

OVERVIEW OF THE APM

A pregnant woman could choose a Maternity Care Team that is participating in the Alternative Payment Model (APM) to deliver maternity-related services prior to, during, and following delivery of the baby. The Team would include all of the clinicians and providers needed to deliver the full range of care the woman could need, and the Team would ideally include at least one birth center as well as a hospital. The woman could change the Maternity Care Team at any time prior to the beginning of labor or during the post-partum period.

Under the APM, the Maternity Care Team would receive five different types of payments during the different phases of care:

- Monthly bundled payments for all pregnancy-related services needed prior to childbirth;
- A standby capacity payment for hospitals in the community to support the minimum capacity needed to offer labor and delivery services on a round-the-clock basis, particularly for high-risk pregnancies;
- A bundled/warranted payment for labor and delivery services, regardless of whether the delivery occurs in a birth center or a hospital;
- Monthly bundled payments for all post-partum care services for up to six months; and
- Outlier payments for infrequent events and unusual circumstances that result in the need for more services or more expensive services.

The bundled payments for prenatal care, labor & delivery, and post-partum care would be stratified into three risk-based categories so that higher payments are made for women who have characteristics that typically require additional or more expensive services. The woman's risk classification could change at any time, and subsequent payments would reflect the new risk category. There would be no cost-sharing for the prenatal and post-partum care services.

The Maternity Care Team would receive no payment during a month or phase of care if the Team failed to provide all evidence-based care to the woman or if a never event occurred (i.e., death of the mother, unexpected death of the infant, or iatrogenic injury to the infant). Payments to the Team would be reduced if desirable outcomes (e.g., physiologic childbirth, successful breastfeeding) were not achieved during a particular phase of care.

The APM would reduce spending and improve outcomes by enabling more women to deliver babies in birth centers rather than hospitals, reducing the frequency of Cesarean sections in low-risk births, supporting more extensive prenatal and postpartum care services for higher-risk women, and tying payments directly to outcomes.

DETAILS OF THE APM

1. Opportunities for Savings and Quality Improvement

Maternity care is one of the largest components of spending for commercial health plans and for Medicaid programs. There are a number of important opportunities for reducing unnecessary and avoidable spending on maternity care in ways that would generate savings while also improving outcomes for mothers and babies:

- Approximately one-third of babies in the United States are delivered by Cesarean section, one of the highest rates among developed countries. Payments to hospitals for C-section deliveries are significantly higher than for vaginal deliveries, so reducing the rate of C-sections would reduce spending on the delivery itself as well as reducing spending on treating complications.
- Most vaginal deliveries in the United States take place in hospitals, even though the majority could safely take place in a birth center. Payments for vaginal deliveries in hospitals are significantly higher than for deliveries in a birth center, so increasing the proportion of births in birth centers would reduce spending and could also improve outcomes for many mothers and babies.
- The United States has a high rate of both infant mortality and maternal mortality relative to other countries.

2. Changes in Care Delivery Needed and Associated Costs

a. New and Different Services to Be Delivered

In most large communities, birth centers exist but they are currently being underutilized. Many smaller communities, however, do not have birth centers, and a birth center would need to be created if one does not exist and if there are a sufficient number of births to sustain one.

In a growing number of small rural communities, the local hospital does not provide planned labor & delivery services, and this increases the risk of poor outcomes, particularly for higher-risk pregnancies. In these communities, the hospital would need to add the capacity for labor & delivery services. In communities where there is no hospital at all, it will be impossible to offer hospital-based labor & delivery services in the community, and a birth center could improve outcomes and reduce the cost of deliveries in low-risk pregnancies.

In most communities, achieving better pregnancy outcomes will require approaches to delivering prenatal care and post-partum care that go beyond traditional office visits with an obstetrician or family physician, particularly for women in higher-risk categories. This would likely include proactive monitoring, education, and support to women during pregnancy and post-partum care through phone contacts and home visits. These types of services can be both effective and affordable when they are provided by healthcare professionals other than physicians, such as nurses, midwives, doulas, and community health workers.

b. Cost of Delivering New and Different Services

Although it is desirable to minimize the total number of deliveries performed in the hospital and the number of C-sections that are performed, there will always be a need for some deliveries to be performed in the hospital and for some of those deliveries to be done by C-section in order to ensure the best outcomes for the mother and baby, and it will be impossible to predict the number and timing of those deliveries. Consequently, a community will need to have at least one hospital that offers labor and delivery services and that hospital will need to incur a minimum level of fixed costs to offer 24/7 access to labor and delivery services, regardless of the actual number of deliveries that occur in the hospital. That means the average cost for hospital-based deliveries will be higher if a smaller proportion of total deliveries in the community are done in the hospital. There is a particularly significant cost for a hospital to maintain the capacity to perform surgeries such as C-sections and so the cost of each C-section will be higher if fewer C-sections and other surgeries are performed at the hospital.

Birth centers and physician/clinician practices will also need to have appropriate staffing, equipment, and facilities in order to provide maternity care services. The major driver of the costs will be personnel costs, and more personnel will be needed if there are more pregnant women in the community. A minimum level of staffing will have to be maintained in order for these services to be available when needed to address maternity care needs in the community, and that will make the average cost of these services higher in smaller communities.

There will also be startup costs involved when new services first begin. For example, if there is no birth center in the community, creating a new one will require incurring costs for construction or renovation of facilities, for recruitment and training of new staff, etc. before any services can be delivered, and there may be lower volumes of births in the birth center initially until both women and maternity care providers in the community become comfortable utilizing the birth center.

c. The Business Case for an Alternative Payment Model

An APM would be feasible if an analysis shows that the expected savings from reduced rates of Cesarean sections, hospital-based deliveries, and complications of pregnancy and childbirth would likely be larger than any increased costs associated with delivering higher-quality care during pregnancy, childbirth, and during the post-partum period. The actual costs and savings will vary from community to community depending on the number of women of childbearing age in the community and the ease of attracting and retaining high-quality maternity care providers in the community.

