



Agenda Item 10

November 19, 2013

ITEM NAME: Leading Practices in Maternity Health Benefits

PROGRAM: Health Benefits

ITEM TYPE: Information

EXECUTIVE SUMMARY

This information item provides an overview of early elective deliveries that are scheduled without a medical reason and potential policy approaches to reduce the frequency of such deliveries.

STRATEGIC PLAN

This item supports the California Public Employees' Retirement System (CalPERS) Strategic Goal A: Improve long-term health benefit sustainability by implementing new approaches and expanding efforts already proven to reduce health care costs and improve health outcomes.

BACKGROUND

At the October 2013 Pension and Health Benefits Committee (PHBC) meeting, the Committee was provided an update of CalPERS participation in the Let's Get Healthy California (LGHC) State Innovation Model Work Group and the award of a federal Center for Medicare and Medicaid Innovation (CMMI) grant for payment reform pilot projects. A key payment and delivery method initiative identified in the LGHC State Health Care Innovation Plan pertains to maternity care.

The Centers for Medicare and Medicaid Services (CMS) reports that over the last several years, organizations such as the March of Dimes, Childbirth Connection, the LeapFrog Group and the Association of Women's Health, Obstetric and Neonatal Nurses have raised concerns about babies being scheduled for birth prior to gestational maturity. These early births scheduled without a medical reason, also known as early elective deliveries, occur between 37 and 39 weeks of pregnancy and do not have an associated medical indication for which there is evidence or expert opinion to support expedient delivery (for example, gestational hypertension or preeclampsia). A 2007 Thomson Healthcare report on the healthcare costs of having a baby attributed early elective deliveries without a medical indication to both providers and expectant mothers for reasons of convenience or patient requests.

According to the American Congress of Obstetricians and Gynecologists (ACOG), early elective deliveries may occur either by induction or cesarean section and are associated with an increased risk of maternal and neonatal morbidity and longer

hospital stays for both mothers and newborns, as compared to deliveries occurring between 39 and 40 completed weeks' gestation. ACOG and the Society for Maternal-Fetal Medicine urge delaying deliveries until 39 completed weeks of gestation or beyond. Elective deliveries prior to 39 weeks result in more cesarean births compared to spontaneous labor, and ACOG asserts that it has not been possible to document any population-level benefit to women or newborns for cesarean rates higher than those seen in the late 1990s.

The Centers for Disease Control National Center for Health Statistics reported earlier this year that the overall cesarean rate in the United States held steady at 31.3 percent each year from 2009 to 2011. Prior to 2009, the national cesarean rate increased annually for 12 years in a row, from 19.7 percent of all non-twin or multiple births in 1996 to 33 percent.

The CalPERS cesarean rate aligns with current national trends: the percentage of cesarean deliveries for all non-Association Basic plans has been stable at between 30 and 31 percent from 2009 to 2012. Preliminary research shows that in 2012, CalPERS and its members paid approximately \$173 million for maternity care (\$102 million for vaginal deliveries and \$71 million for cesarean deliveries).

ANALYSIS

A variety of non-medical factors can affect the rate of early elective deliveries. For facilities, spontaneous vaginal deliveries may be more difficult to plan and manage compared to scheduled deliveries. And for providers, scheduling a birth ensures that they will be the ones to perform the delivery and they will not have to transfer care and associated payment to a colleague or be delayed from office or other hospital duties. Additionally, malpractice avoidance and fear of malpractice litigation can drive providers to favor intervention when there is sign of fetal distress.

There are various approaches that can impact the rate of early elective deliveries, for example educating expectant mothers and network physicians on the benefits of full-term births and the health consequences of elective deliveries, but the most practical option available to large group purchasers of health insurance is modifying payments. The current model in most hospitals is that physicians make decisions regarding patient care, not hospitals, and any change to this model must consider today's dynamics. With that in mind, some payment policy approaches are discussed below.

Blended Payments for Maternity Care

Currently, hospitals charge different rates for vaginal and cesarean births. Instead of different payment rates for vaginal birth or cesarean birth, a single rate could be set for "birth". The blended payment approach has the potential to remove economic incentives for performing cesarean deliveries and reward those hospitals with lower cesarean rates.

