

Virtual Meeting Track 2: Alternative Service Models for Maternity Care

Maternity Multi-Stakeholder Action Collaborative

May 22, 2017
2:00-3:00pm ET

Highlights and Key Takeaways

MAC members participated in the virtual meeting for Track 2: Alternative Service Models for Maternity Care. Below are highlights and key takeaways from the interactive meeting, which included a live interview with Cara Osborne, Certified Nurse Midwife and Founder of Baby+Company, a network of freestanding birth centers in Colorado, North Carolina, and Tennessee. She presented her experiences with incorporating birth centers into the classic hospital-based birth models, and discussed how others can interface these alternative service models with episode-based payment programs.

Overview of Alternative Models of Maternity Care Delivery

This session focuses on topics to consider when incorporating alternative service models into a maternity episode. An overview of the flow of a potential maternity episode was discussed, as well as services that are typically reimbursed and some services that are not typically reimbursed. Some of the services discussed during this session that might be included in an episode may extend from the prenatal period through postpartum care.

Based on the live polling results (full poll results are available in the appendix), 71% of participants who responded to the question of “What is/are your biggest challenge(s) related to including alternative care delivery models in a maternity APM?” answered “Negotiating Competitive Contracts.” Some participants offered further explanation related to this challenge, stating that based on historical experience with health plans, birth centers have not been reimbursed for all of the services they provide. Birth centers do not have the market power like some of the bigger health systems and hospitals, and they’re not physicians, so they are not in any clear category of how health plans organize their contracting area or their claims payment area. There are also a number of challenges due to birth centers falling in between both the facility fees and the professional fees. Other participants commented that it seems as though payers are behind in understanding APMs, and some participants are not sure how to even start the discussion with providers on including alternative models of maternity care delivery into episodes.

This session reviewed alternative delivery models, including birth centers, midwifery care, doula care, and group based care. For a better understanding of the current environment, data from 2015 was reviewed, which shows the opportunities available in the maternity field to incorporate alternative delivery models:

- In hospital births accounted for 98% of births, with 92% of those having a physician as the attending provider and 8% attended by midwives.
- Of those out-of-hospital births, 74% were delivered by midwives, 4% by physicians, and 22% other or unspecified.

Birth Centers

A birth center is a home-like facility that is designed around a wellness model of pregnancy and birth. Data from the National Vital Statistics System from 1990-2012 shows there are at least twice as many births occurring in homes versus birth centers in the U.S. Use of birth centers has historically trended quite low and remained flat, however, in the last few years the use of birth centers has slowly been on the rise. This is important because birth centers can potentially save health care dollars due to reduced cesarean deliveries, reduced costs of vaginal births, and various other efficiencies they offer. On an individual service unit basis, reported facility costs are much lower for birth centers, but many hospital costs are fixed costs, so ultimately the real savings is if the fixed costs come out of the

hospital. Looking at the charges associated with facility costs for a vaginal birth at a birth center, the costs are significantly below what has been reported by hospitals for vaginal births.

Birth centers can be reimbursed through episode payment, but there are some considerations when incorporating them into episode payment models. Birth centers often deliver care using more personalized care and less standardized care plans, which can include a mix of individual and group visits, or care planning visits. This is different from what is traditionally a part of current global obstetric fees or the standard regimen of obstetric care. In addition, because women who deliver within a birth center tend to have lower clinical risk, it's more feasible to consider a flat-fee episode-based payment that does not vary by individual case, as opposed to a hospital setting where risk adjustment is used due to the range of risk.

A payer who wants to increase the use of birth centers for low risk women could consider doing so by educating members or beneficiaries about the value of delivering in this setting. In the case of an employer group, create benefit packages may be created to incentivize and encourage their use.

Midwifery Care

Midwifery care is another alternative service to offer in a maternity episode. Midwives are licensed, independent health care providers with prescriptive authority in all 50 states and are considered primary care providers by federal law. They provide a broad range of primary care for women that extend beyond the maternity episode.

The percentage of births attended to by Certified Nurse Midwives or Certified Midwives has been growing between 2005 and 2014, and the percentage of vaginal births attended by a midwife as of 2014 is 12% of births. Although births attended by midwives has been growing, there were no examples of midwife-oriented episodes found to share with MAC participants prior to this session. This may be because many midwives work in practices in a shared model collaborating with physicians, so when a claim is submitted, it is difficult to know which births have been attended by midwives, which have been attended by physicians, and which births had both providers in attendance. This challenge may make developing a budget for a midwife-focused episode more difficult as well.