Table 1 shows data for a hypothetical community with 1,000 births per year. Currently, one-third of the deliveries are by Cesarean section, and only 10% of babies are delivered in a birth center. The average payment for vaginal deliveries in the hospital is \$10,500, the average payment for a C-Section is \$12,000, the average payment for delivery in a birth center is \$4,000, and payments for prenatal and post-partum care average \$3,500. Approximately 2/3 of the costs of labor and delivery in the hospital are assumed to be fixed, and approximately 1/2 of the costs of labor and delivery in the birth center are assumed to be fixed.

As Table 1 shows, if the rate of C-Sections decreased to 20% and the rate of deliveries in the birth center increased to 30%, the average cost of a birth in the hospital would increase because there would be fewer deliveries there, and the average cost of a birth in the birth center would decrease because of the greater number of deliveries there. (The birth center is presumed to have adequate capacity to handle the increase in births). The reduction in the number of C-Sections and the greater number of births in the lower-cost setting of the birth center would generate enough savings to preserve the operating margins of the hospital, improve the operating margin of the birth center, and still generate a net reduction in overall spending. Consequently, there would be a business case for both payers and providers to implement an Alternative Payment Model designed to support the change.

**TABLE 1
BUSINESS CASE FOR CHANGES IN MATERNITY CARE**

	Current Services, Cost, Spending			Services/Costs Under APM			
	# of Mothers	\$ Per Patient	Total	# of Mothers	\$ Per Patient	Total	Change
Services/Revenues							
Hospital Delivery							
C-Section	330	\$12,000	\$3,960,000	200	\$12,930	\$2,586,000	
Vaginal Delivery	570	\$10,500	\$5,985,000	500	\$12,930	\$6,465,000	
Birth Center							
Vaginal Delivery	100	\$4,000	\$400,000	300	\$2,700	\$810,000	
Prenatal Care	1,000	\$3,200	\$3,200,000	1,000	\$3,200	\$3,200,000	
Post-Partum Care	1,000	\$300	\$300,000	1,000	\$300	\$300,000	
Total Births/Payments	1,000	\$13,845	\$13,845,000	1000	\$13,361	\$13,361,000	-3%
Costs							
Hospital Services							
Fixed Cost			\$6,000,000			\$6,000,000	
Variable - C-Section	330	\$5,000	\$1,650,000	200	\$5,000	\$1,000,000	
Variable - Vaginal	570	\$3,500	\$1,995,000	500	\$3,500	\$1,750,000	
Margin			\$300,000			\$301,000	
Birth Center							
Fixed Cost			\$180,000			\$180,000	
Variable Cost	100	\$2,000	\$200,000	300	\$2,000	\$600,000	
Margin			\$20,000			\$30,000	
Prenatal/Post-Partum							
Cost	1000	\$3,500	\$3,500,000	1000	\$3,500	\$3,500,000	
Margin			\$0			\$0	

3. Barriers in the Current Payment System

There are a number of important barriers in current payment systems that discourage delivery of desirable maternity care services and that increase the frequency of undesirable services and poor outcomes:

- Hospitals are generally paid significantly more when Cesarean sections are performed than for vaginal delivery births, so reducing the percentage of births by C-section results in a significant reduction in hospital revenue.
- Hospitals are only paid for their labor & delivery services when a baby is actually delivered in the hospital, and the payment is the same regardless of how many births occur in the hospital, so increasing the percentage of births in birth centers could leave the hospital with insufficient revenue to cover the fixed costs of its standby capacity for hospital deliveries.
- Many health plans do not pay for births in birth centers or do not pay enough to cover their costs.
- Obstetricians are generally paid as much or more for C-sections as for vaginal deliveries, even though a normal vaginal delivery will often take significantly more time and is more likely to occur outside of normal working hours, so reducing the percentage of births by C-section will increase costs and reduce revenues to the obstetrical practice, making it more difficult to cover its costs.
- Midwives are generally paid less than obstetricians to deliver babies, so increasing the use of deliveries by midwives would reduce spending on births but could make it difficult for an obstetrician to sustain an obstetrical practice, particularly in a small community.
- Midwives need adequate payment and enough births to financially sustain a practice in the community.
- Obstetricians are generally paid a fixed “global fee” to cover all prenatal care and post-partum care services as well as delivery of the baby, so an OB practice will have more difficulty covering its costs if it encourages early and frequent prenatal care visits and if it provides additional services to high-risk women.

4. Design of the APM

The Alternative Payment Model described below could remove the barriers in the current payment system and enable and encourage maternity care providers to pursue the opportunities for improvement described above. (This is not the only way in which an APM could be designed to achieve these goals, and other approaches may be preferable for women with specific needs, or for women living in communities that are very small or have challenges in attracting and retaining maternity care providers.)

a. Defining the Eligible Patients and Physician Practices

i. Eligibility Criteria for Patients

Any pregnant woman would be eligible to receive services supported by the APM from a Maternity Care Team participating in the APM.

ii. Eligibility Criteria for Maternity Care Teams

A Maternity Care Team would be eligible to participate in the APM if it includes:

- At least one clinician (a physician, nurse practitioner, midwife, etc.) who is qualified and licensed to provide prenatal care to pregnant women;
- At least one clinician who is qualified and licensed to assist in vaginal delivery of babies;
- At least one physician who is qualified to treat women with high-risk pregnancies, to treat complications experienced during pregnancy or childbirth, and to perform Cesarean sections;
- At least one clinician who is qualified and licensed to provide care to newborn babies;
- At least one hospital that has the capability to perform Cesarean sections and treat common complications of labor and delivery; and
- At least one physician practice, hospital, clinical laboratory, or other entity that has the ability to perform any laboratory tests or imaging studies needed as part of prenatal care, labor & delivery, and post-partum care.

