



Employer Actions to Progress Value-Based Payment in Maternity

The push to move health care from a fee-for-service system to fee-for-value is rapidly gaining momentum. Pregnancy and newborn care serve as a logical condition for the episode model as it occurs frequently and has a wide margin for improvement.

To help employers increase value in maternity care, the Pacific Business Group on Health (PBGH) developed an [Employer Action Guide](#). This brief further explores initiatives in maternity value-based payment (VBP), describing existing models and actions California purchasers can take to implement VBP into existing payer contracts.

Purchasers are essential to advancing VBP reform efforts. Employers, Medicaid/Medicare, and state insurance exchanges can learn and work together to build momentum and expand impact.

How to increase value of maternity services?

Value-based payment seeks to change incentives for hospitals and physicians to reward quality over quantity; evaluating healthcare services based on the outcomes for the price charged. To increase value in maternity care, payment reform needs to improve quality, reduce costs, or both. Using more midwives, for example, can help [to reduce pre-term birth and inappropriate C-sections and improve patient care experience](#). Reducing C-sections and sick babies will also help lower costs.

What actions can employers take to support VBP in maternity care?

1) Blended case rate for delivery

A blended case rate reimburses physicians and hospitals, respectively, one flat rate regardless of delivery method (cesarean or vaginal), removing financial motivations to perform a C-section.

Focusing on unnecessary C-sections during inpatient birth care, PBGH piloted the blended case rate with a quality improvement effort in three hospitals and two health plans in Southern California – successfully [reducing low-risk C-sections by an average of 20% at pilot hospitals](#).

Building off this success, Covered California – California’s state insurance exchange that insures more than 1.4 million people, updated its 2018 health plan contract terms to require all participating health plans re-negotiate provider contracts to eliminate incentives to perform C-sections. Although Covered California’s contract terms are agnostic to VBP methodology, they establish that purchasers expect plans and providers to begin implementing maternity VBP reforms in 2017.

HOW YOU CAN IMPLEMENT A BLENDED PAYMENT

- Request your health plans mirror Covered California's contract terms for your employee population.
- Ensure that plans do not pay more for C-sections.

2) Health plan contract requirements

Using health plan contracts to institute quality metrics can stimulate quality improvement activities at facilities in your plans' network. For example, including thresholds for hospital low-risk C-sections in health plan contracts can help ensure best performing facilities are in your health plan's network. To be effective, use a measurable metric in competitive markets with substantial care choices. This approach works best with a high birth volume in a particular geography or across multiple purchasers in the state.

Covered California, for example, requires health plans to include quality of care as a criteria for network inclusion by 2019 and specifically endorses the Surgeon General's Healthy People 2020 recommendation of 23.9% for low-risk C-sections. Implementing standards signal to hospitals and providers the need to lower their low-risk C-sections to stay in-network

HOW YOU CAN IMPLEMENT NARROW NETWORKS

Encourage your health plan to exclude hospitals with C-section rates higher than 23.9% from health plan contracts (currently 54% of hospitals in California).

Since many hospitals and plans are preparing to meet the Covered California requirements, now is a good time to add your voice.

3) Maternity bundled payment

In a [bundled payment arrangement](#), health plans make one payment for the entire pregnancy episode (conception through postpartum), no longer paying separately for each service provided during pregnancy and delivery. The contract and ongoing payment are contingent on achieving good outcomes, encouraging providers to examine their care models and deliver whatever services will yield the best outcomes.

To encourage private and public sectors to adopt new payment models, including [maternity care](#), the federal government launched the [Healthcare Payment Learning and Action Network \(HCPLAN\)](#).

As with bundled payment arrangements for other conditions, episode payment design varies widely. Small pilot projects are underway with the boldest efforts among state [Medicaid agencies](#). Such payment innovations have not gained traction with commercial health plans – placing purchasers in the position to push for progress in bundled payments among private payers.

HOW YOU CAN IMPLEMENT A BUNDLED PAYMENT

- **Know your market.** How many babies are born among your beneficiaries each month? What's the low-risk C-section rate? How much is your annual spend on prenatal and newborn care?
- **Meet with local provider systems.** Evaluate interest in piloting a bundled payment program.
- **Meet with your health plan(s).** Request implementation of bundled payment arrangements consistent with HCPLAN recommendations. Payers in other regions and systems have transitioned bundle payment arrangements – and they can too.
- **Contact PBGH for support.** We're always speaking with payers and providers, and may be planning a meeting in your market.