To find more information on the number of midwives licensed in each state, visit the [American College of Nurse-Midwives](#) website.

Doula Care

DONA International, a doula certifying organization, defines a doula as “a trained professional who provides continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible”. There is some [research](#) available on the impact of doula care, finding that it lowers the likelihood of cesarean births and epidural use, and improves breastfeeding rates, among many other benefits.

Group Based Care: Prenatal and Parenting

Group-based care is group education for prenatal care and parenting. This provides women and their families with the opportunity for interactive learning with a larger community. An example of a successful group-based care model was reviewed during the session. This service is not typically part of a maternity episode, but can be incorporated.

Interview: Alternative Service Models for Maternity Care (Baby+Company)

Cara Osborne started the first birth center in Arkansas and replicated this model five more times in three states: Tennessee, North Carolina, and Colorado. She hopes to continue expanding this model in more areas. Cara also has a doctorate in public health and has been involved in public health programming as well as the American Association of Birth Centers National Birth Study.

- **Question 1:** Describe how your birth center is staffed.

- Baby+Company staff includes a group of nurse midwives who are the providers in the center. There are also nurses who are often the second set of hands at a birth, lactation specialists, and a team of administrative personnel such as childbirth educators and patient consultants.
 - There is an administrative team in each birth center which consists of a Center Manager, Assistant Center Manager, and an Outreach Manager. The Outreach Manager helps us tie the birth center to the local community and be more ingrained in the community.
- **Question 2:** When and how did you enter your first episode-based payment? Did you reach out to an insurer, or did an insurer come to you?
 - After the initial birth center in Arkansas, our first replication of this model was in Cary, North Carolina. We had a relationship with the Chief Medical Officer of North Carolina’s Blue Cross Blue Shield plan who was involved in many primary care and end of life alternative care models. She understood that the current FFS model of reimbursement was not going to provide appropriate reimbursement for the value of services provided by birth centers.
 - We worked together to create a flat-fee structure which includes antepartum transfer rates, intrapartum transfer rates, and full episode rates. We also discussed, at a fundamental level, what our perceptions are for the actual definition of a visit. Most obstetric providers in typical OB clinics spend around 5 minutes of provider time per patient in a typical visit. In a birth center, we provide more relationship-based, education-focused care, so we are spending closer to 30 minutes of provider time per patient for return visits, and about an hour for initial visits.
- **Question 3:** Are all six of your birth centers operating using episodes?
 - If we are working with plans as out-of-network providers, we default to using a FFS schedule.
 - For our contracted payer relationships, we have set episodic flat-fee contracts.
- **Question 4:** Do you have contracts with any Medicaid programs?
 - Medicaid plans are different in every state, so it has been a challenge, but we do have a new contract in Tennessee with the Blue Cross Blue Shield TennCare plan.
 - In Arkansas, we are not contracted with any Medicaid plans but we still see Medicaid patients.
- **Question 5:** What are the parameters you have set for your episodes; do they begin with the first prenatal visit?
 - For a full episode, it begins at the first prenatal visit and continues through six weeks postpartum. Some services included in the episode are education, group prenatal visits, face-to-face visits, home visits, telemedicine visits, and lactation visits up through 6 weeks. This model takes away the need to have a standardized approach to prenatal care and allows us to tailor the care to each individual person. There is risk on our side to make sure we are providing the care that we want to provide within the cost parameters that we’ve set with that episode in mind. Over a population of people, however, it works out quite well.
 - For intrapartum and antepartum transfers, the episode begins with the first prenatal visit and continues through the time of the transfer. For intrapartum transfers, the mother needs to be admitted into the birth center in labor to fit into that episode. Otherwise, any mother who transfers out prior to being admitted while in labor falls into the antepartum category.
- **Question 6:** How does proration work for the episodes where there are transfers?
 - We negotiate with each health plan for each transfer episode by looking at the full episode and essentially guessing at how much of that episode we will have delivered. Each plan has their own actuarial data to support their suggested reimbursement rate. Typically, if a mother is transferring out

of the birth center after beginning labor, we are able to negotiate a reimbursement between 70-90% of the episode. For antepartum transfers, its typically between 50-70% of the full episode rate.

