater control over care during the intrapartum period.

Bundling payments alone may not drive enough resources to adequately transform care to fully meet the needs of women and their families. All of these elements are, however, foundational for the stated goals of the White Paper: reducing costs and improving outcomes, as well as the experience of care, for the woman and her baby.

Please see the attached document for specific, detailed edits and suggestions on the draft White Paper. In the attached document, our comments reflect the need to broaden the concept of "low risk" to adequately characterize the included population; make edits to correct or update statistics, measures, and other information; and address the need to direct resources from intrapartum to prenatal and postpartum office settings.

We reiterate our appreciation of the Clinical Episode Payment Work Group and the opportunity to provide comments on Accelerating and Aligning Clinical Episode Payment Models: Maternity Care White Paper. If you have any questions about our comments and recommendations, please contact Stephanie Glover, Health Policy Analyst, at sglover@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness
President

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

National Partnership for Women &

Families

Comments on behalf of Carol Sakala:

In keeping with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population-based payments by 2016, and 50% by 2018. One promising area for payment innovation and alignment is in payment for "episodes of care" to improve patient outcomes, enhance health system performance, and control costs. A **clinical episode payment** is a bundled payment for a set of services that occur over time and across settings. This payment model can be focused on a:

Comments on behalf of Carol Sakala:

The goal of using clinical episode payments is to improve the value of maternity care by **reducing costs and improving outcomes, as well as the experience of care, for the woman and her baby.** Although the payment incentives in episode payment provide support for this goal, the design and implementation of the episode's care pathway(s) and delivery model(s) are also critical; for example, rates of cesarean births or early elective inductions could be impacted by changing protocols within a hospital. The Work Group believes that the goal of episode payment should go beyond lowering costs and be designed such that it supports a more patient-centered approach to care. Specific goals of maternity episode payment include:

Comments on behalf of Carol Sakala:

Positive outcomes can be reflected in a variety of ways: a greater percentage of appropriate vaginal births; a greater percentage of full-term babies born at healthy weights; strong recoveries for women; and healthy starts for the babies. Thoughtful episode payment seeks to achieve these outcomes at a lower overall cost to the system and lower cost to women and families. The Work Group's recommendations provide an outline for how to achieve this goal without becoming overly prescriptive about the exact mechanisms for doing so.

Comments on behalf of Carol Sakala:

A study by Truven Analytics shows the cost of birth varies significantly by payer (commercial or Medicaid), type of birth (vaginal or cesarean section), and setting where the birth occurs (see Figure 1). In 2013, the average total maternal-newborn payments for cesarean births, including all facility and provider fees for prenatal, labor and delivery, and postpartum/newborn care, was $27,866 for a commercial payer and $13,590 for Medicaid. For both payer types, total payments for cesarean births were roughly 50% higher than for vaginal births. One of the reasons that cesarean birth costs more is that there are 50% higher neonatal intensive care unit (NICU) payments associated with these surgeries, compared to the percentage of vaginal births requiring NICU stays.

Comments on behalf of Carol Sakala:

Commented [CS1]: Needs to be updated: …, the LAN aimed to have 30% of health care payments in APMs or population-based payments by 2016, a target that has been reached; and it aims to have 50% in such models by 2018.

Commented [CS2]: Recommend leading with the people: "… by improving the outcomes and experience of care for the woman and her baby while reducing costs."

Commented [CS3]: Unclear whether this refers to copayments, etc. or to health and well-being

Commented [CS4]: Generally, cesareans involve two extra hospital days. And downstream, at present about 9 in 10 women with a past cesarean have repeat cesareans, adding to the cost of the initial cesarean.

- Reduce pre-term rates: 9.57% of births in 2014 were pre-term, a statistic that includes early elective deliveries. The American College of Obstetricians and Gynecologists (ACOG) recommends no early births unless medically indicated.

Comments on behalf of Carol Sakala:

Reduce racial/ethnic disparities: The percent of pre-term births for non-Hispanic white is 8.91%, non-Hispanic black is 13.23%, and Hispanics is 9.03%, with additional significant disparities in infant mortality and low-birth weight babies.

Comments on behalf of Carol Sakala:

The setting in which a woman gives birth also affects the cost, as well as the type of delivery. The average national cesarean rate in the United States in 2014 was 32.2%[1, 2] despite the fact that the U.S. Surgeon General calls for a reduction in cesarean rates for low-risk women to 23.9% by 2020. Just as with other surgical procedures, there is significant, non-clinically supported variation in cesarean rates across hospitals. Even hospitals in the same city show wide variation. For example, Jersey City Medical Center near Newark, NJ, reported a 35% cesarean section rate for low-risk women, compared to a 19% rate at Trinitas Regional Medical Center in nearby Elizabeth, NJ.[3] In California, rates varied from 18% in one hospital to more than 50% in another, according to a recent study.[4] This story repeats all throughout the country.

Comments on behalf of Carol Sakala:

These data demonstrate that too often the resources spent on maternity care services are not leading to the highest value birth care. This is reflected in the fact that the United States has a higher rate of infant mortality than 38 other countries and a lower successful breastfeeding rate than 98 other countries.[5] It is also reflected in the 9.57% pre-term birth rate (which includes early elective deliveries) in 2014.[1] This rate

Comments on behalf of Carol Sakala:

The good news is that evidence-based care practices can deliver higher quality care at a lower cost. For the majority of low-risk births, lower resource-intensive births do correlate with positive outcomes. Based on the definition of a low-risk pregnancy as full-term, singleton, and head-first presentation, some estimates show that as many as 85% of births are low-risk. However, this number does not take into

Commented [CS5]: The "early elective delivery" measure is based on births in weeks 37 and 38. Preterm births are prior to 37 weeks. So, they are independent. Best figure from The Joint Commission (from hospitals with 1,100 or more births/year) is that the early elective delivery rate was down to 3.3% of 37-38 week births, or less than 1% of all births, in 2014. Especially considering that the right rate is more than 0%, opportunities for improvement are limited. (Source of 3.3% figure: #0469 at http://www.qualityforum.org/ProjectMeasures.aspx?projectID=80680)

Commented [CS6]: This is the tip of the disparities iceberg. For a credible summary of disparities for many indicators, see Table 16-2 in http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review_focus_area_16.pdf

Commented [CS7]: The Healthy People target is the "NTSV" NQF-endorsed Cesarean Birth measure (Elliott Main says that HP failed to indicate that this is low-risk *first-birth* cesarean rate), and 32.2% is a total rate, so these are not comparable. The Joint Commission reports that in 2014 the NTSV rate among hospitals with 1,100 or more births was 26.8% (source of this figure: #0471 documentation at http://www.qualityforum.org/ProjectMeasures.aspx?projectID=80680)

Commented [CS8]: This WHO report uses exclusive breastfeeding for the first six months of life, the national and international standard ("successful" doesn't correspond to a specific indicator)

Commented [CS9]: Preterm births are prior to 37 weeks. The denominator for the early elective delivery measure is births at 37 and 38 weeks, so the two are independent. As noted above the latter was down to 3.3% in 2014 or less than 1% of all births, so overall opportunities for improvement are limited.

Commented [CS10]: Recommend including this language in the goals list on p. 5: "Consistently providing evidence-based maternity care and a family-centered experience."

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[1] Ibid.
[2] World Health Organization. WHO Statement on Cesarean Section Rates. Geneva, Switzerland: WHO 2015. Accessed at http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf
[3] Haelle, Tara, "Your Biggest C-Section Risk May be Your Hospital," Consumer Reports, April 13, 2016. Accessed at http://www.consumerreports.org/doctors-hospitals/your-biggest-c-section-risk-may-be-your-hospital/
[4] Main EK, Morton CH, Hopkins D, Giuliani G, Melsop K and Gould JB. 2011. Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality. Palo Alto, CA: CMQCC. (Available at www.cmqcc.org)
[5] World Health Organization. World Health Statistics 2014. Geneva, Switzerland: WHO, 2014. Accessed at http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf

consideration other risk factors, such as chronic diseases or factors in the woman's obstetric history. [6] If the percentage of safely achievable vaginal births were to increase, resulting in a decrease in cesareans, overall birth costs would decrease. Outcomes should improve as well, given that vaginal births have fewer complications. Further, with a decrease in the rate of early elective and pre-term births, fewer babies would need high-cost NICU care, and babies would have better survival rates and a healthier start.