Ideally, the Maternity Care Team will also include at least one birth center that is licensed to provide labor and delivery services if the volume of births in the community is sufficient to support both a birth center and a hospital that offers labor and delivery services (since both will be needed to adequately serve all pregnant women).

iii. Designation of the Patient's Maternity Care Team

If a pregnant woman wanted to receive the enhanced services and accountability for cost and outcomes under the APM, the woman would designate a Maternity Care Team that is participating in the APM to provide her with high-quality prenatal care, safely deliver her baby, provide the initial care for the baby immediately following birth, and provide the woman with high-quality post-partum care. A woman could select or change her Maternity Care Team any time prior to the beginning of labor or during the post-partum period.

Before a woman decides to designate a particular Maternity Care Team to provide her maternity care, the Team would describe the services it would commit to deliver and the approach it would use for decision-making about services in various circumstances that might arise prior to, during, and after birth. The team could also ask the woman to commit to taking actions during pregnancy and following birth that would support good outcomes (e.g., attending prenatal care exams, abstaining from smoking, drinking, and drugs during the pregnancy, contacting the Team when a problem arises, etc.). The Team could also ask the woman to only obtain maternity care services from the members of the Team unless the Team specifically recommends that the woman receive services from other providers.

In order to receive payments under the APM for a woman, the Maternity Care Team would need to verify and document that the woman was pregnant and that she had designated the Team to provide her with complete maternity care.

b. Removing the Barriers in the Current Payment System

There would be five components to the payments to the Maternity Care Team for care of the pregnant mother, covering three phases of maternity care delivery:

- Monthly payments for pregnancy-related services needed prior to childbirth;
- Standby capacity payments for the minimum capacity needed in hospitals to support labor and delivery;
- Bundled/warranted payments for labor and delivery;
- Monthly payments for post-partum care services; and
- Outlier payments for infrequent events and unusual circumstances.

Each of these payments would be stratified based on factors affecting the risk of complications and conditions that typically require additional or expensive services.

Health care services for the infant beyond the immediate post-delivery care would be paid for separately because the types of care needed would not be clearly known until after birth, and different sets of providers (e.g., pediatricians) would likely be involved in the delivery of the care to the child. A separate Alternative Payment Model could be developed to address the specific opportunities and barriers to improvement for infant care.

i. Stratification of Patients Based on Need/Risk

Each participating woman would be classified by her Maternity Care Team into one of three categories: (1) Low Need/Risk, (2) Moderate Need/Risk, and (3) High Need/Risk. The criteria for this classification would be based on objective, measurable characteristics of the woman and her baby that evidence or analysis show have a significant impact on the risk of complications during birth or the types of services needed in order to ensure a good outcome. The Team would document the characteristics used to make the classification for each woman receiving maternity care from the Team.

A woman's classification could change if new risk factors or needs developed while she was receiving prenatal care, during labor and delivery, or during the postpartum care period. Payment amounts in each category would be based on the most recent classification assigned prior to the initiation of the services covered. For example, if the mother's risk level increased after the first prenatal care visit but before labor began, the Labor & Delivery Bundled Payment would be based on the higher risk category.

ii. Monthly Payments for Pregnancy Care Services

The Maternity Care Team would receive a pre-defined standard Monthly Pregnancy Care Payment each month to support delivery of all of the pregnancy-related care services a pregnant woman needed during the month. This would include prenatal care visits, laboratory tests and imaging studies, and any medical procedures. A higher amount would be paid to the Team to deliver pregnancy-related care services to women who are in the higher need/risk categories.

The Maternity Care Team would be responsible for dividing the revenues from these payments among the members of the Team to pay for the staff, equipment, travel, etc. used to deliver the prenatal care services and to pay for any services delivered by providers who are not members of the Team that deliver pregnancy-related services needed by a woman who is receiving care from the Team. The Team would have flexibility regarding the exact services it delivered, the type of personnel it used, etc., but it would be expected to follow evidence-based standards of care whenever they were applicable in order to receive payment.

The payment amounts in each category would be based on the estimated per-patient cost of pregnancy-related care services for patients in that category, with adjustments for performance as described below. (These payments would be stratified, bundled, condition-based payments, i.e., the payments would differ based on the patient's characteristics, rather than on the services provided, and the Team receiving the payment would have the flexibility to deliver multiple services and combinations of services.)

Payment amounts would be periodically adjusted based on analyses of the actual costs incurred by Maternity Care Teams that successfully achieve the performance targets.

iii. Standby Capacity Payment for Hospital Delivery Services

The hospitals that are part of the Maternity Care Team would receive a standard, pre-defined Standby Capacity Payment for each pregnant woman who receives labor and delivery services from the Team, regardless of whether the woman delivered her baby in the hospital or not. A higher amount would be paid for women in higher need/risk categories. The revenues from these payments would be designed to support the cost of the minimum on-site and on-call staffing and equipment the hospital(s) must maintain in order to be ready to deliver a baby who needs hospital-level services for a successful delivery.