- The challenge is helping the plans understand the cost benefits of birth center care, especially when they are concerned about what their costs may be on the receiving end of the transfer. We have used about 3½ years of cost data associated with transfers to show such examples as mothers who had birth center based prenatal care are less likely to have a cesarean delivery as opposed to mothers who never had birth center based prenatal care. This helped ease fears of increased costs on the back side for the health plans.
- **Question 7:** Do health plans give you their preference of which hospital the transfers should be directed toward when there is a need?
 - When we set up a birth center in a community, we typically enter that community with a designated hospital partner. This could be an affiliation, a transfer agreement, or a joint venture business arrangement.
 - In Nashville, Tennessee, Vanderbilt University Medical Center was overflowing with patients, so they saw a birth center as a way to shift their lower risk volume away from the higher cost, higher acuity setting and into the birth center. Vanderbilt has a successful midwifery practice, performing about 1,200 births per year, with more than 50% of those mothers choosing not to receive epidural anesthesia or other services like continuous monitoring or IV's. We developed a partnership agreement with Vanderbilt where the midwives are employees of the hospital and work for the birth center on a professional service agreement. After the birth center was open, we began to see a high volume of women who are not necessarily considering Vanderbilt as their hospital of choice, but are interested in this type of care. As a result, Vanderbilt's volume has not changed much.
 - It is possible that there are hospitals who would view a birth center as a competitor as opposed to an aid to help reduce volume. Baby+Company has not personally experienced this, but we have had hospital partners who had lower volumes and want to partner with birth centers to potentially increase their volume that might otherwise go to competing hospitals.
- **Question 8:** Are all your arrangements full risk?
 - Yes, and we are looking for ways to take on more risk. With our physician partners in place, the birth center could serve as the primary accountable entity in a full scope episode, and distribute savings down to hospitals and physician partners as necessary. We are hoping to test this with the new redesign of Medicaid in North Carolina where Centene has come in as an operating partner. We would like to find ways to bring people in to the birth centers for prenatal care whether or not they are planning a birth center birth or midwifery-attended birth, and let them have the advantage of the extended provider time and extra education and group visits, while still having the full range of delivery options.
- **Question 9:** To what extent are quality measures integrated into your payment arrangements, and what kind of measures are incorporated?
 - Quality measures are only a part of the contract in Colorado with Anthem. We gravitated toward the Joint Commission and National Quality Forum maternity measures, although they do not all relate to birth centers. For example, we do not have early elective inductions, but it helps to be able to report O's in those measures. In other measures, such as breastfeeding rates, we have reached 99+% of mothers, so it's important to measure these areas and show our results. Our NTSV cesarean rates are around 8-10%, and our cesarean rates for people who endure labor in the birth center, whether they're first time mothers or not, are steady around 5-6%.

- Although we are not required to within our contracts, we do review quality measures extensively at all birth centers and run outcomes reports every week. We are committed to doing everything we can to make this a great experience for patients and their families. Eventually we would like to have a re-evaluation of our rates based on quality metrics, but during negotiations with payers regarding maternity care, it does not seem like they use any of those metrics to set rates at this time. Contracts may require quality metrics be reported, but payment is not tied to the results.
- **Question 10 [From MAC Participants Linda Davis & Annette Pounders]:** Why haven't payers been more involved in using incentives for quality regarding maternity care and if they don't have any metrics, why do they focus on cesarean rates only?
 - From my perspective, it may be because they don't feel they can ask me to be held accountable for quality metrics results when they are not asking anyone else to. I would be hesitant to guess why they are not having anyone else tying quality metrics to payment.
 - Obstetrics has historically stayed outside of measurement, but thanks to MAC Co-Chair Elliott Main's work, we are moving in that direction. However, other specialties have come into the quality reporting game in a much bigger way than obstetrics has, and part of that may be driven by the fact that services like hip and knee replacements are often reimbursed by Medicare, whereas 50% of births are reimbursed by Medicaid. The state by state nature of Medicaid has made it harder for there to be a consistent voice about the role that quality metrics should play, as opposed to the more consistent voice on the Medicare side pushing for the incorporation of quality metrics. That's a wild guess but that's my guess.
- **Question 11:** Are your payments prospective, retrospective, or a mix?
 - Our payments are retrospective. We bill after a baby is born or after the time of transfer.
- **Question 12:** Either during an episode or after the episode, do you receive reports from the payers that break down the mix of services and expenditures?
 - We have not had access to that information at this point.
- **Question 13:** What has been the most challenging issues for you when working with health plans?
 - The initial rate setting conversation is usually challenging. Unfortunately, birth center benchmarks are based on old data and they have not been adjusted over time. They do not reflect what it takes to run a birth center or the current value of birth center care.
 - Birth center charges are about 50% of hospital charges in our local markets. Individual market provider representatives within health plans are not looking at value or cost savings, such as if it would be better for the plan and the mother to deliver in a hospital versus a birth center. These representatives are held to existing service line benchmarks, and they look at the code and place of service, and that rate is the one they are held to during contract negotiations. We have to encourage them to go outside of the typical local market negotiations, and that usually involves incorporating the regional or national teams within the health plan who are paying closer attention to cost savings and value. Reaching those players has been very challenging.
- **Question 14:** What recommendations would you make to the health plans and Medicaid programs participating on the MAC who might be interested in contracting with birth centers on an episode basis?
 - Again, that initial rate setting issue is very important. Start looking at birth centers as alternative platforms for maternity care from physician-led hospital based care to midwifery-led birth center based care. Receiving prenatal care from a birth center does not mean a patient is locked in to only receiving care from a birth center. At a birth center, you have access to midwives, but also physicians if you need