Comments on behalf of Carol Sakala:

Although the relationship between quality of care and better health outcomes is recognized by the field, this relationship is not always reflected in the current U.S. payment system, which is characterized by the fact that it often incentivizes higher cost, lower quality care. In the maternity care context, for example, vaginal births cost less,[7] have fewer complications, and involve shorter stays, thus providing less reimbursement to hospitals; but they also require patience and often several hours of hard work by the women, as well as support from obstetricians/gynecologists (OB/GYNs), nurses, and midwives. In contrast, cesareans are sometimes considered more convenient by women, practitioners, and facilities because of the shorter duration of labor and the ability to schedule in advance. Thus, the rate of cesareans has increased 60% from the most recent low of 20.7% in 1996[8] — despite the fact that they are considered riskier for both the mother and baby. **ACOG and the Society for Maternal-Fetal Medicine have both stated that this increase has not been accompanied by discernable gains in maternal or newborn health.**

Comments on behalf of Carol Sakala:

Blended rate for hospital labor and birth (regardless of delivery type). Several purchasers and providers are implementing episodes framed specifically around hospital-based labor and birth, and which do not include costs for prenatal or postpartum care or care for the baby. This model blends cesarean and vaginal birth reimbursement rates into a blended case rate for hospitals. The primary goal is to decrease cesarean rates. Hospital payments and the clinical professional fees are the same regardless of the delivery method. The episode price also includes the costs of postpartum complications, but no other postpartum costs are included.

Comments on behalf of Carol Sakala:

1. Episode Definition	The episode is defined to include prenatal care, labor and birth, and postpartum/newborn for low-risk women and their babies. The intent of the Work Group is to define low-risk as broadly as possible, with limited exclusions.

Commented [CS11]: Important to not leave family physicians out; could simplify here by referring to "the care team"

Commented [CS12]: Good to give source, an official detailed recommendation statement: https://www.acog.org/-/media/Obstetric-Care-Consensus-Series/oc001.pdf?dmc=1&ts=20160511T0030582580

Commented [CS13]: This is true for PBGH, but not true for the comprehensive TX model that Karen Love presented at LAN Summit

Commented [CS14]: PBGH also negotiated blended case rate for maternity care providers, and I think that Community Health Choice TX model has a single blended case rate for all maternal care (hospital + provider + lab, etc.).

Commented [CS15]: In TX, they had a blended case rate for newborns with the goal of reducing nursery care levels. SO, blended case rate could be a way of setting payment level for a comprehensive bundle (#1)

Commented [CS16]: This depends: not for PBGH, but TX does include newborn costs.

Commented [CS17]: Low-risk ≠ "as broadly as possible, with limited exclusions" (also the best place for this statement is the "patient population" section; it's repetitive here)

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[6] Stapleton, S. R., Osborne, C. and Illuzzi, J. (2013), Outcomes of Care in Birth Centers: Demonstration of a Durable Model. Journal of Midwifery & Women's Health, 58: 3-14. doi: 10.1111/jmwh.12003

[7] Truven Health Analytics. The Cost of Having a Baby in the United States. Ann Arbor, MI: Truven, January 2013. Accessed at

[8] Wier LM (Thomson Reuters), Pfuntner A (Thomson Reuters), Maeda J (Thomson Reuters), Stranges E (Thomson Reuters), Ryan K (Thomson Reuters), Jagadish P (AHRQ), Collins Sharp B (AHRQ), Elixhauser A (AHRQ). *HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2009*. Rockville, MD: Agency for Healthcare Research and Quality, 2011 (http://www.hcup-us.ahrq.gov/reports.jsp).

Comments on behalf of Carol Sakala:

1. Patient Population	The population includes low-risk pregnant women and their babies. The intent of the Work Group is to define low-risk as broadly as possible, with limited exclusions. Clinical episode payment can provide incentives for needed care improvement for the vast majority of pregnant women.

Commented [CS18]: Low-risk ≠ "as broadly as possible, with limited exclusions"

Comments on behalf of Carol Sakala:

1. Accountable Entity	The accountable entity should be chosen based on its ability to engineer change in the way care is delivered to the woman and its ability to accept risk for an episode of care. In most situations, a clinician (obstetrician, midwife, or family practitioner) or clinical practice will be most able to impact change.

Commented [CS19]: These edits align with narrative below.

Comments on behalf of Carol Sakala:

1. Episode Price	The episode price should strike a balance between provider-specific and multi-provider/regional utilization history. The price should: 1) acknowledge achievable efficiencies already gained by previous programs; 2) reflect a level that potential provider participants as feasible to attain; and 3) include the cost of services that help achieve the goals of episo payment.

Commented [CS20]: Is this "in recent years"? What programs are intended here?

Comments on behalf of Carol Sakala:

The episode is defined to include prenatal care, labor and birth, and postpartum/newborn care for low-risk women and their babies. The intent of the Work Group is to define low-risk as broadly as possible, with limited exclusions.

Commented [CS21]: This is better situated under #3

Comments on behalf of Carol Sakala:

The Work Group recommends defining the episode to include all services and care delivered during three phases of maternity: prenatal, labor and birth, and postpartum (see Figure 4). Including these three phases within the episode (as opposed to narrowly defining the episode around labor and birth, which are arguably the most costly aspects of maternity care) is key to achieving the goals of episode payment. Additional discussion of the episode timeline and population are offered below.

Commented [CS22]: Isn't this for #4?

Comments on behalf of Carol Sakala:

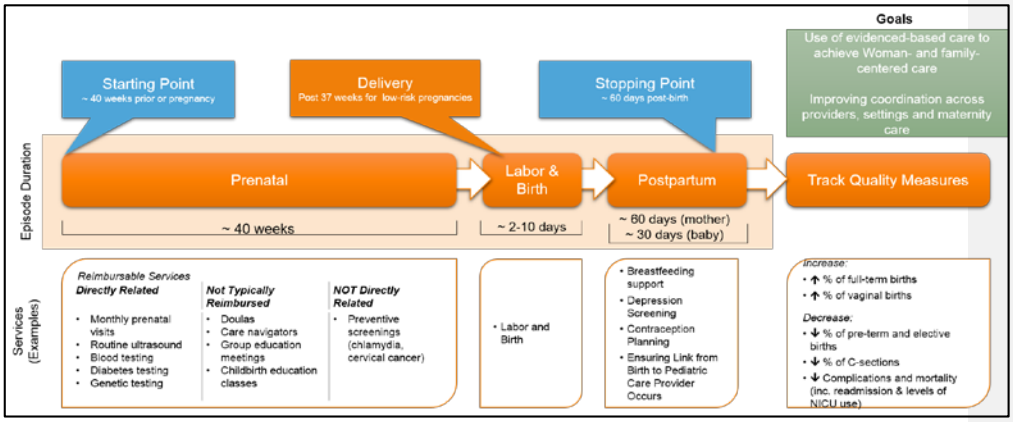
Figure 4: Maternity Episode Definition and Timeline

Commented [CS23]: In diagram, please use "depression screening and referral" and "contraceptive care"

Also, by "group education meetings," do you mean "group prenatal care"?

Prenatal visits vary in frequency and are only "monthly" early in pregnancy

For orange "Delivery" rectangle: could you call it Birth (and recommend removing the weeks because it happens when it happens and could be preterm"



Source: Ripple Effect Communications, Inc.