The hospitals would determine their monthly standby capacity cost for maternity care, i.e., the cost each hospital would need to incur each month to staff and equip its labor and delivery services if only one baby were delivered during the month. If a hospital uses some of the same staff and equipment for other types of patients (e.g., emergency surgery cases), then a portion of those shared costs would be assigned to the estimated cost of labor and delivery services based on the proportion of pregnant women who would be using the shared services. The monthly maternity care standby capacity cost would be divided by the total number of women delivering babies in the community served by the hospital, regardless of where the delivery actually occurred (i.e., women delivering in birth centers or at home would also be counted), to determine the per-patient standby capacity payment the hospital would receive for each woman receiving care from the Maternity Care Team.

iv. Bundled/Warranted Payment for Labor and Delivery

The Maternity Care Team would receive a single, standard, pre-defined Labor & Delivery Bundled Payment to support all of the services from any member of the Team or any other providers that the woman needed to deliver her baby and that the woman and infant needed immediately following birth. The Team would be responsible for dividing the revenues from the Labor & Delivery Bundled Payments among the individual members of the Team for the services they deliver, including facility services (at the hospital or birth center where the delivery occurred) and all professional services. The Maternity Care Team would not charge for or receive any additional payments for any services delivered to the woman or baby to treat complications of childbirth, unless the circumstances qualified for an Outlier Payment. A higher Labor & Delivery Bundled Payment amount would be paid to the Team for a woman classified in one of the higher risk categories.

The amount of the Labor & Delivery Bundled Payment for women in a particular need/risk category would be based on the expected average cost of labor and delivery services for all pregnant women in that category, except for the services or costs that would be covered by Outlier Payments and Standby Capacity Payments. The expected cost would be determined by taking the estimated cost per birth of each of the three potential modes of delivery – vaginal delivery in a birth center,

vaginal delivery in a hospital, and Cesarean section in a hospital – and weighting them by the percentage of births that could be expected to be safely delivered in a birth center in each risk category and the percentages of births that would be expected to require delivery in a hospital or a C-section. The cost per birth used for births in a birth center would be based on the estimated total cost of labor & delivery services in a birth center divided by the expected number of births in the community that could safely be delivered in a birth center. The cost per birth used for the hospital-based deliveries would be based on the hospitals' *marginal* cost of an *additional* delivery in the hospitals beyond the first birth, since the Standby Capacity Payments would already be covering a portion of the fixed costs of the hospital delivery services.

v. Monthly Payment for Post-Partum Care

The Maternity Care Team would receive a single, standard, pre-defined Monthly Post-Partum Care Payment for each month of post-partum care the woman needs, for up to six months. Higher payment amounts would be paid for women in higher need/risk categories, and higher payment amounts would be paid in the first two months than in the third through sixth months.

The Maternity Care Team would be responsible for dividing the revenues from these payments among the members of the Team to pay for the staff, equipment, travel, etc. used to deliver the post-partum care services and to pay for any services delivered by providers who are not members of the Team that deliver post-partum services needed by a woman who is receiving care from the Team. The Team would have flexibility regarding the exact services it delivered, the type of personnel it used, etc., but it would be expected to follow evidence-based standards of care whenever they were applicable in order to receive payment.

The monthly payment amounts in each risk category would be based on the estimated per-patient cost of post-partum care services for women in that category, with adjustments for performance as described below.

vi. Outlier Payments for Infrequent Events and Unusual Circumstances

The Maternity Care Team could receive one or more Outlier Payments, in addition to all other payments, for a woman who:

- experienced an unavoidable event that occurs infrequently but typically requires a significant number of additional services or additional time or costs; or
- had unusual characteristics that required additional services or additional time or costs in the delivery of typical services.

For events that occur infrequently but require predictable responses, the Team would receive a standard, pre-defined Outlier Payment. For example, Outlier Payments would be pre-defined for:

- Extended labor
- Conditions that occur during pregnancy that require a hospital admission to prevent premature labor

For unusual events, there would not be a standard pre-defined payment; instead, the amount of the Outlier Payment would be based on the actual additional costs that the Maternity Care Team incurred in delivering care to the woman during a particular phase of care (i.e., prenatal, delivery, or postnatal care). The Team would calculate the actual costs it incurred for the woman's care, and subtract the payments it had otherwise received; the Outlier Payment would then be set equal to 90% of that amount.

vii. Patient Cost-Sharing

In order to encourage women to obtain prenatal and post-partum care, there would be no copayment or other cost-sharing for the Monthly Pregnancy Care Payments, for the monthly Post-Partum Care Payments, or for Outlier Payments. Alternatively, a copayment could be charged but waived if the woman had adhered to all of the recommended actions in the plan of care developed by the Maternity Care Team.

The woman would be expected to pay a pre-defined copayment for the Labor & Delivery Bundled Payment. The copayment for the Labor & Delivery Bundled Payment would not differ based on the woman's risk category. However, higher copayments would be charged in the following circumstances:

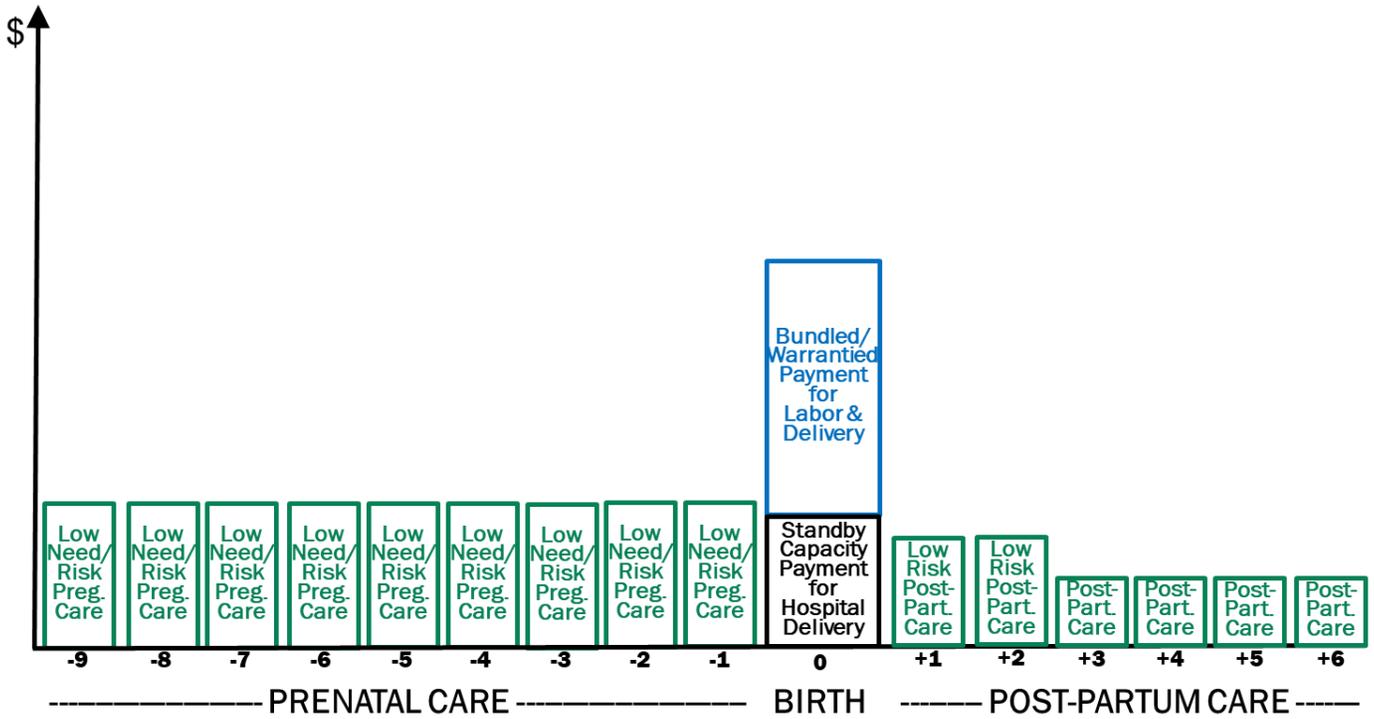
- The woman did not adhere to the prenatal care plan developed by the Maternity Care Team;
- The woman was classified in the Low or Moderate Risk categories and the Maternity Care Team felt that delivery in a birth center would be safe for the mother and baby, but the woman was only willing to give birth in a hospital;
- The woman wanted to plan a Cesarean section even though the Maternity Care Team felt that pursuing a vaginal delivery was safe or safer for the mother and baby; and/or
- The woman obtained pre-natal or post-partum care services from a provider other than the Maternity Care Team without approval from the Team.

viii. Non-Standard Charges for Maternity Care

A Maternity Care Team would be permitted to charge more than the standard payment amounts for one or more of the payment components if the Team wanted to commit to more or better outcomes than required for the standard payments. If a woman chose to use a Team that charged more, she would pay the difference between the team's charge and the standard payment amount.

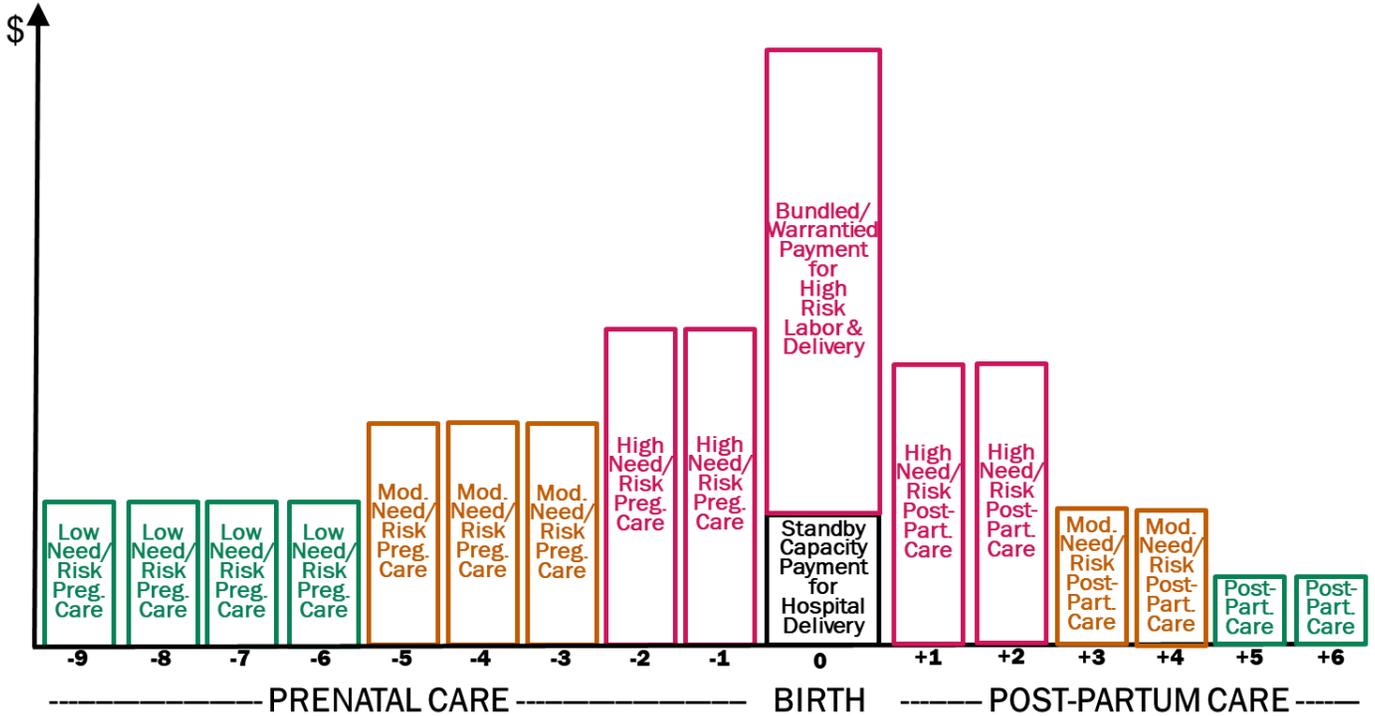
A Maternity Care Team could also charge less than the standard amount for the Labor & Delivery Bundled Payment, in which case the copayment amount would be proportionally reduced.

