American Association of Birth Centers

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 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 single largest Medicaid budget expenditure.[2,3] For commercial payers whose enrollees include the Medicare population, maternity care is also a considerable expenditure. 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 higher-level 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]

Midwives are the care providers in the majority of birth centers. Relationship-building and time-intensive prenatal care significantly impacts 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 Infants 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 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.[16,17] Preliminary data

show that AABC Strong Start participants enrolled in the study experienced preterm birth rates of 3.5%, low birth weight rates of 2.8%, and a primary cesarean rate of 9.3% for the first 4000 births.[16]

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.[18] However, this number represents an increase of 75% in the past ten years.[19] According to the AABC, there are only 315 birth centers in the United States, limited in part due to regulatory barriers and inadequate reimbursement or due to denials of coverage and contracting by Medicaid, Medicaid Managed Care Plans, TRICARE and other health plans.

Alternative Payment Models in Freestanding Birth Centers

FSBCs have the demonstrated ability to reduce unneeded medical interventions and the cost of maternity care for women who are medically low-risk, even if they have low socioeconomic risk status and lack of social support. The birth center model of care meets the Triple Aim of better health, greater client satisfaction and cost savings.[20] The care model should be integrated into APM planning to the fullest extent possible. AABC believes that a risk stratification of women eligible for low-risk care would be needed, with eligibility screening by the birth center or other low-risk midwifery provider at the beginning of care. Birth centers operating under the AABC Standards utilize risk criteria that would determine at the outset of care whether a woman is eligible or not, and her risk status is tracked in AABC's Perinatal Data Registry throughout the pregnancy. Freestanding birth centers may be willing to accept varying levels of risk, depending on the volume of patients served, population served (whether largely commercial or Medicaid), and other factors that would vary from state to state. Because many birth centers are small, initial alternative payment arrangements may need to focus on incentivized payments for the enhanced level of care that leads to improved outcomes documented above.

Episode of care. The episode of care (EOC) most reasonable for birth centers is the time when a pregnant woman enrolls in care in the freestanding birth center through and including her 6-week postpartum care visit. Some women transfer care into or out of birth center care partway through pregnancy if they relocate, change insurance coverage, or if they learn about the option of FSBC later in pregnancy.

Women would be included in the low-risk episode of care if they are eligible for birth center care upon enrollment for pregnancy care at the birth center. 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 a maternal-fetal medicine specialist, then the episode of care would end at the birth center and recommence with the perinatologist.

It is within the scope of midwifery care to provide care for the newborn through 28 days of life and to give full support to address breastfeeding issues for the mother-infant dyad.

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] Bilingual staff would be hired if there is a significant need in the population served. Services would include standard prenatal care, nutrition, patient navigation, care coordination, discussion of options for birth, breastfeeding and childbirth preparation instruction, and health education and support to avoid preventable complications. Women with risk factors or emerging risk status would receive consultation or be referred for collaborative care with mental health providers, nutritionists, obstetrician/gynecologists, or pediatric care providers. Services such as lab testing or ultrasound may or may not be included, but may be billed outside the episode covered in the birth center depending on factors such as ability to contract with nearby hospital facilities.

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. If primary care providers (PCPs) were included in an APM network, healthy women could be screened by their PCPs and advised when they meet criteria for birth center delivery that the birth center is an option.

Risk and Payment. FSBCs are typically small facilities, however, there are a few birth centers that cover a larger volume of clients. Risk level for birth center facilities would be set based on size and population served; whether majority Medicaid, Medicaid Managed Care or commercially insured clients.

For smaller facilities that serve fewer than 200 births per year or a majority of Medicaid beneficiaries, it would not be feasible to accept significant risk. These centers would benefit from incentivized payment for the enhanced prenatal care model that leads to improved outcomes and confident, prepared parents (HCP-LAN Category 2c or 3a).[21] 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.