Comments on behalf of Carol Sakala:

Episode Timing

Commented [CS24]: This section doesn't clarify why the 60- and 30-day windows were selected

Comments on behalf of Carol Sakala:

Consistent prenatal care – in addition to providing continuous care for the woman – can identify high-risk markers, such as gestational diabetes. Prenatal services can also include childbirth education to prepare a woman for the mental and physical challenges of childbirth and other supports during pregnancy, around the time of birth, and in the transition to new parenthood. High-quality postpartum support can lower readmissions, increase rates of breastfeeding, reduce postpartum depression, and provide a strong foundation for the woman as a caregiver to her baby and her family.

Commented [CS25]: Calling GDM high-risk clarifies that the included population goes beyond "low-risk"

Comments on behalf of Carol Sakala:

There may be concerns among stakeholders that including prenatal and postpartum care in the episode can lead to decreased access to or limited delivery of those services by a provider trying to utilize fewer resources to maximize potential savings. Another concern regarding postpartum care is whether the clinician who manages the birth should also be accountable for postpartum care. The Work Group believes these concerns, although valid, are manageable. For example, some initiatives require the collection and monitoring of certain performance metrics, such as number of visits and delivery of certain prenatal tests and screening before the birth and the provision of breastfeeding support or contraceptive advice afterwards to ensure their delivery. Concerns have also been raised about whether to include women who do not opt to access prenatal care. To address these concerns, one bundling initiative adjusts the episode definition and price based on differing numbers of prenatal visits. Another option is to exclude from the episodes women who do not have a minimum number of visits.

Commented [CS26]: Does t`he paper specify anywhere that accountable person is the clinician who manages the birth?

Comments on behalf of Carol Sakala:

The population includes low-risk pregnant women and their babies. The intent of the Work Group is to define low-risk as broadly as possible, with limited exclusions. Clinical episode payment can provide incentives for needed care improvement for the vast majority of pregnant women.

Commented [CS27]: This modifier doesn't fit for the population described here

Comments on behalf of Carol Sakala:

The inclusion of the baby in the episode population raises issues related to assigning an accountable entity (e.g., when managing the pregnancy requires a neonatology specialist in addition to or instead of the OB/GYN or the midwife). Although these cases are relatively rare in a population of low-risk women, such instances highlight the need for reliable provision of team-based care with cooperation among all providers across the episode, as well as the need for clear policies on the level of risk when the provider identified as the accountable entity has limited ability to manage care across providers.

Commented [CS28]: The population described here is broader than low-risk women

Commented [CS29]: Recommend using words in title from 2016 ACOG report and citing report: http://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/womenhealth/index.html

Comments on behalf of Carol Sakala:

Defining the pregnancy level of risk. The Work Group recommends limiting the population to low-risk pregnant women. However, the episode should be defined to include as broad a group of women as possible. All pregnant women, regardless of risk levels, can benefit from improvements in care delivery. Limiting the population to low-risk pregnant women is intended to acknowledge that some high-risk pregnancies introduce a level of variability and potential risk for the accountable entity that could be difficult to manage, particularly for small practices. In the event that a low-risk pregnancy results in a baby who requires intensive care, stop-loss policies should be established to mitigate potential unanticipated risks. Critical to the episode population design element is defining a low-risk or high-risk pregnancy. Definitions vary, depending on when in the maternity period the determination is made and by whom. Some have used the Healthy People 2020 definition of a full-term, single baby with head-first presentation at birth and calculate 85% of pregnancies meet this definition of a low-risk pregnancy.[9] Therefore, the list of exclusions should be limited and could include those with active cancer, AIDS, multiple sclerosis, renal dialysis, pulmonary embolism, or triplets and other higher-order gestation. Other ways to limit risk through risk-adjustment, including factors that might arise during pregnancy, and stop/loss limits will be discussed in the discussion on the Level and Type of Risk below. See Appendix E for links to resources that provide lists of exclusions.

Commented [CS30]: The field would not consider this term to apply, e.g., to people with gestational diabetes, prolonged pregnancy, higher levels of obesity, etc. – all of whom are good candidates for episode payment

Commented [CS31]: Twins fall within the category of high likelihood of good outcomes following attentive, evidence-based care (and are included in at least some of the models examined)

[9] Healthy People 2020 Objective MICH 7.1, https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives. Eighty five percent cited in Stapleton, S. R., Osborne, C. and Illuzzi, J. (2013), Outcomes of Care in Birth Centers: Demonstration of a Durable Model. Journal of Midwifery & Women's Health, 58: 3-14. doi: 10.1111/jmwh.12003

Comments on behalf of Carol Sakala:

- **Currently covered but underused services not directly related to pregnancy and birth:** Some initiatives see the OB/GYN, midwife, family physician, or osteopath as the primary care provider and view the prenatal care period as an opportunity to perform preventive screenings, such as for screenings for chlamydia or cervical cancer. These screenings are not specifically related to pregnancy but it may be important to include them in the episode price, as they are commonly provided to women as part of their pre-natal care.[10] Another option might be to pay separately for them through FFS, but include them in episode quality metrics, perhaps with a pay for performance incentive in addition to the bundled payment incentives.

Commonly uncovered (and underused) high-value services directly related to pregnancy and birth: A variety of services that have been shown to improve a woman's birth experience and potentially improve outcomes are not commonly part of typical benefit packages. One important service that clinical episode payment is designed to encourage is greater care coordination across providers by the maternity care providers themselves. Typically, providers are expected to provide some level of this coordination without additional reimbursement, but experience with maternity care homes and medical homes suggests that there is value in support for more reliable and attentive care coordination consistent with goals of episode payment. Other services not typically covered include those provided by doulas, care navigators (e.g., for shared decision-making, shared care planning, community referrals, and follow up on such matters as smoking cessation, mental health referrals, anticipatory discussion of contraceptive methods, and completion of postpartum visits), group prenatal visits, and breastfeeding support.

Comments on behalf of Carol Sakala:

Although bundling currently covered services could result in efficiencies and improved outcomes, providing incentives to increase the use of the enhanced services described above may lead to even higher-value care. Prospective payment (as described in the Payment Flow Recommendation below) allows for provider flexibility to deliver these services, as it does not rely on a direct payment from the payer for individual covered services. Evaluation of the enhanced prenatal care models—through maternity care homes, group prenatal care, and birth centers—being tested within the CMS Center for Medicare and Medicaid Innovation's Strong Start initiative provides lessons for the types of services that support maternity care episode payment models (see "Patient Engagement" recommendation below). Regardless, it is important to monitor the shift in service patterns to ensure that the Strong Start initiative results in the highest value care feasible and does not lead to unintended consequences of restricting important services.

Comments on behalf of Carol Sakala:

Some patient engagement efforts involve enhanced services, such as the maternity home and group prenatal visits being studied in the CMS-sponsored Strong Start demonstration.[11, 12] In the maternity

Commented [CS32]: Increasingly osteopaths complete standard educational pathways, including residencies, so that OD and MD are largely equivalent. Recommend not referencing it here (as it parallel to MD, not referenced here): they are called ob-gyns and FPs. We are taking it out of our new web content this month.

Commented [CS33]: I think this is not quite right. 1. It is understood that chlamydia, cervical cancer, etc. would complicate a healthy pregnancy and thus warrant attention during prenatal care. So, maybe these should not be classed as "not directly related." 2. Since these are so unlikely and other matters so much more impactful that they are not a priority for quality measures. 3. Would be good to broaden this category to "Currently covered but underused services" and include such matters as intermittent auscultation, non-pharmacologic measures for comfort and progress in labor, ambulation and upright positioning during labor

Commented [CS34]: Another one not mentioned here is resources for QI: e.g., audit and feedback, drills and simulations, safety/quality courses. These can pay off, but aren't reimbursed.

Commented [CS35]: Could cite Strong Start Year 2 evaluation for maternity homes and good sources for this component in medical homes.6

Commented [CS36]: Address volume responsibly on the back end of this model.

Commented [CS37]: Isn't this an example of care coordination function? These details bring the concept to life and point to major opportunities for improvement.

Commented [CS38]: For clarity, can you give examples of how such unintended consequences might arise?