PAYMENT UNDER THE MATERNITY CARE APM FOR A LOW-RISK PREGNANT WOMAN



Note: Relative heights of bars are not intended to represent actual relative amounts of payment

PAYMENT UNDER THE MATERNITY CARE APM FOR A PREGNANT WOMAN WHO BECOMES HIGHER-RISK



Note: Relative heights of bars are not intended to represent actual relative amounts of payment

c. Creating Accountability for Utilization and Spending

In return for receiving the payments specified in the previous section, the Maternity Care Team would be responsible for delivering (or paying other providers to deliver) all maternity care services the woman needed during the phase of care for which the Team was receiving payment under the APM. No other payments would be made to the Team for maternity-care related services delivered to the woman. If a provider other than a member of the Team delivered a maternity care-related service to a woman who had designated the Team for her care and that other provider billed the woman's health insurance plan for the service, the plan would pay for that service and deduct the amount it paid from the payments due to the Maternity Care Team for the phase of care in which that service was delivered.

d. Creating Accountability for Quality

i. Measures of Quality/Outcomes

There are many dimensions to the quality of maternity care. Good measures are not currently available for all aspects of maternity care quality, the relative importance of measures differs for different women, and the knowledge of how to reliably achieve them also varies. To address this, three groups of quality measures would be used:

- **Never Events.** These are serious events that would be always viewed as unacceptable. The patient-level measure would be whether the never event occurred, and the population-level measure would be the proportion of patients experiencing the never event. The never events would include:
 - ◆ Death of the mother
 - ◆ Death of the infant
 - ◆ Iatrogenic injury to the infant
- **Desirable Outcomes.** These are outcomes that are desirable to achieve and that are believed to be feasible to achieve for the individual patient. The patient-level measure would be whether the desirable outcome occurred, and the population-level measure would be the proportion of patients achieving the outcome, excluding those patients for whom the outcome was impossible or contraindicated. These would include:
 - ◆ Physiologic ("natural") childbirth
 - ◆ Successful breastfeeding
 - ◆ Lack of postpartum depression
- **Evidence-Based Care.** These would be services for which there is evidence that delivery of the service increases the likelihood of desirable outcomes by a large amount. The patient-level measure would be whether the patient received care that followed evidence-based care guidelines. If the guidelines indicated that a service was not necessary or appropriate for all patients, the measure would only apply to patients with the characteristics for whom the service was appropriate.

ii. Target for Quality Measures

- Never Events: The Target would be a rate of 0%.
- Evidence-Based Care: The Target would be 100%.
- Desirable Outcomes: The Target would be 100%.

iii. Mechanism for Accountability

Never Events

If a never event occurred, the Maternity Care Team would not receive any payments at all and would refund any payments that had already been made prior to the occurrence of the never event.

Evidence-Based Care

If the services delivered by the Maternity Care Team during a particular month or phase of care failed to meet evidence-based guidelines, the Team would not receive payment for that month or phase. For example, if the Team failed to perform a prenatal test required by evidence-based guidelines, the Team would not receive the Monthly Pregnancy Care Payment for the month in which the test should have been performed.

Desirable Outcomes

The payment for a particular month or phase of care would be reduced if one or more of the specified desirable outcomes for that month or phase of care was not achieved. The amount of the reduction associated with each outcome would be specified in advance, and the amounts would differ for different outcomes. If there are multiple desirable outcomes to be achieved in a particular month or phase, there would be a cap on the total amount by which the payment could be reduced if none of the outcomes were achieved.

e. Ensuring the APM Design Supports the Business Case

Table 2 shows examples of payment amounts that would support the business case. The payment for labor and delivery would be based on the need/risk characteristics of the mother and baby, not where the delivery occurred or the method of delivery used. The hospital would receive a standby capacity payment for each delivery, including for deliveries in the birth center, in order to help support its fixed costs. The total payment for delivery for a low-risk mother (\$3,500 + the \$1,200 standby capacity payment) would be similar to what a woman would have paid for a birth center delivery previously, but without the risk of a much larger payment if the woman had to be transferred to the hospital during the delivery. The total payment for a medium-risk mother (\$9,000 + \$1,200) would be similar to what is currently being paid for a vaginal delivery in the hospital. The total payment for delivery of a baby by a high-risk woman would be much higher than it is today, more accurately reflecting the higher cost. Total spending (based on the expected number of births and distribution of risk categories in the community) would be lower than it is currently.

