# Hospital Contracting Options

## Introduction

Entering into a clinical partnership with high-performing maternity providers gives purchasers the opportunity to introduce contracts that include alternative payment models (APMs). APMs are payment approaches that incentivize high-quality and cost-efficient care, by holding providers accountable for costs, care outcomes and the patient experience.[1] Some APMs can also introduce incentives for improving health equity and reducing racial disparities in clinical outcomes and patient experience. [2] This tool explores options for alternative payment models geared toward maternity care, providing an overview of different models, evidence of their success, and other considerations purchasers will want to examine. Given the many options purchasers can explore in a hospital contracting strategy, this tool is designed to be introductory; however, it also includes links to additional resources for further exploration. Payment models discussed in this tool include:

- Pay for Performance
- Blended Payment for C-Sections and Vaginal Deliveries
- Non-payment for Early Elective Delivery
- Episode Bundled Payment

## Pay for Performance

*MODEL OVERVIEW*

Under a Pay for Performance Contract (P4P) providers are paid fee-for service but also receive incentive payments "based on a provider's ability or inability to meet certain performance expectations based on predetermined measures."[1] Traditionally, P4P programs reward providers by tying fee schedule increases (or forfeitures) to performance on a pre-defined set of quality metrics.[2] Some programs reward providers simply for reporting on quality metrics – irrespective of their actual performance on those measures; one of the most prominent examples of a "Pay for Reporting" program is Medicare's Physician Quality Reporting System (PQRS) which was retired in 2016.[3]

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[1] Robert A. Berenson, Divvy K. Upadhyay, Suzanne F. Delbanco and Roslyn Murray, "Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care - Pay-for-Performance," *The Urban Institute,* April 2016 https://www.urban.org/sites/default/files/2016/05/03/09_pay_for_performance.pdf

[2] Catalyst.nejm.org. 2021. What Is Pay for Performance in Healthcare?. Available at: <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245>

[3] "Understanding the Transition from PQRS to MIPS," Healthcare Resolution Services, https://hcrs-inc.com/blog/understanding-the-transition-from-pqrs-to-mips/#:~:text=Since%20the%20Physician%20Quality%20Reporting,Incentive%20Payment%20System%20(MIPS).

*RESULTS AND EVIDENCE*

Although P4P programs have been operational for decades, there is limited and conflicting evidence that they produce better patient outcomes.[4] Studies measuring the impact of maternity P4P programs have similarly ambiguous findings. A 2015 British study examined the effects of a P4P program on reducing elective c-sections and found no effect.[5] A RAND literature review summarizing findings from multiple P4P programs cites a 2009 study that evaluated the impact of offering $100 each to patients and their providers for timely and comprehensive prenatal care; this study found the incentive was associated with fewer NICU admissions, but not with a change in low birth weight.[6,7] There is, however, more compelling evidence, particularly from the Integrated Healthcare Association's (IHA) long-standing P4P program in California, that P4P incentives can improve providers' adherence to specific clinical protocols, improve outcomes on process measures and encourage infrastructure investments that are intended to improve care coordination and efficiency – however, these findings are not specific to maternity care and there was no effect on clinical outcomes in the study.[8]

*PROGRAM CONSIDERATIONS*

Beyond the benefits of encouraging adherence to clinical protocols and processes, P4P programs can serve as a stepping stone to move hospitals along a continuum toward payment models that instill accountability for cost and clinical outcomes. For a hospital or provider group with limited experience operating under any form of APM, a P4P program is a good starting point.

An analysis of CMS's Premier Hospital Quality Incentive Demonstration (PHQID) recommends the following considerations when building a P4P program:[9]

1. Who will be paid?
2. What set of quality measures will determine performance bonus payments?
3. What are the criteria for bonuses or penalties?
4. How big are the payouts?
5. What are the indicators of success that will demonstrate whether the program is working?

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[4] Aaron Mendelson et al, "The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care," *Annals of Internal Medicine,* March 7, 2017

[5] MerveErtok, "Evaluation of a Pay for Performance Scheme in Maternity Care: The Commissioning Quality and Innovation Payment Framework in England," Procedia - Social and Behavioral Sciences, Volume 195, 3 July 2015, Pages 93-102.

[6] Cheryl L. Damberg, Daniel Mandel. 2021. "Measuring Success In Health Care Value-Based Purchasing Programs: Findings From An Environmental Scan, Literature Review, And Expert Panel Discussions". https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161317/.