[10] Current ed. Of *Guidelines for Perinatal Care* from AAP and ACOG discusses many and provides ACOG's Antepartum Record.
[11] https://www.centeringhealthcare.org/what-we-do/centering-pregnancy
[12] Hill I, Benatar S, Courtot B, et al. (2014). Strong Start for Mothers and Newborns Evaluation: Year 1 Annual Report; Volume 1 – Cross-Cutting Synthesis of Findings. Urban Institute, Health Management Associates, American Institutes of Research, Briljent.

care home model, clinical or community health worker care coordinators are assigned to work with pregnant women to support their goals, provide referrals to community resources (such as smoking cessation programs, childbirth education, mental health services, breastfeeding support), foster successful care transitions, and ensure that women attend postpartum visits. The Year 2 Strong Start evaluation suggests that this model is associated with a decrease in interventions that are not medically indicated and that women are pleased with the enhanced service model.[13] Strong Start participants experiencing enhanced prenatal care in birth centers had a reduction in cesareans and other interventions, strong breastfeeding results, and were especially happy with their experiences.[14] In the context of this clinical episode payment model, a care coordinator is also well positioned to ensure that childbearing women complete self-reported surveys of experience and outcome. In addition, women who have had access to doula services are much less likely to have a cesarean birth, more likely to be satisfied with their care and experience other benefits; when these services are inclusive of prenatal and postpartum support, they experience increased breastfeeding.[15]

Commented [CS39]: Maybe use this term throughout (e.g., in place of "care navigator" above)

Commented [CS40]: In the Cochrane review, Continuous support for women during childbirth, the doula role is associated with a considerable 28% reduction in cesarean birth; that would be a good statistic and source to cite in this paper. Good option for increasing expectations for fewer cesareans.

Comments on behalf of Carol Sakala:

Further, based on the success of the Open Notes project, a growing proportion of patients are gaining full access to their electronic health records. Early results are consistent with aims of episode payment, including greater patient involvement with health and health care; better patient-clinician communication and relationships; and better knowledge/recall, sense of control, adherence to regimens and efficiencies.[16] Another initiative—Maternity Neighborhood[17]—helps clinicians and women communicate and query one another, track women's progress, schedule appointments, and share educational resources. Meanwhile, the initiative enables women to review, discuss, and contribute to their health record. Existing experience suggests that full and interactive access to health records may contribute to the success of episode payment models. Patient portals can deliver a broad range of user-friendly, evidence-based tools and educational resources. While not yet standard practice, a wide variety of patient engagement support is now available (see Appendix E for a list of resources, including patient engagement tools).

Commented [CS41]: Recommend explicitly naming early Open Notes experiences

[13] https://downloads.cms.gov/files/cmmi/strongstart-enhancedprenatalcare_evalrptyr2v1.pdf
[14] Year Two Evaluation Report: Strong Start for Mothers and Newborns: Evaluation Year 2 Annual Report. March 2016. https://downloads.cms.gov/files/cmmi/strongstart-enhancedprenatalcare_evalrptyr2v1.pdf
[15] National Partnership for Women & Families and Childbirth Connection (January 2016). *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health* [Issue Brief]. Retrieved from http://transform.childbirthconnection.org/wp-content/uploads/2016/01/Insurance-Coverage-of-Doula-Care-Brief.pdf
[16] http://www.bmj.com/content/350/bmj.g7785.long
https://jamia.oxfordjournals.org/content/early/2016/02/10/jamia.ocv167
http://www.ncbi.nlm.nih.gov/pubmed/26827154
[17] http://maternityneighborhood.com/products/

Comments on behalf of Carol Sakala:

While local situations will vary, the CEP Work Group favors clinicians as the preferred accountable entity. The accountable clinicians are more likely to be involved throughout the entire pregnancy, and they also have less of a stake than a hospital in the type of delivery, as their fees do not vary as much with delivery type. In addition, if the payment is FFS payment with retrospective reconciliation, hospitals may have less of an incentive to decrease practices that provide higher reimbursement because the bulk of the costs for this episode are in the labor and birth facility fees.

Commented [CS42]: This is an incomplete picture. Hospital does get more money, but typical maternity care provider benefits greatly from scheduled births in juggling a broad scope of practice and office, hospital and home/personal commitments. A major factor in use of interventions to drive more and more births into daytime, weekday, non-holiday hours (e.g., induction, augmentation, rupturing membranes) is growing professional expectations for work-life balance and what has come to seen as acceptable to achieve this, as well as being the specialty with the highest proportion of women (who are less likely to have someone else managing home and family). So, within the present system and culture of practice, clinicians are major drivers of unwarranted overuse and underuse and less-than-optimal practice. To the extent that this payment model can foster re-engineering of care along the lines of birth center model, women/families, payer and purchasers will be big winners. This model needs to help point in a new direction.

Comments on behalf of Carol Sakala:

Optimally, accountability would be shared among all involved providers, such that incentives are aligned. In circumstances where the provider is a health system, accountability should be shared between the clinicians and the facility (either the hospital or birth center). One initiative brought together the facility and the providers through a birth center as the accountable entity. If the woman needs to go to the hospital for the actual birth, the facility fee is paid outside the bundle. Others use a blended (vaginal and cesarean) case rate with a discount built in to encourage lower cesarean rates, and, in these cases, hold the hospital and clinicians accountable separately for the overall payments.

Commented [CS43]: Not sure how this works in TX.

Comments on behalf of Carol Sakala:

One challenge will be if a newborn needs intensive care. In such an instance, the newborn specialist will take over as the decision maker, and the episode design would need to recognize this change. While we anticipate that limiting the population to low-risk pregnancies, stop/loss limits and risk adjustment may limit the risk of the assigned accountable entity, it will remain difficult for that clinician who managed the birth to coordinate with or impact the care delivered by the specialist. Another challenge is that, in some cases, the clinician who managed the woman's care before the birth may not be available to manage the actual labor and birth or the hospital may use a "laborist" to manage the birth. Regardless, the determination of the accountable entity must take into consideration the specific context.

Commented [CS44]: care manager? Hopefully, team, including woman and family are involved in decision making

Commented [CS45]: This is now the goal for our health care system; maybe rephrase: e.g., need to develop new ways of communication and teamwork

Comments on behalf of Carol Sakala:

Nevertheless, prospective payment has advantages in that it is a clear break from legacy FFS payment and may encourage greater coordination and innovation in episode payment. For example, in a prospective payment initiative, it may be more feasible to be flexible in delivering otherwise uncovered services, such as childbirth education or patient navigation, which assist providers in achieving the goals of fewer pre-term deliveries and a higher level of vaginal births.

Commented [CS46]: Recommend consistent term, whatever it is

Comments on behalf of Carol Sakala:

The episode price should strike a balance between provider-specific and multi-provider/regional utilization history. The price should: 1) acknowledge achievable efficiencies already gained by previous programs; 2) reflect a level that potential provider participants see as feasible to attain; and 3) include the cost of services that help achieve the goals of episode payment.

Commented [CS47]: As above, is this "in recent years"? Not sure what "programs" refers to.

Comments on behalf of Carol Sakala:

The monetary rewards or penalties that an accountable entity may experience are determined in large part by the manner in which the episode price is established. In addition, there are several key aspects that interact in the establishment of the episode price. All payers will expect some return on their investments in this payment design and can choose a variety of mechanisms to generate some level of savings. It is also important to consider including in the target episode price costs for historically underused services, as discussed in Recommendation 4, and additional services, such as a patient navigator/care coordinator, group visits, a doula, or breastfeeding support. Further, whether to build in savings for improvements, such as lower cesarean rates is also a consideration.

Commented [CS48]: Each of these needs its own strategy to help enable them to happen. Not sure that these enabling mechanisms are in here yet.