**TABLE 2
HOW THE APM WILL ACHIEVE THE BUSINESS CASE FOR IMPROVED MATERNITY CARE**

	SERVICES/SPENDING UNDER CURRENT FFS			SERVICES/SPENDING UNDER ALTERNATIVE PAYMENT MODEL					
	#	\$ Per Patient	Total	#	\$ Per Month	# Mo.	\$ Per Patient	Total	
Services/Revenues									
Hospital Delivery				Delivery					
C-Section	330	\$12,000	\$3,960,000	High-Need	200		\$15,500	\$3,100,000	
Vaginal Delivery	570	\$10,500	\$5,985,000	Med. Need	500		\$9,000	\$4,500,000	
Birth Center				Low Need	300		\$3,500	\$1,050,000	
Vaginal Delivery	100	\$4,000	\$400,000	Standby	1,000		\$1,200	\$1,200,000	
Prenatal Care	1,000	\$3,200	\$3,200,000	Prenatal Care					
				High-Need	200	\$422.22	9	\$3,800	\$760,000
				Med. Need	500	\$355.56	9	\$3,200	\$1,600,000
				Low Need	300	\$311.11	9	\$2,800	\$840,000
Post-Partum Care	1,000	\$300	\$300,000	Post-Partum Care					
				High-Need	200	\$66.67	6	\$400	\$80,000
				Med. Need	500	\$50.00	6	\$300	\$150,000
				Low Need	300	\$41.67	6	\$250	\$75,000
Total Spending	1,000	\$13,845	\$13,845,000	Total Spending	1,000			\$13,355	\$13,355,000
Costs									
Hospital Services				Hospital Services					
Fixed Cost			\$6,000,000	Fixed Cost				\$6,000,000	
Variable Cost C-Section	330	\$5,000	\$1,650,000	Variable Cost C-Section	200		\$5,000	\$1,000,000	
Variable Cost Vaginal	570	\$3,500	\$1,995,000	Variable Cost Vaginal	500		\$3,500	\$1,750,000	
Birth Center				Birth Center					
Fixed Cost			\$180,000	Fixed Cost				\$180,000	
Variable Cost	100	\$2,000	\$200,000	Variable Cost	300		\$2,000	\$600,000	
Prenatal/Post-Partum				Prenatal/Post-Partum					
Cost	1,000	\$3,500	\$3,500,000	Cost	1,000		\$3,500	\$3,500,000	
TOTAL COST			\$13,525,000	TOTAL COST				\$13,030,000	
Margin			\$320,000	Margin				\$325,000	

5. Operationalizing the APM

In order for a Maternity Care Team to be paid for delivering maternity care services under the APM, the team would submit claims forms for each eligible woman using a series of new billing codes. Penalties for failure to achieve Desirable Outcomes would be operationalized as “withholds,” i.e., the default amount of payment for a service code would be determined by calculating the estimated cost of delivering services and subtracting the maximum penalty for failure to achieve the outcomes. Additional codes would be created to enable the Team to recoup the penalty when one or more Desirable Outcomes were actually achieved.

Monthly Pregnancy Care Payments

- MC011: one month of pregnancy care to a woman who meets the criteria for the Low Need/Risk category;
- MC012: one month of pregnancy care to a woman who meets the criteria for the Moderate Need/Risk category; and
- MC013: one month of pregnancy care to a woman who meets the criteria for the High Need/Risk category
- MC014: occurrence of an infrequent and unavoidable condition that requires additional time or services during pregnancy
- MC015: occurrence of an infrequent and unavoidable condition that requires inpatient care during pregnancy
- MC016: occurrence of unusual circumstances requiring additional services or costs
- MC101-MC108: achieving specified Desirable Outcomes during a month (each outcome would be assigned a separate code)
- MC109: maximum additional payment for achieving Desirable Outcomes. If the Maternity Care Team had achieved multiple Desirable Outcomes, it would submit individual codes (MC101-MC108) for each of those outcomes, and if the total additional payments for those codes exceeded the maximum additional payment per patient, the Team would also submit code MC109 and the payment would be made for that code instead of the others. (All of the codes would still be submitted so it was clear which outcomes had been achieved.)

Bundled/Warranted Payments for Labor and Delivery

- MC021: labor & delivery services to a woman who meets the criteria for the Low Need/Risk category;
- MC022: labor & delivery services to a woman who meets the criteria for the Moderate Need/Risk category; and
- MC023: labor & delivery services to a woman who meets the criteria for the High Need/Risk category
- MC024: extended labor

- MC025: occurrence of an infrequently-occurring condition that requires additional time or services during labor and delivery
- MC026: occurrence of unusual circumstances requiring additional services or costs during labor and delivery
- MC201-MC208: achievement of specified Desirable Outcomes during labor & delivery
- MC209: maximum additional payment for achieving Desirable Outcomes.

Monthly Post-Partum Care Payments

- MC031: one month of post-partum care during the first two months following delivery for a woman who meets the criteria for the Low Need/Risk category
- MC032: one month of post-partum care during the first two months following delivery for a woman who meets the criteria for the Moderate Need/Risk category
- MC033: one month of post-partum care during the first two months following delivery for a woman who meets the criteria for the High Need/Risk category
- MC034: one month of post-partum care during the third through sixth months following delivery for a woman who meets the criteria for the Low Need/Risk category
- MC035: one month of post-partum care during the third through sixth months following delivery for a woman who meets the criteria for the Moderate Need/Risk category
- MC036: one month of post-partum care during the third through sixth months following delivery for a woman who meets the criteria for the High Need/Risk category
- MC037: occurrence of an infrequent, unavoidable condition that requires additional time or services during the post-partum care period
- MC038: occurrence of an infrequent, unavoidable condition that requires extended inpatient care or a readmission following delivery
- MC039: occurrence of unusual circumstances requiring additional services or costs
- MC302-MC308: achievement of specified Desirable Outcomes during post-partum care
- MC309: maximum additional payment for achieving Desirable Outcomes during post-partum care

Submission of Claims

The date of service on the claim would be the last day of the month in which the pregnancy care or post-partum care services were delivered (for the Pregnancy and Post-Partum Care Payments), the day on which the baby was delivered (for the Labor & Delivery Payments), or the day on which the Desirable Outcome was achieved or documented (for the bonus payments based on achieving Desirable Outcomes).