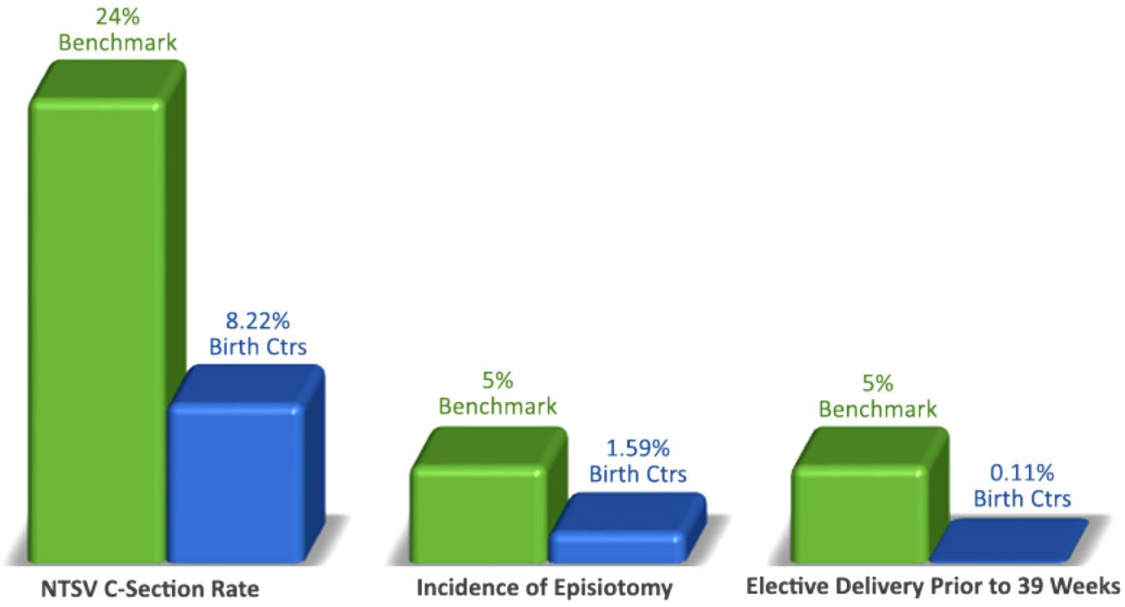
Larger volume FSBCs (>500 births/year) will be more able to accept some risk (Category 3b) and could accept bundled payments to include basic imaging, usual lab tests, and consults to obstetricians or pediatricians, including uncomplicated vaginal delivery or cesarean sections at the hospital. There would need to be a set of high-risk complications during which the episode of care at the birth center would end or be suspended until the complication was resolved and care could resume at the birth center. In some cases, care can resume during pregnancy, and in other cases, care would not resume until postpartum care, or not at all. Payment would flow to larger birth centers as bundled payments for their acceptance of risk for the entire pregnancy. However, some outcomes would need to be excluded in the bundle, such as referral or transfer to a perinatologist for high-risk pregnancy. At the point of this change in care setting, the episode of care could end at the birth center and recommence with perinatologists. It would also be an option for birth centers willing to assume a higher level of risk to continue the Episode of Care (EOC) for any woman eligible at the beginning of pregnancy to continue throughout, offering clients continued midwifery support and care coordination even after they are referred to specialists.

Smaller birth centers would receive incentivized enhanced prenatal care payments at the end of pregnancy care. Labor and birth care in the FSBC are usually paid as separate payments for professional and facility services similar to the hospital. If payment for birth center care is bundled, it should be sufficient to support services provided and adequate numbers of midwives and support staff. FSBC operating costs vary in different regions of the US depending on rents and overhead, liability insurance and cost of living for staff, so it is difficult to set a standard cost for this care. Typically, facility costs for a

birth center are approximately 2/3 of the cost of low-risk vaginal birth in hospitals located in the same area.

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, 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 for example of quality benchmark data from the Strong Start data set.[16] Incentivized payment would be received for providing effective prenatal and birth care.

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]



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.

2) Bundled payment where birth center is part of network of community providers/options for low-risk women including FSBC, midwifery care in hospital, or obstetrician care in hospital. Birth center receives incentive payments for each participant provided enhanced services and shared savings for overall cost savings.
3) Bundled payment where FSBC is Principal Accountable Provider (PAP) managing EOC from entry to birth center care. Women are eligible for birth center care if they meet low-risk criteria at beginning of care at birth center. FSBC contracts with referral providers and remains EOC even when women require transfer to hospital. Professional services of physicians are covered in EOC. Hospital charges are included or billed separately, depending on relationship with hospital.
4) 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 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 are 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 fee. The global contracts cover all professional services related to a birth. 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, hearing screen and circumcisions). Reimbursement vary based on the contract; some contracts pay a reduced rate for a direct hospital admit and others 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 a 5% 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 (FSBCs). 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 FSBCs 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 *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 chooses to be accredited by the CABC, they are measured against the rigorous, national AABC Standards for Birth Centers. There are currently 104 accredited birth centers.