Comments on behalf of Carol Sakala:

Typically, the target episode price is set using some combination of regional and provider-specific claims data for a period of time that includes a sufficient number of cases used in estimates for the coming year. In some cases, the payer can also include an estimate of a decrease in costs based on quality improvements, such as lower cesarean rates or less need for NICU care. The Work Group recommends balancing regional-/multi-provider[18] and provider-specific cost data:

Commented [CS49]: Speaks to importance of building in support for undertaking QI

Comments on behalf of Carol Sakala:

However, taking on downside risk may be difficult for smaller providers, including many OB/GYN and midwife practices that are also the providers best able to support a new model of maternity care. Further, inclusion of downside risk may be a barrier to provider participation when the initiative is voluntary. In addition, it is important to acknowledge that several of the primary goals of the maternity care episode (for example decreasing cesarean and NICU use) will result in lower per patient reimbursement for the hospital. This means that if the clinician practice is the accountable entity and there is no upside or downside risk to the hospital where the majority of births will occur, then the providers—the clinicians and the facilities— will have very different incentive structures. This source of

Commented [CS50]: In some areas of the country, FPs could be in this role.

[18] For purposes of this paper, region is not defined. The region will be defined as a combination of the experience of multiple providers. We use the term "regional" to reflect this assumption.

tension will need to be explicitly addressed, either through some type of shared accountability and the ability to share in the savings or risk for any potential losses.

Comments on behalf of Carol Sakala:

Mechanisms for Limiting Risk

The level at which those risk limits are set is a critical design element. There are several issues to consider, such as whether the accountable entity will be required to pay the full difference between the total dollars over the established episode price and the actual episode costs back to the payer or whether limits will be established. Limits are especially important considering that an accountable entity is accountable for care provided by other providers. In the case of maternity care, the facility accounts for the largest percentage of overall costs. What the accountable entity (the clinician practice) is paid through FFS payment is limited compared to the liability associated with the entire cost of the episode over the estimates for the entire population of included births.

Commented [CS51]: Paper needs to consider new info presented at LAN Summit on slide from Community Health Choice in TX:
"Nursery level determination may be less objective than previously thought and may not be best indicator of ultimate cost:
- Significant differences in level distribution across providers and over time
- Correlations of LBW and/or preterm with nursery level is uneven
- Birth defects can be costly but are not necessarily dealt with in Level 4 nursery

Recommendation: to protect both provider (from extreme oulier episodes) and plan (from arbitrary placement), keep all babies in but use stop loss aimed at true outliers"

Comments on behalf of Carol Sakala:

CQMC measures related to the ambulatory OB/GYN setting include:

- Frequency of ongoing prenatal care;
- Cervical cancer screening;
- Chlamydia screening and follow up.

Commented [CS52]: This one may lose NQF endorsement.

Comments on behalf of Carol Sakala:

Figure 6: Medicaid and CHIP Child and Adult Core Measures for Maternity Care

Commented [CS53]: Could also add a column for TJC with X for PC-01, PC-02 and PC-03

	Source	Adult Core	Child Core	CQMC
PC-01: Elective delivery	NQF 0469	X		X
PC-03: Antenatal steroids	NQF 0476	X		X
Timeliness of Prenatal Care	NQF 1517	X	X	
PC-02:Cesarean Section	NQF 0471		X	X
Live births less than 2500 grams	NQF 1382		X	
Frequency of ongoing prenatal care	NQF 1391		X	X
Behavioral health risk assessment for pregnant women	AMA-PCPI		X	
Pediatric Central Linked Associated Bloodstream infections: neonatal ICU and pediatric ICU (CLABSI)	NQF 0139		X	
Postpartum contraceptive use among women ages 15-44	Developmental measure (OPA/CDC)	Likely to be included in future sets		

Commented [CS54]: Status: Recommended for inclusion in this set in 2015 pending NQF endorsement. Perinatal and Reproductive Health Standing Committee recommended endorsement of this measure in May 2016, and it will continue to go through consensus development process. NQF number is 2902.

Comments on behalf of Carol Sakala:

- Several other measures are also of interest, including rates of unexpected newborn complications and rates of vaginal birth after cesarean. Rates of newborn complications, particularly unexpected complications, measure a primary outcome of the birth—the baby's health. A measure of the vaginal birth after cesarean (VBAC) rate (e.g., IQI 34) would address an important opportunity for improvement that would be complementary to the above-mentioned cesarean rate. Further, provision of influenza vaccines prenatally also has been shown to decrease complications. These measures are not the only ones that various initiatives have used, and each initiative may want to customize its quality metrics to some extent, depending on the needs of its population.

Commented [CS55]: New CMQCC Cesarean Toolkit notes high correlation between the low-risk and the better known overall VBAC rate; since low-risk adds little value, recommends IQI 34. This is easy to collect with discharge diagnosis file.

Comments on behalf of Carol Sakala:

Two other legal issues also impact the implementation of clinical episode payment—medical liability and the Emergency Medical Treatment and Active Labor (EMTALA) requirements. Regarding medical liability, it may be the case that clinicians and facilities need to balance concerns related to liability with their preference for delivering a certain type of care. Payers need to be aware of and respectful toward these concerns. In the maternity context, it may be helpful for the various participants to know that a series of evaluations of rigorous quality improvement programs have documented rapidly plummeting claims, payouts and premiums. Systematic attention to quality improvement may also contribute to improved professional satisfaction. It will be important to include these dimensions of care in evaluations of episode payment models. EMTALA is important, as some pregnant women will be seen for the first time in the emergency room and will be given whatever care the hospital and clinician on call determine feasible without regard or

Commented [CS56]: http://transform.childbirthconnection.org/wp-content/uploads/2013/02/Maternity-Care-and-Liability.pdf and http://transform.childbirthconnection.org/wp-content/uploads/2013/01/CC_LiabilityFactSheet_09.pdf

Commented [CS57]: http://www.ncbi.nlm.nih.gov/pubmed/21376160

Comments on behalf of Carol Sakala:

Appendix D: Summary Review of Selected Maternity Care Initiatives – DRAFT[19]

Commented [CS58]: NYS DSRIP model is extremely rich, should inform the final paper, and should be included in this table

General Resources:

Commented [CS59]: Recommend adding Truven Health Analytics cost report

Comments on behalf of Carol Sakala:

Support for Healthy Breastfeeding Mothers and Healthy Term Babies	**The Cochrane Library provides a discussion on the effectiveness of encouraging early and ongoing support for breastfeeding.**

Commented [CS60]: Why limit to a single Cochrane review? Others (e.g., continuous support, midwifery-led care) also very germane here.

[19] MITRE Corporation analysis; results reported are based on studies of varying statistical rigor and extrapolated from several publications.

Comments on behalf of Carol Sakala:

American Congress of Obstetricians and Gynecologists (ACOG) **Quality Improvement in Maternity Care**	**ACOG provides guidelines that address areas where quality ~~improvement initiatives may provide positive outcomes for the~~ mother and infant during a perinatal episode.**

Commented [CS61]: Also important here: their team-based care report and the recommendations (with SMFM) on safely preventing primary cesareans

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

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NATIONAL RURAL HEALTH ASSOCIATION

March 7, 2016

The Clinical Episode Payment (CEP) Work Group
Health Care Payment Learning & Action Network

Re: Draft White Paper: Accelerating and aligning clinical episode payment models: Maternity Care

Dear working group members:

The National Rural Health Association (NRHA) is pleased to respond to the Maternity Care draft White Paper prepared by the Clinical Episode Payment Work Group convened by the Health Care Payment Learning & Action Network. We appreciate your continued commitment to the needs of the 62 million Americans residing in rural and underserved areas, and look forward to our continued collaboration to improve health care access and quality.

The National Rural Health Association (NRHA) is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and patients. We work to improve rural America's health needs through government advocacy, communications, education and research.

NRHA supports the goals of "reducing costs and improving outcomes, as well as the experience of care, for the woman and her baby," however, this goal can only be achieved if the first aim is to ensure access to care for the whole episode of care outlined in the white paper.