One model used to establish a blended rate for a delivery is cited by a national organization, the Catalyst for Payment Reform, in their *Action Brief on Maternity Care Payment*. This model multiplies the desired percentage of utilization for each type of delivery by the respective reimbursement rate. As an example using 2005 average cost data, when an uncomplicated vaginal delivery costs \$7,773 and a cesarean delivery costs \$10,958, a cesarean delivery rate of 32 percent would result in a blended delivery rate of \$8,792.14. Although the reimbursement rate for vaginal deliveries increases, the anticipated drop in cesarean births leads to fewer dollars spent on labor and delivery.

Blending payments for maternity care is an emerging approach which has been adopted by some health insurers and providers, but is not yet a standard practice. Typically, the blended payment model includes some form of risk adjustment. For example, the Minnesota Department of Human Services adjusted Medicaid payments to a blended rate for deliveries that assumed up to five percent fewer cesarean deliveries. Payments for uncomplicated vaginal and cesarean deliveries were equalized, thereby increasing the rate for vaginal births slightly, while decreasing cesarean delivery reimbursement significantly. The overall projected facility savings estimated for the state of Minnesota is almost \$2.25 million annually.

Performance Measures

Beginning with the 2012 plan year, CalPERS health plans began implementing programs to address elective deliveries at less than 39 weeks gestation, recognizing the risk of non-medically necessary early deliveries. These programs include implementation of scheduling policies at hospitals, development and adoption of medical policy language, member prenatal education, and stakeholder collaboration.

Payment for meeting performance measures is common, but has rarely been applied to maternity care. One consideration for implementers is that measurement of gestational time periods using claims or procedural codes is currently evolving, making measurement of early elective delivery performance targets challenging.

For the 2012 plan year, early indications are that CalPERS plans have been successful in implementing policies that have demonstrated success in reducing elective deliveries before 39 weeks gestational age.

Payment Adjustment

Some state Medicaid programs have implemented policies which reduce payments for cesarean delivery, increase them for vaginal births or withhold payment for elective deliveries before 39 weeks. These policies require review by physician panels, are based on an assessment of medical indication, and depend upon implementation of claims code modifiers to enable measurement of gestational age.

For example, as of January 2013, South Carolina's Department of Health and Human Services (SCDHHS) no longer provides reimbursement to hospitals or

physicians for elective inductions or non-medically indicated deliveries prior to 39 weeks. Non-reimbursable early deliveries include both inductions of labor and cesarean sections. SCDHHS reported that, in 2012, non-medical inductions prior to 39 weeks were reduced by half at 43 birthing hospitals as a result of their commitment to end the practice of early elective deliveries, and the decision to withhold reimbursements has broad support. This support comes from organizations in the health care community, including the South Carolina Birth Outcomes Initiative which is a collaboration of the SCDHHS, the South Carolina Hospital Association, the South Carolina Obstetrical and Gynecological Society, the South Carolina Chapter of the March of Dimes, maternal fetal medicine physicians from all five regional perinatal centers, BlueCross Blue Shield of South Carolina and other stakeholders.

Other Efforts

The U.S. Department of Health and Human Services launched various initiatives in 2012 to improve perinatal health outcomes. The CMS Strong Start for Mothers and Newborns initiative led by the CMMI, is a multi-media and educational outreach campaign focused on providers and expectant women that promotes awareness of risks associated with early elective deliveries. Additionally, over 3,700 hospitals are participating in Partnership for Patients, a public-private effort to improve the safety, reliability and cost of hospital care, as part of Hospital Engagement Networks (HENs) to identify and spread best practices. Reduction in early elective deliveries is one obstetric safety area of focus within most of the HENs.

At the California state level, the California Maternal Quality Care Collaborative (CMQCC) is developing resources, tools, measures, and quality improvement techniques and is collaborating with providers, administrators, and public health leaders. For example, Sutter and Dignity Health hospitals which participated in CMQCC pilot programs that focused on education and intervention have nearly eliminated early elective deliveries.

Finally, Kaiser has implemented a Maternity Care program that has reduced the frequency of early elective deliveries. For a description of their program, see Attachment 1. Dr. Sonia Soo Hoo, MD, Obstetrics and Gynecology, will provide a presentation of the Kaiser program at the PHBC meeting.

BUDGET AND FISCAL IMPACTS

Not Applicable

ATTACHMENTS

Maternity Care – Kaiser Permanente

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