one. You receive care in a birth center, but may also be transferred to a hospital, if needed. Based on our data, the transfer rates are significant enough that we would never want mothers to feel they were in an either/or situation when choosing where to deliver, it is a both/and.

- Another suggestion is to run your own maternity data and analytics and determine the cost savings that may be associated with outcomes such as drastically reduced cesarean rates, or downstream effects such as NICU admissions post cesarean delivery.
 - If health plans and Medicaid programs are interested in birth centers as an option, set a reasonable, sustainable rate that will likely still produce quite a savings for you from the rate for a vaginal birth in a hospital, but may be well outside the birth center benchmark set in your state.
- **Question 15 [From MAC Participant Lisa Strasheim]:** Can you comment on in-hospital midwifery run birth centers, as to success and if there are significant opportunities for value in a hospital center separate from the main labor and delivery unit?
 - Cost in a maternity episode is driven by the facility fee, and even the cost differential between a vaginal and cesarean birth is driven by days in the facility. It does not matter if it is called a birth center or not, if it is operating inside the walls of the hospital, services must be billed based on hospital standards and meet hospital staffing requirements, so it is difficult to affect the cost basis.
 - A midwifery led service, regardless of what the physical space looks like, has a lot of cost savings implications around cesarean rates, which tend to be lower with midwifery services. But then we focus too much on the method of delivery and not enough on what happens during prenatal care. Midwives tend to provide more relationship-based prenatal care regardless of their place of practice, which has a lot of value with averting complications and improving patients' health with diet, exercise, smoking cessation, and addressing social determinants of health for patients who have a higher social risk profile. I do think there is value and savings that can come from midwifery-led units within hospitals, but I think it's a more difficult to see drastic cost difference based on just the fixed costs.

Appendix: Interactive Poll Results

Alternative Service Models for Maternity Care Poll Questions

Setting the Patient Population Poll Question	Participant Response	Total Percent
Which Service(s) Would You Most Like To Be Able To Reimburse For In Your Episode or APM?*	Midwifery Care	58%
	Doula Care	33%
	Prenatal/Labor/Birth - Birth Center	75%
	Group Prenatal Education	58%
	Group Parenting Education	42%
	Other • No "Other" responses entered in Chat Box	8%
What Is/Are Your Biggest Challenge(s) Related To Including Alternative Care Delivery Models In A Maternity APM?*	Lack of Historical Data (non-FFS)	29%
	Account for Birth Setting Changes	14%
	Negotiating Competitive Contracts	71%

* Participants had the option to choose more than one response for these questions, therefore results do not equal 100%

Feedback on the Value of this Meeting

Question	Answer	Total Percent
Please let us know how you would rate the value of this meeting?	Very Valuable	38%
	Valuable	56%
	Somewhat Valuable	6%
	Not Valuable	0%
How Useful Did You Find the Pre-Read Materials Supplied on the MAC Events Page?	Reviewed prior to today, useful	40%
	Downloaded, not yet reviewed	33%
	Not accessed, know where to find	13%
	Will not use/do not find useful	0%
	Did not know about pre-reads	13%