Access is consistently the number one issue in rural American health care. However, local access to care is particularly important for maternity care since a laboring woman needs to be able to reach a hospital with delivery services in a relatively short period of time. Unfortunately, "[l]ess than one half of rural women live within a 30-minute drive to the nearest hospital offering

perinatal services."[1] Since the 1980s local hospitals offering obstetric services have steadily declined, 44 percent of non-metropolitan counties lacked hospital-based obstetric services in 2002, compared with 24 percent in 1985.[2] Between 2010 and 2015, another 7.2 percent of rural hospitals shuttered their obstetrics units, requiring rural women to drive an additional 29 miles.[3] In Tennessee, only one of the state's 16 critical access hospitals provides "active" obstetric services.[4] In Alabama, only 17 out of 54 rural counties have a facility that offers delivery services (down from 46 in 1980).[5]

When rural hospitals close access to delivery services further diminishes. Rural hospitals are closing. Seventy-two rural hospitals have closed since 2010. Right now, 673 additional facilities are vulnerable and could close—this represents over 1/3 of rural hospitals in the U.S. In fact, the rate of closure has steadily increased since a steady stream of cuts hit rural hospitals; resulting in a rate six times higher in 2015 compared to 2010.

Rural populations as a whole are more likely to be underinsured or uninsured, be poorer than their urban counterparts, and experience more chronic disease. Rural facilities, which have higher fixed costs and less ability to negotiate volume discounts, also face lower reimbursements since they care for a larger percentage of uninsured and Medicaid patients. Since Medicaid pays about half as much as private insurance for childbirth, the financial aspect of keeping a labor and delivery unit open is harder in rural areas. While some hospitals retain obstetric services even though it loses the facility money[6], more and more hospitals are forced to cut the services or risk

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[1] Rayburn WF, Richards ME, Elwell EC. Drive times to hospitals with perinatal care in the United States. Obstet Gynecol 2012;119:611–6. American Congress of Obstetricians and Gynecologists. The obstetrician-gynecologist distribution atlas. Washington, DC: ACOG; 2013.

[2] Zhao, L (April 2007), Why are fewer hospitals in the delivery business?, The Walsh Center for Rural Health Analysis. Working Paper #2007-04.

[3] Hung, P., Kozhimannil, K. B., Casey, M. M. and Moscovice, I. S. (2016), Why Are Obstetric Units in Rural Hospitals Closing Their Doors?. Health Services Research. doi: 10.1111/1475-6773.12441

[4] Obstetrics a Money Losing Challenge for Rural Hospitals, John Commins, April 8, 2015, http://www.healthleadersmedia.com/communityrural/obstetricsmoneylosingchallengeruralhospitals

[5] Many Alabama women drive 50+ miles to deliver their babies as more hospitals shutter L&D departments, Anna Claire Collers, February 10, 2015, updated February 1, 2016, available online at http://www.al.com/news/index.ssf/2015/02/many_alabama_women_drive_50_mi.html

[6] "Almost every hospital administrator I've talked to says their biggest payer in obstetrics is Medicaid, which doesn't pay anywhere near the costs. That's the start of the issue," says Tim Putnam, CEO of Margaret Mary Health, a critical access hospital in Batesville, IN, says his hospital delivers about 450 to 500 babies a year, even though it's a money loser. "The other thing is that there are a lot of fixed costs to obstetrics because of the requirement to have anesthesia on call. You have your obstetrics team be able to do a Csection at a moment's notice." Obstetrics a Money Losing Challenge for Rural Hospitals, John Commins, April 8, 2015, http://www.healthleadersmedia.com/communityrural/obstetricsmoneylosingchallengeruralhospitals

closing the hospital entirely. Requiring hospitals to take on downside financial risk will only further decrease access to obstetric care in rural America.

When the local hospital makes the financial decision to stop providing money losing delivery services, or closes altogether, the challenge of recruiting and retaining a physician providing obstetric services in a rural location becomes nearly insurmountable. Fewer than 6.4% of obstetrician-gynecologist practicing in rural America, leaving 49% of rural counties without an obstetrician-gynecologist to provide access to necessary care. While family practice doctors also provide maternity care services, the rate of family practitioners choosing to provide maternity services is declining, in the past 10 years family physicians providing any obstetric services have declined by 50% with only 19.2% of family physicians providing routine delivery services. However, the case is even worse since fewer physicians are choosing family practice or are opting to practice in a non-rural setting. As a result, seventy-seven percent of rural counties labeled as a Primary Care Health Professional Shortage Area[7].

As a result of these shortages, several studies have indicated that rural women are more likely to initiate prenatal care late, and to subsequently have poorer outcomes.[8] Overall, pregnant rural women when compared to their urban counterparts are younger, more likely to be obese or have poor nutritional status, and more likely to smoke, use alcohol or drugs. All of these risk factors make early prenatal interventions more important. Indeed, women without local access to obstetric care and delivery services are "more likely to have complicated labor and premature deliveries, and their infants are more likely to have longer and more expensive hospital stays than the children of their rural counterparts who deliver in local facilities communities with greater access to care."[9] Women in rural areas were more than twice as likely as urban women to report the absence of a provider as a barrier. Women who travel further for maternity services

[7] There is no designation of a health professional shortage areas focused on those providing obstetric care.
[8] Larson EH, Hart LG, Rosenblatt RA. Is non-metropolitan residence a risk factor for poor birth outcome in the U.S.? Soc Sci Med. 1997;45(2):171–188. Lishner DM, Larson EH, Rosenblatt RA, Clark SJ. Rural Maternal and Perinatal Health. In: Ricketts TC, ed. Rural Health in the United States. New York, NY: Oxford University Press; 1999:134–149. Peck J, Alexander K. Maternal, infant, and child health in rural areas: a literature review. In: Gamm L, Hutchinson L, Dabney B, Dorsey A, eds. Rural Healthy People 2010: A Companion Document to Healthy People 2010, Volume 2. http://srph.tamhsc.edu/centers/rhp2010/Volume2.pdf. Published in 2003. Accessed May 2012.
[9] Nesbitt T, Connel F, Hart LG, Rosenblatt R. Access to Obstetric Care in Rural Areas: Effect on Birth Outcomes. Am J Public Health 1990; 80:814-818, 817.

have worse birth outcomes, including higher rates of infant mortality and admission to the neonatal intensive care unit.[10]

The calibration of a bundle priced to incentivize the selection of a lower cost provider is only effective if such a lower cost provider is locally available. In rural America, most women not only do not have a choice between multiple provider options, but do not have local access to a provider at all. In rural America, this bundle may instead further limit the availability of obstetric care and ultimately lead to women foregoing care that would lead to a healthier mother and baby. That is not to say a bundled arrangement could not work in rural America, but merely that it would need to take into account the special characteristics of rural and focus on increasing access to care, especially for the most vulnerable women.

In addition to the availability of rural provider other rural characteristics may influence the choices women make about child birth. For example, a woman living in a rural location without local access to a facility that provides birthing services may choose an early elective delivery or c-section because winter storms make the roads to the hospital impassible or the drive would take hours and risk her not making it to the hospital in time. Furthermore, limited access to transportation may mean that a woman would not be able to get to a distant location without planning and cooperation from family and friends that need to schedule around work or child care. One Colorado doctor reported patients electing elective early delivery increases for women due in the winter months, especially those due when storms are forecasted. These women do not select this as their first choice in birthing plan but instead because out of the available options it is the best choice. For other women, once they have one c-section all subsequent births are c-sections since rural settings generally cannot perform a Vaginal Birth After Cesarean (VBAC) due to The American College of Obstetricians and Gynecologists (ACOG) and international guidelines recommendation that resources for emergency cesarean delivery be "immediately available.[11]" Small rural hospitals rarely have an anesthesiologist on site twenty-four hours a day, additionally, if the VBAC is successful the hospital receives no compensation for the cost of having the staff required for a c-section on site throughout the course of the labor; making

[10] Grzybowski S, Stoll K, Kornelsen J. Distance matters: a population based study examining access to maternity services for rural women. *BMC Health Serv Res.* 2011;**11**(1):147-155.
[11] Vaginal birth after previous cesarean delivery. Practice Bulletin No. 115. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:450–63.