[7] Meredith B Rosenthal, Zhonghe Li, Audra D Robertson, Arnold Milstein, "Impact of Financial Incentives for Prenatal Care on Birth Outcomes and Spending," *Health Services Research,* October 2009. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2754543/

[8] Cheryl L. Damberg, Kristiana Raube, Stephanie S. Teleki, and Erin dela Cruz, "Taking Stock Of Pay-For-Performance: A Candid Assessment From The Front Lines," *Health Affairs,* MARCH/APRIL 2009. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.2.517?sid=85dcbf17-043f-4ab4-b1cf-47734fe222e0

[9] Andrew Ryan, "Hospital-based Pay-for-Performance in the United States," *Health Economics,* July 2009. https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/hec.1532

### *ADDITIONAL RESOURCES*

The following resources provide additional information on P4P program design, evidence and considerations:

- Pay For Performance, *The Urban Institute*
- Measuring Success in Health Care Value-Based Purchasing Programs, *RAND Health Quarterly*
- Hospital-based Pay-for-Performance in the United States, *Health Economics*

## Blended Payment for C-Sections and Vaginal Deliveries

### *MODEL OVERVIEW*

A blended payment strategy offers a single rate for delivery, regardless of whether the birth is vaginal or by cesarean section. According to the latest research from the Health Care Cost Institute, the average cost in the commercial market in 2017 for a vaginal delivery is $12,235, whereas the average C-section is $17,004 (about 30% more).[10] This potentially creates a financial incentive for hospitals to perform more c-sections and fewer vaginal deliveries. A blended rate does not take a straight-line average between the two numbers, but instead sets a target rate for C-sections and uses a weighted average to set the blended payment rate. So, for example, if the goal is to achieve a C-section rate of 28% (the OECD average), the blended rate would be $13,570.[11,12] While payment for vaginal delivery increases, the hospital obtains lower payment for each C-section, and if C-sections rise above 28%, the hospital loses revenue overall compared to a non-blended contract.

### *RESULTS AND EVIDENCE*

The evidence on the effectiveness of a blended payment strategy is mixed. In 2009, Minnesota's Medicaid program launched a blended payment for uncomplicated deliveries; while the initial results were promising, showing a 3% decline in C-section rates and lower labor and delivery costs, a state-wide expansion of the program failed to lower C-section rates.[13] Out of concerns that the financial incentives could put patients and their babies at risk, the policy was rescinded in 2015.[14] On the other hand, the Purchaser Business Group on

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[10] William Johnson, Anna Milewski, Katie Martin, Elianna Clayton, "Understanding Variation in Spending on Childbirth Among the Commercially Insured," *Health Care Cost Institute,* May 13, 2020. https://healthcostinstitute.org/in-the-news/understanding-variation-in-spending-on-childbirth-among-the-commercially-insured

[11] "Caesarean Sections | Health At A Glance 2019 : OECD Indicators | OECD Library". 2021. Oecd-Ilibrary.Org. https://www.oecd-ilibrary.org/sites/fa1f7281-en/index.html?itemId=/content/component/fa1f7281-en#figure-d1e26448.

[12] ($12,235*0.72)+($17,004*0.28)=$13,570

[13] "Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes," *MACPAC Issue Brief,* April 2019. https://www.macpac.gov/wp-content/uploads/2019/04/Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf

[14] Jonathan M. Snowden PhD et al. "Cesarean birth and maternal morbidity among Black women and White women after implementation of a blended payment policy," *Health Services Research,* July 16, 2020. https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13319

Health's blended payment pilot in 2014 found that C-section rates declined between 19-25%, without any increase in unexpected newborn complications.[15]

### *PROGRAM CONSIDERATIONS*

The success of a blended payment for delivery model hinges on setting the right target for C-sections. Offering too high a rate would continue to encourage cesarean delivery, while offering too low a rate could encourage professionals to delay the decision to move to a cesarean delivery when medically indicated. It's also important to point out that a blended payment model does not directly introduce accountability for quality improvement and/or adherence to clinical guidelines and best practices. However, given the significant overuse of C-sections in the U.S., a *disincentive* to perform them when they are not medically necessary may ultimately improve the quality of care.