2.1.16

[1] Pfuntner, A, Wier, L, & Stocks, C. Most Frequent Procedures Performed in U.S. Hospitals, 2010. HEALTHCARE COST AND UTILIZATION PROJECT Agency for Healthcare Research and Quality: 2013 http://www.hcup-us.ahrq.gov/reports/statbriefs/sb149.pdf

[2] The Cost of Having a Baby in the United States, *Truven Health Analytics*, January 2013. Available at: http://transform.childbirthconnection.org/reports/cost/.

[3] Wier L., Andrews R. *The national hospital bill: The most expensive conditions by payer, 2008.* (Healthcare Cost and Utilization Project Statistical Brief #107). Rockville, MD: Agency for Healthcare Research and Quality: 2011 http://www.hcupus.ahrq.gov/reports/statbriefs/sb107.pdf

[4] World Health Organization. *World Health Statistics, 2014.* Geneva, Switzerland: WHO Publications: 2014. http://www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Full.pdf

[5] Callaghan WM, Creanga AA, Kuklina EV. Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. *Obstetrics & Gynecology 2012*;120(5):1029-36.

[6] Declerq ER, Sakala C, Corry MP, Applebaum S, Herrlich A. *Listening to women III: New mothers speak out.* New York, NY: Childbirth Connection; 2013.

[7] Alliman, J. & Phillippi, J. Maternal outcomes in birth centers: An integrative review of the literature. Journal of Midwifery and Women's Health, Jan-Feb, 2016.

[8] Howell, E. , Palmer, A., Benetar, S., Garrett, B. (2014). Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center. Medicare & Medicaid Research Review. Available at: https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a06.pdf.

[9] Cawthon, L (2013). Assessing Costs of Births in Varied Settings. DSHS, Planning, Performance and Accountability, Research Division. Olympia, Washington.

[10] Rooks JP, Weatherby NP, Ernst EKM, Stapleton SR, Rosen D, Rosenfield A. Outcomes of care in birth centers: The national birth center study. *New England Journal of Medicine.* 1989; 321(26), 1804-1811.

[11] Stapleton S, Osborne C, Illuzzi J. Outcomes of care in birth centers: Demonstration of a durable model. *J Midwifery Womens Health.* 2013; 58(1); 3-14.

[12] Spong CY, Berghella V, Wenstrom KD, Mercer BM, Saade GR. Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop. *Obstet Gynecol 2012*;120(5):1181.

[13] American College of Obstetricians & Gynecologists, Society for Maternal-Fetal Medicine. Obstetric Care Consensus No. 1: Safe Prevention of the Primary Cesarean Delivery. *Obstet Gynecol 2014*;123(3):693-711.

[14] American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine. Obstetric Care Consensus No. 2: Levels of Maternal Care. *Obstet Gynecol 2015*;125(2):502-15 10.1097/01.ACOG.0000460770.99574.9f

[15] American Association of Birth Centers. Standards for Birth Centers. Perkiomenville, PA; 2013. Available at: http://www.birthcenters.org/open-a-birth-center/birth-center-standards

[16] American Association of Birth Centers. AABC Perinatal Data Registry. 2016.

[17] 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 in preparation

[18] Hamilton, B., Martin, JA, Osterman, JKA, Curtin, & Mathews, TJ. (2015) Division of Vital Statistics, National Vital Statistics Reports Volume 64, Number 12. Hyattsville, MD: National center for Health Statistics.

[19] MacDorman MF, Mathews TJ, Declercq E. (2014). Trends in Out-of-Hospital Births in the United States, 1990–2012. NCHS data brief, no 144.Hyattsville, MD: National Center for Health Statistics

[20] Berwick DM, Nolan TW, and Whittington J. The triple aim: care, health, and cost. *Health Affairs.* 2008; 27(3): 759-769. http://content.healthaffairs.org/content?27/3/759.full.html

[21] Health Care Planning Learning and Action Network, Alternative Payment Model (APM) Framework
Final White Paper, Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group, 2015.