VBACs both a practical and financial impossibility in most rural hospitals. While these and other similar factors may not be evident from the medical record, they are clearly and powerfully impacting the best choice in care for these rural women and babies.

Reducing local access to maternity care will decrease the use of essential prenatal care known to lead to better outcomes for mother and baby and lead to increased infant mortality, lower birth weight, and a variety of other complications. This will be especially evident in the patients at highest risk including the poor and women with worse overall health. Additionally, in rural bundling these services may incentivize local providers that may currently provide some elements of care, such as pre-natal care but not delivery services. While having the same provider is theoretically preferable, establishing regular prenatal care is more important than being delivered by the same provider or one that is willing to participate in a bundle with the entity providing the delivery and post-natal care.

It is essential in rural America that access to maternity care is the number one priority. NRHA supports expanded options for women in choosing their providers and birthing care experience. A bundled payments set to incentivize lower cost options may ultimately backfire and eliminate options for rural women when the low cost options are not available locally or not appropriate based on their situation. NRHA believes access to care must be taking into account first and foremost for both content and price of the bundle, as well as whether a bundled payment is appropriate for a given population.

We look forward to working with the committee to address the problems of rural access to maternity care and ensuring any final bundling recommendations includes the very real primary concern about access to maternity care in rural America. If you would like additional information, please contact Diane Calmus at dcalmus@nrharural.org, or 202-639-0550.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Pacific Business Group on Health

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May 23, 2016

Lew Sandy, MD
Clinical Episode Payment Workgroup
Health Care Payment Learning and Action Network
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Dear Dr. Sandy:

Thank you for the opportunity to provide comments on the clinical episode payment (CEP) workgroup's recent paper on maternity care. The Pacific Business Group on Health (PBGH) is a non-profit organization that leverages the strength of its 65 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system. Several PBGH employers have had to consider and make important design decisions around alternative payment models in both self-funded and fully insured arrangements.

These deliberations and multi-faceted experiences inform our feedback today. As the largest collective underwriter of American healthcare, public and private employers are increasingly interested in alternative payment methods like CEP. Properly designed and aligned across payers, episode-based payments have the potential to increase value throughout the broader system in which we all purchase and receive care. The workgroup's current recommendations regarding maternity care are an important foundational component of that effort, and we are deeply appreciative of the LAN's work in these endeavors.

We preface our comments by reiterating our strong support and offer limited feedback for improving the CEP maternity care recommendations in three areas. These include:

1. **Clearly state that prospective negotiation of the comprehensive maternity care bundle is both possible and necessary.**

   The LAN CEP document emphasizes challenges with moving toward prospective payment and the ways in which retrospective fee-for-service (FFS) reconciliation is simpler and more practical to implement in our current system. The workgroup should be more aspirational and point to many successful instances of prospectively negotiated maternity bundles functioning in the market today. Employers we spoke with recommended that the workgroup refer to several areas where ambitious alternative maternity payment models that share many of the CEP group's priorities have already been implemented, including South Carolina, Texas (Community Health Choice), New Jersey (Horizon Blue Cross Blue Shield), and California (Comprehensive Perinatal Service Program).

2. **Endorse the principle that bundle reimbursement is contingent on the reporting of patient reported outcomes and patient experience measures.**

   While the workgroup mentions the utility and desirability of patient-reported outcome (PRO) and experience measures, there is no explicit call for mandatory reporting of them. As the group notes, PROs and patient experience measures are a necessary complement to existing process and outcome

measures that ensure providers are delivering patient- and family-centered care. They must be collected and publicly reported. Accountable providers should also demonstrate use of evidence-based shared decision-making tools (e.g., CAHPS shared decision-making measure) as a condition of bundle reimbursement.

3. **Provide examples of how plans and providers have successfully managed risk exclusion while ensuring that complex patients (e.g., severely depressed, substance abuse) have access to needed services.**

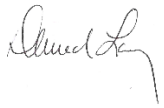
   As the workgroup notes, the comprehensive maternity bundle should encompass the broadest possible patient population. Employers we spoke with believe it would be helpful for the CEP group to provide examples of how plans and providers already using comprehensive maternity bundles have designed minimal patient exclusion criteria and stop-loss mechanisms that ensure complex patients still have access to needed services.

Finally, several purchasers felt that providing explicit language, talking points, or instructions for employers who want to encourage their carriers to adopt this type of prospectively negotiated, comprehensive maternity bundle could increase the uptake and impact of the CEP workgroup's recommendations. A "gold standard" and set of metrics with which to evaluate the maternity bundles offered by carriers and TPAs would also be helpful. We strongly advise the group to develop a short implementation toolkit for commercial purchasers as part of the white paper.

Thank you again for the opportunity to provide feedback to the CEP workgroup on this important methodological document. We look forward to continuing to engage public and private purchasers in the workgroup's activities, and strongly support the LAN's broader effort to increase value across the U.S. health system.

Please contact me should you require any additional information or clarification.

Sincerely,



David Lansky, PhD
President and CEO
Pacific Business Group on Health

HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS:

Maternity Care

White Paper

Comments:

Texas Health Resources

May 20, 2016

Healthcare Payment Learning and Action Network
Email: paymentnetwork@mitre.org

Subject: Comments on the Clinical Episode Payment (CEP) Work Group recommendations on an episode payment for maternity care

On behalf of Texas Health Resources, we support the efforts of the work group in putting forth a proposal to improve maternity care outcomes, from an economic, quality, and patient engagement perspective. Maternity care presents a viable and high impact opportunity to move away from a volume rewarding FFS model to a system that aligns incentives across all providers involved in an episode of care, rewards clinical choices that meaningfully contribute to better outcomes, and minimizes economic waste. Moreover, it is an area of keen interest for both payers and employers due to the relatively high proportion of total charges (~15-20% of commercial payer spend). Due to the same reasons cited in the proposal, over the past two years we have invested significant time and resources in building a maternity care bundle. In our experience this is not only an area ripe for positive change, but also one that requires a thoughtful and measured approach, given the complexity in care delivery (eg, managing pre-term delivery within the context of an episode payment), number of specialists involved (OB / GYN, pediatrics, anesthesia), and the importance of hospital / facility and physician collaboration. Below are our comments on each element of this initial proposal, based on our experiences over the past two years analyzing both national claims and region specific data, working with a diverse set of physicians, and engaging hospital administrators and practitioners in the design and implementation of this bundle. The intent of our comments are to encourage a dialogue around how to design a maternity episode payment that has the greatest potential to positively impact the economics, quality, and patient experience for mothers and babies – by reaching the broadest population, enabling providers, and setting realistic and achievable operational guidelines.

1. Episode Definition
We support the initial recommendation of the workgroup to define the episode as broadly as possible, including pre-natal, labor and birth, and postpartum care. We agree that a broader episode window is instrumental in achieving the goals of the episode payment.

In addition, we propose building on the initial set of quality measures to include a more expansive list intended to achieve two goals:
1) Identify the underlying contributors to broader measures such as caesarean section rate
2) Allow for appropriate practitioner variation that is important to maintaining clinical integrity

In the quality metrics sections we have proposed a set of outcome measures that we believe support these two goals.

2. Episode Timing
As discussed in the above section, we support the proposal of the work group to include the pre-natal and postpartum components of the episode. We do believe that this raises the importance of engaging pediatricians in the clinical design and implementation, as well as the economic model, given their integral role in managing

newborn care immediately post partum and ensuring a timely discharge. Our perspective on how to manage funds flow in this scenario is included in our comments below.

3. Patient Population
Essential to the success of episode payment models is an inclusive patient population. Many models have had less impact due to excluding higher risk patient populations, where much of the unnecessary variation in outcomes occurs. In other episode payments we have designed (orthopedic, cardiovascular), we have built a comprehensive set of risk tiers that enable upfront risk adjustment to account for clinical and financial variation. This enables inclusion of nearly the entire patient population for a given episode payment. A maternity bundle is a more complex episode, due to the length of time care is delivered over and the unpredictable nature of pre-term labor. Outliers / high cost cases in maternity are almost exclusively driven by pre-term labor, which is difficult to predict and therefore to risk adjust for.