### *ADDITIONAL RESOURCES*

The following resources provide additional information on blended payment program design, evidence and considerations:

- Maternity Care Payment – *Catalyst for Payment Reform*
- Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes – *MACPAC*
- Case Study: Maternity Payment and Care Redesign Pilot – *Pacific Business Group on Health*

## Non-Payment for Early Elective Delivery

### *MODEL OVERVIEW*

The evidence is clear: Early elective deliveries (EED) – i.e., a birth where either an induction or cesarean section has taken place without medical indication between the 37th and the 39th completed week of gestation – increase the risk of maternal and neonatal morbidity and result in longer hospital stays for both mothers and newborns.[16] Yet, despite recommendations against EED from the American College of Obstetricians and Gynecologists dating back to 1979, by 2010, the rates of EED in the United States were alarmingly high - averaging an alarming 17% of all births.[17]

Fast forward six years, and by 2016, the rate of EED had fallen to less than 2% - a remarkable and almost unheard of rate of change in clinical practice.[18] This dramatic turn can be attributed in part to an unrelenting drumbeat of advocacy and reporting and transparency from groups like The Leapfrog Group and Catalyst for Payment Reform; however, an equally important factor in reducing EED rate can be the decision of states like South

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[15] "Case Study: Maternity Care Redesign Pilot," Purchaser Business Group on Health (formerly *Pacific* Business Group on Health) October, 2015. https://www.pbgh.org/wp-content/uploads/2020/12/TMC_Case_Study_Oct_2015.pdf

[16] Clark SL;Miller DD;Belfort MA;Dildy GA;Frye DK;Meyers JA;. "Neonatal and Maternal Outcomes Associated with Elective Term Delivery." American Journal of Obstetrics and Gynecology. https://pubmed.ncbi.nlm.nih.gov/19110225/.

[17] "Early Elective Deliveries". 2021. Leapfrog. https://www.leapfroggroup.org/influencing/early-elective-deliveries#:~:text=These%20are%20early%20elective%20deliveries,costs%20to%20patients%20and%20payers.

[18] "Early Elective Deliveries Occur In Less Than 2% Of Births". 2021. Mdedge.Com. https://www.mdedge.com/obgyn/article/132931/obstetrics/early-elective-deliveries-occur-less-2-births?sso=true.

Carolina to put a hard-stop on payments for elective deliveries before the 39th week of gestation.[19]

*RESULTS AND EVIDENCE*

South Carolina's Birth Outcomes Initiative is the seminal example of using non-payment for EED to change practice behavior – but there are others.[20] Between 2011 and 2014, South Carolina's non-payment policy for non-medically necessary early elective inductions reduced the EED rate by 73%; as of 2016, 76% of hospitals had a non-medical early induction rate of **zero.** In Oregon, a similar policy introduced in 2012 reduced elective inductions from 4.0% to 2.5% and reduced elective early-term cesarean deliveries from 3.4% to 2.1%.[21] The Perinatal Quality Collaborative of North Carolina (PQCNC), a partnership between the state Medicaid program and 39 hospital teams across the state, also instituted a hard-stop policy on payment for EED in 2010, and found that the program prevented 370 non-indicated early elective deliveries and shifted 769 deliveries to 39 weeks or greater gestation.[22]

*PROGRAM CONSIDERATIONS*

A successful program to reduce EED depends on two primary factors. First, the program must clearly define payment policy terms, including medical exclusions; it must also outline the claims adjudication process and an agreed upon course of action when an early induction does occur. Second, the program must proactively engage, educate and obtain buy-in from the provider community. Details on program parameters and best practices can be found in the tools and playbooks below.

*ADDITIONAL RESOURCES*

Early Elective Delivery Non-Payment Guide – *Catalyst for Payment Reform*
Early Elective Delivery Playbook – Maternity Action Team – *National Quality Forum*
Early Elective Deliveries Toolkit – *California Maternal Quality Care Collaborative*

## Bundled Payment

*MODEL OVERVIEW*

Episode Bundled payment programs offer a single payment amount, or budget, to providers or health care facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment - i.e., an episode of care.[23] Providers in bundled payment contracts can either be paid prospectively or retrospectively. Under a prospective bundled payment model, program administrators pay providers in advance, essentially capitating

[19] 2021. Catalyze.Org. https://www.catalyze.org/wp-content/uploads/2017/04/2013-Using-Education-Collaboration-and-Payment-Reform-to-Reduce-Early-Elective-Deliveries_SC-Case-Study.pdf.
[20] See: https://www.scdhhs.gov/organizations/south-carolina-birth-outcomes-initiative
[21] Jonathan Snowden et al., "Oregon's Hard-Stop Policy Limiting Elective Early-Term Deliveries: Association With Obstetric Procedure Use and Health Outcomes," Obstetrics & Gynecology: December 2016 - Volume 128 - Issue 6 - p 1389-1396. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5121072/#:~:text=Conclusions,in%20maternal%20or%20neonatal%20outcomes
[22] "Reducing Early Elective Deliveries in Medicaid and CHIP," https://www.medicaid.gov/medicaid/quality-of-care/downloads/eed-brief.pdf
[23] See Catalyst for Payment Reform Definitions - https://www.catalyze.org/payment-reform-definitions/

payment for the procedure or the services required to treat a condition; while in retrospective payment models, administrators pay providers incrementally through fee-for-service, then reconcile the total episode cost against a predetermined budget at the end of the episode.