Submission of a claim form with one of these billing codes would represent a certification by the Maternity Care Team that:

- The woman met the eligibility criteria for the APM and for the assigned Need/Risk category.
- The team had delivered services to the woman that met all required evidence-based standards for that phase and month of care.
- The mother and the baby had both survived without any iatrogenic injuries.

If the Maternity Care Team wished to charge women more than the amount that would be paid by their health plans, the Team would publish its charge for each of the billing codes, and the woman would agree to those charges at the time that she was enrolling to receive maternity care from the Team. A Team that charged a higher amount would charge the same amount to all women, regardless of their health insurance plan, and the Team would bill the woman for the difference between the charge and the amount paid by her health insurance plan.

On a quarterly basis, the Maternity Care Team would calculate its performance on all of the quality measures (Never Events, Evidence-Based Care, and Desirable Outcomes). These rates would be calculated separately for women in each of the three need/risk categories. The rates would be provided to the Team's patients and to the health insurance plans for those patients.

The Maternity Care Team would make information about its performance on the quality measures and its charges for services publicly available so that women who were seeking a Maternity Care Team could compare the cost and performance of different Teams.

Standby Capacity Payments

Because the hospitals participating in the APM would receive a Standby Capacity Payment for all women delivering babies as part of the APM regardless of whether the baby was actually delivered in the hospital, it would be difficult for the hospital to bill directly for all of these payments. Instead, since the payments would be made if and only if a Maternity Care Team received a Labor & Delivery Bundled Payment, the submission of a claim by a Maternity Care Team to a participating health insurance plan for one of those payments would also automatically trigger a Standby Capacity Payment from the health insurance plan to each participating hospital.

To distinguish the payment made to the Maternity Care Team from the Standby Capacity Payment made to a hospital, a modifier would be added to the codes listed earlier:

- -OP: Labor & Delivery Bundled Payment to the Maternity Care Team
- -IP: Standby Capacity Payment to a hospital

For example, if a Maternity Care Team submits a claim with a MC021 code for a birth in a birth center, the health plan would issue a payment to the Maternity Care Team with the amount assigned to the MC021-OP code and modifier, and the health insurance plan would also

issue a payment to each participating hospital with the amount assigned to the MC021-IP code and modifier.

6. Implementing the APM

a. Obtaining Participation by Payers, Providers and Patients

The Maternity Care APM would have a number of advantages that should encourage payers to implement the APM, encourage providers to participate in the APM, and encourage pregnant women to seek care from providers who are participating in the APM.

i. Advantages for Payers

- Participating health insurance plans could reduce spending on plan members who are pregnant or have recently delivered a baby without negative impacts on their members.
- Health insurance plans could implement the APM with minimal administrative costs by creating new billing codes in the payer's existing claims payment system.

ii. Advantages for Maternity Care Providers

- Maternity care providers would have the flexibility to deliver services to their patients in the ways that are most feasible for the providers and most effective for their patients, including delivery of appropriate services by obstetricians, midwives, nurses, doulas, and/or community health workers.
- Participating maternity care providers would receive higher payments to cover the additional time they would spend with women who begin prenatal care early in their pregnancies, who have higher risk pregnancies, and/or who need additional time to deliver their baby through natural childbirth. Obstetricians could focus their time more on high-risk pregnancies and still receive enough revenues to sustain their practices.
- Participating maternity care providers would be responsible for following evidence-based clinical guidelines and for avoiding never events, but they would not be penalized for delivering care that their patients needed nor would they be penalized for increases in the amounts that other providers charged for their services or for increases in the prices of drugs and medical devices.
- Participating physician and midwife practices would know when to expect payment and how much to expect based on the bills they submit to payers and the cost-sharing charged to patients. The largest financial loss a practice could experience would be the loss of the payments under the APM.
- Participating hospitals would no longer have all of their revenues tied to the number of babies delivered in the hospital and the method of delivery; the hospital could support efforts to reduce inappropriately high C-section rates and to encourage more births in birth centers without losing money by doing so.

- Participating maternity care providers could bill for services using their standard billing systems.

iii. Advantages for Pregnant Women

- Women would have the choice of whether to receive maternity care services supported by the APM based on a clear understanding of the services they would receive, the actions they would need to take, and the results they could expect to achieve.
- Women would have the choice about where to deliver their babies and the method of delivery that would be used.
- Women could change maternity care providers before and after delivery if they wished to do so.
- Women would know that their maternity care providers would be rewarded for achieving good outcomes but would have no financial incentive to withhold needed care.
- Women would know how much they would need to pay for maternity care services before choosing to receive them.

b. Finalizing the APM Parameters

A “beta test” of the APM will likely be needed with willing providers in order to finalize several key parameters of the APM:

- **Criteria defining the categories of need/risk.** The categories should be defined so that they distinguish which women will be at higher risk of complications and which women will need more time and care management services from maternity care providers in order for them to follow evidence-based care guidelines and to improve patient outcomes. However, data may not be available on all of the factors that would be expected to affect need and risk, and the APM will need to be implemented in order to enable those data to be collected.
- **Dollar amounts of the various payments.** The payment amounts in each phase of care and for each need/risk level should be based on the cost of the services that would be delivered to women in that phase and level, but the cost of the services will depend on the number of patients the providers can manage and the number of patients in each of the need/risk categories, and this can only be estimated after the services are actually implemented with support from the APM. For example, the cost of births in birth centers might be reduced below current levels if a larger number of women begin to use them.
- **Benchmark rates of desirable outcomes.** Data are not currently being collected for many types of desirable outcomes for maternity care because there is no means of paying for the costs of doing so. Consequently, performance targets and payment amounts for many types of desirable outcomes can only be determined after services under the APM begin.

Best estimates of these parameters would be used to initiate the beta test process, and the participants would gather and share data from their actual experience in implementing care changes with payments under the APM in order to make adjustments to the parameters.