However, our analysis suggests that despite the unpredictability of pre-term labor, a majority of pregnancies can be included in the episode payment. We recommend the following guidelines to enable inclusion of the broadest population possible, while minimizing risk to the accountable entity:

- Include all deliveries after a specific gestational age, target between ~33-38 weeks. The specific timing can be flexible and tested as a part of the pilot rollout of this episode payment
- Risk adjust the prospective payment for deliveries in the second trimester; at this time the majority of conditions that are known to contribute to pre-term labor or an unexpected outcome can be identified. Specific timing to be determined and requires additional analysis, potentially as a part of the pilot rollout of this episode
- Agree on a set of conditions that would trigger stop loss after the risk adjustment period
- Include neonatal care in the episode payment; the relatively proportion of "late preterm" – over 33 weeks - deliveries requiring NICU care can be reliably predicted and built into the overall price for the maternity bundle. Furthermore, we see significant variation in management of "late pre-term" deliveries in the NICU and therefore see this as a sizable opportunity to improve both financial and quality indicators. Additionally, this encourages coordination across all the specialists involved in the maternity ecosystem – anesthesiology, neonatology, pediatrics – a stated goal of episode payment. Recommendations on how to structure payment in this scenario is included in later comments

We agree with the discussion in this initial recommendation on when a patient is ineligible for the episode payment. Given the importance of pre-natal care, we recommend deciding on a specific gestational age for excluding any pregnancy that has not presented for care; we believe this date should be around 20 weeks, with the specific timing to be determined. The prenatal visits that occur after this gestational age, as well as the diagnostic testing critical to assigning risk tiers, is essential to the success of the episode payment.

Finally, we encourage the workgroup to consider multiple gestations. Our approach to this scenario is to price the episode payment by fetus, rather than by mother. This enables capture of a larger population and furthermore presents an additional opportunity to minimize variation seen for multiple gestations. Further discussion is required on whether this should include gestations higher than twins.

4. Services

In the service definition, we believe additional work needs to be done on the specific genetic tests included in the episode payment. There is a real debate going on with regards to the tradeoff in these new tests, particularly those that are non invasive. There is a set of relatively standard genetic tests that we recommend including for all patients, at gestational age of ~11-13 weeks:

- Nuchal translucency
- PAPP-A and hCG Blood testing
- Cell-Free fetal DNA
- CVS

Beyond this, we recommend further discussion and analysis on the cost-benefit tradeoff for some of the more specific tests, such as CF and aneuploidy.

5. Patient Engagement

We support the emphasis of the workgroup on enabling a coordinated and focused effort to improve patient engagement over the course of the episode. We believe that patients should be aware that their care is part of a maternity episode, and would go so far as to encourage the adoption of a "patient covenant" to encourage this participation.

6. Accountable Entity

In maternity care, both the physician and the facility are integrally involved in the clinical, quality, and economic outcomes. For example, post partum length of stay, one of the areas of high variation across facilities (when accounting for differences in risk) and a significant contributor to the financial burden of maternity care, is largely driven by facility choices, specifically in discharge planning, rounding, and staffing models. These are often outside the control of the delivering OB. Conversely, as discussed at length, prenatal care falls entirely within the purview of the designated OB.

However, given the weight of labor and birth on the clinical and financial profile of maternity care, we recommend holding the hospital / facility ultimately responsible for the episode payment. We recommend setting a risk adjusted prospective price (in the second trimester, at a specific gestational age) that is paid to the hospital / facility. The hospital / facility will be responsible for contracting rates with all involved physicians, with the opportunity for shared savings by the physicians. This enables a broad and appropriate group of physicians to be involved in the economic upside, while minimizing downside risk for physicians that may be due to factors outside their control. As shared savings come from the total prospective, risk adjusted payment, this aligns the economic and clinical incentives of the hospital / facility and involved physicians.

7. Payment Flow

We recommend a prospective payment scheme, to best motivate all involved administrators / practitioners / physicians to deliver a care model that optimizes both clinical and quality outcomes. If too difficult to administer, we propose starting with a retrospective funds flow (paid out FFS as is current practice), but reconciled against a prospective price determined upfront.

8. Episode Price

In addition to the recommendations made by the work group, we propose considering building in share shift as a component of the pricing model. We believe this can encourage a shift to the highest quality care models in

any given region and appropriately rewards providers for achieving economic and quality improvements. Additionally, there is an investment required to support an episode payment model. Share shift is one lever to help offset that initial investment and support hospitals / facilities in adopting this model.

An open question that the workgroup needs to be thoughtful on is how to account for variation in practice – eg the use of laborists in the hospital. This facility variation would encourage a more specific pricing calculus than one that relies on regional data.

9. Type and level of risk
As discussed above, we recommend risk adjustment in the second trimester, when most conditions known to contribute to higher cost / lower quality outcomes can be identified.
We recommend excluding patients born before a certain gestational age (to be determined, ~33-38 weeks). This enables the opportunity to improve management of the NICU while minimizing losses that cannot be predicted or prevented from pre-term labor

10. Quality metrics
We suggest including the following outcomes measures as a way to evaluate the impact of the episode payment. Further discussion is necessary on what parties will and should have access to these specific metrics, but we believe that transparency, particularly to patients, will be important in communicating the impact of this episode payment.

Economic
- Average risk adjusted charges per case, vaginal and ceasarean section, by gestational age

Operational
- Average risk adjusted LOS
- Maternal LOS post partum (vaginal and ceasarean)
- Maternal ICU admissions
    - Maternal Admission to ICU per delivery ≥ 20 wks gestation
    - Maternal ICU days per delivery ≥ 20 wks gestation
    - Maternal ICU Admissions with Pre-eclampsia
    - Maternal ICU Days with Pre-eclampsia
- Newborn Bilirubin Screening Prior to Discharge
- Unexpected maternal transfusion

Clinical
- Ceasarean section rate
    - Appropriate DVT Prophylaxis in Women Undergoing C- Section
- NTSC Ceasarean section rate
- Elective deliveries <39 weeks
- Episiotomy rate
- Induction rate
    - Medically indicated
    - Non medically indicated
- Failed induction rate

    - Total
    - Medical vs. elective induction
- Unexpected newborn complications
- 5 Minute APGAR < 7 Among All Deliveries > 39 weeks
- 5 Minute APGAR < 7 in Early Term Newborns
- Birth Trauma - Injury to Neonate (AHRQ PSI 17)

Finally, while outside the scope of the initial recommendation, we recommend a discussion on the structure for engaging physician leadership in this pilot. Our maternity bundle design has been supported by a physician board (162b), that has been responsible for building the initial episode payment clinical model. This 162b will also be the vehicle through which funds flow for the episode payment, and will hold responsibility for revising the clinical model as analysis is performed on the economic, quality, and patient satisfaction impact of the episode payment. Purposefully, the physician board has been designed to include representatives from multiple geographic locations, employed and affiliation physicians, as well as those with different specialties (eg, high-risk OB). We have also involved a set of specialists (eg, anesthesiology, neonatology) as relevant to the clinical model. We strongly believe that early and proactive physician involvement not only focuses this product design on the critical quality elements but also positions the episode payment for a successful adoption, as garnering physician buy-in is integral to driving and sustaining positive change.

Texas Health Resources is committed to driving innovation in episode payments – in addition to a maternity bundle, we have also designed CABG, valve replacement, lumbar fusion, cervical fusion, and major joint replacement bundles. We have invested significant resources and energy into understanding the critical success factors – from an economic, operational, and clinical standpoint. As these bundles rollout, we are committed to evaluating their impact real-time and adjusting our bundle parameters as needed to drive success, for all involved parties. As such, we hope to be active participants in the work the LAN is engaged in on this episode payment and look forward to working together in an active partnership.

Sincerely,

Daniel Varga, MD
Chief Clinical Officer, Senior Executive Vice President
Texas Health Resources