The value theory behind bundled payment programs is that offering payment for an episode of care promotes coordination and collaboration across provider groups and care settings, establishes provider accountability for care outcomes, and creates incentives to adhere to clinical protocols and reduce variation in care.[24] Whether paid prospectively or retrospectively, bundled payment programs can (and should) include incentives for clinical care outcomes. Retrospectively paid bundles can encourage quality improvement through a shared savings model: if actual costs are lower than the target cost, providers can earn shared savings bonus payments that are calibrated against a scorecard of relevant quality metrics. Under a prospective model, the program administrator can withhold a portion of the provider's rate, which is then paid in whole or in part depending on the provider's performance on a quality scorecard.

Maternity is particularly well-suited to payment by bundle given that pregnancy, labor and delivery have clearly defined beginning and endpoints. There are a variety of available options for maternity bundled payment structure:

- Bundle the hospital payment and the professional fee for labor and delivery into a single payment.
- Bundle the hospital delivery payment for both mother and infant into a single payment.
- A comprehensive, single bundled payment for a maternity care "episode," covering pre-natal and post-natal care as well as labor and delivery. This type of bundle can also encourage hospitals to provide services they don't typically pay for, such as doulas.

### *RESULTS AND EVIDENCE*

Evidence from payers and providers who have executed bundled payment for maternity demonstrate that the programs can reduce C-section rates, generate cost of care savings, and improve performance on maternal quality metrics. A 2018 report from the State of Tennessee's Medicaid Program (TennCare), shows that their comprehensive maternity bundle (covering pre/post-natal care plus labor and delivery) achieved $13.5M in savings (9.2%).[25] Geisinger Health System's Perinatal ProvenCare Initiative demonstrated a 25% reduction in NICU admissions and a 26% reduction in C-sections.[26] Horizon Blue Cross Blue Shield's maternity bundled payment program includes over 300 practices across the State

[24] "BPCI Advanced | CMS Innovation Center". 2021. Innovation.Cms.Gov. https://innovation.cms.gov/innovation-models/bpci-advanced#:~:text=A%20bundled%20payment%20methodology%20involves,during%20an%20episode%20of%20care.

[25] "Episodes of Care 2018 Performance Period," TennCare, https://www.tn.gov/content/dam/tn/tenncare/documents2/EpisodesOfCare2018PerformancePeriod.pdf

[26] Kelsey Brewer and Rosie Fitzgibbon, "Maternity Bundled Payment Literature Review," Dr. Robert Bree Collaborative, http://www.breecollaborative.org/wp-content/uploads/Maternity-Bundled-Payment-Literature-Review.pdf

of New Jersey; under this retrospectively paid maternity bundle, C-section rates declined from 32.9% in 2009 to 28.1% in 2014.[27]

*PROGRAM CONSIDERATIONS*

Because maternity bundled payment programs vary significantly in their scope and structure, there are multiple decision points purchasers or program administrators must consider in program design. Here are a few high-level questions administrators should examine:

- What is the scope of the episode of care? Will it include care for both mother and newborn? Will it encapsulate pre and post-natal care or labor and delivery only?
- Will payment for the episode be executed prospectively or retrospectively? If prospectively, which entity will receive payment – the hospital, or provider group? If retrospectively, what is the data infrastructure required on the part of the provider and program administrator to identify claims associated with the episode of care?
- How will the administrator embed incentives for quality into the payment model? Which quality metrics will be included? What is the threshold level of performance required for the incentives to activate?

*ADDITIONAL RESOURCES*

The following resources provide additional information on maternity bundled payment program design, evidence and considerations:

- Maternity Bundled Payment: A Literature Review – *Bree Collaborative*
- Maternity Care Payment – *Catalyst for Payment Reform*
- Transforming Maternity Care: A Bundled Payment Approach – *Integrated Healthcare Association*

[27] Caffrey, Mary. "NJ's Horizon BCBS Pays $3M In Shared Savings For Episodes Of Care; Readmissions, C-Sections Reduced". AJMC. February 2016. https://www.ajmc.com/view/njs-horizon-bcbs-pays-3m-in-shared-savings-for-episodes-of-care-readmissions-c-sections-reduced-.