

# Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes

Pregnant women in the United States experience delivery via cesarean and early elective deliveries at higher rates than medically recommended for positive outcomes (ACOG 2019, WHO 2015). Delivery via cesarean or induction may be desirable for complicated births, but when not medically indicated, such procedures pose health risks for both the woman and child, and may increase the length of a hospital stay and admissions to neonatal intensive care units, thereby increasing the cost of care (NCSL 2018, Ashton 2010, Kamath et al. 2009).

The use of unnecessary interventions during delivery has significant implications for Medicaid, which is the nation's largest payer of maternity care, paying for nearly half of all births (NGA 2014). State Medicaid programs are implementing payment initiatives to reduce unnecessary or potentially harmful procedures, such as non-medically indicated cesarean sections and early elective deliveries, as well as to improve access to prenatal and postpartum care.

In this brief, we look at how state Medicaid programs are using payment incentives to improve maternal and birth outcomes. The brief first describes practices in maternity care that are known to influence maternal and birth outcomes. It then describes Medicaid payment models such as bundled payments, blended payments for delivery, pay for performance, and medical homes.<sup>1</sup> The federal government, the states, and other stakeholders are undertaking many other initiatives to improve maternal and neonatal outcomes that are not payment based, but these are beyond the scope of this brief.

## Background on Maternity Care

Cesarean sections, early deliveries, and elective inductions pose unwarranted risks for the woman and child when the procedure is not medically indicated. For instance, cesarean deliveries increase the risk of hemorrhage, infections, blood clots, and other complications leading to surgery, and early elective deliveries are associated with neonatal morbidity (Curtin et al. 2015, Clark et al. 2009, and Liu et al. 2007). Insufficient prenatal care can increase risk for preterm birth and neonatal mortality (Partridge et al. 2012). Postpartum care is important for monitoring, diagnosing, and treating complications and other conditions after birth (ACOG 2018).

**Cesarean deliveries.** An estimated 10 to 15 percent of pregnancies require birth by cesarean delivery; however, such deliveries in the United States account for nearly one in three births (31.9 percent). This is considerably higher than the rate in other comparable nations (Martin et al. 2018, Betran et al. 2016, Ye et al. 2014)). Financial and administrative incentives may contribute to these high rates of cesarean deliveries. For example, both commercial payers and Medicaid pay about 50 percent more for maternal and



neonatal care associated with cesarean deliveries compared to vaginal deliveries (Truven 2013). There are also administrative incentives for providers to perform cesarean deliveries since they allow for greater ease in scheduling, better management of staff time and resources, and are shorter in duration compared to the uncertainty of vaginal births (Main et al. 2011).

**Early elective deliveries.** Early elective deliveries occur prior to 39 weeks by induction or cesarean, without medical need. Educational campaigns and initiatives to prevent scheduling of early elective deliveries have helped to reduce their rates over the past decade, but these deliveries still occur; one study found that in 22 states, early elective deliveries accounted for nearly 9 percent of births paid by Medicaid from 2010 through 2012 (Fowler et al. 2014). Although some providers and patients may opt for such deliveries for scheduling convenience, they have long been advised against by the American College of Obstetricians and Gynecologists (ACOG 2019, Sakala and Corry 2008). Early elective deliveries increase risk of maternal and neonatal morbidity and also are associated with longer hospital stays for both mothers and newborns and higher hospital costs (Ashton 2010).<sup>2</sup>

**Prenatal and postpartum care.** Evidence-based prenatal and postpartum care, such as routine screenings for gestational diabetes, HIV, and postpartum depression, can reduce the risk of adverse outcomes for both the woman and child (Horowitz et al. 2013).<sup>3</sup> A majority of women with Medicaid coverage receive adequate prenatal care; however, they do so at significantly lower rates than women with private insurance, and at higher rates than those who are uninsured. From 2012 through 2014, nearly two in three women with Medicaid (64.2 percent) received adequate prenatal care, compared to 84.1 percent of women with private insurance and 35.7 percent of women who were uninsured for prenatal care and delivery (MACPAC 2018).<sup>4</sup> Prenatal care received early during pregnancy can address conditions affecting the mother and that may result in preterm births and low birthweight newborns, both of which can affect a child's physical and cognitive development (Martin and Osterman 2018, Womack et al. 2018).

## Medicaid Payment Initiatives

To reduce the rate of early elective deliveries and unnecessary cesarean sections, and improve access to prenatal and postpartum care, states are changing financial incentives for providers. Below we describe payment initiatives focused on improving maternal and birth outcomes, and how these efforts have affected spending and health outcomes.

### Bundled payments

A bundled payment is a single, fixed payment for a group of services provided to treat a condition during a defined episode of care.<sup>5</sup> The bundled payment aims to create incentives for providers to manage costs for each episode, since providers will not be paid more for providing additional or more costly services.

To implement bundled payments, states must decide which services to include in the bundle and whether to use bundles for all patients. For perinatal care, most bundled payment models only include low-risk pregnancies and exclude comorbidities or conditions related to pregnancy, largely because the services needed for low-risk patients are more predictable than those for complicated births. The provider or facility



delivering the baby is typically designated to coordinate prenatal and postnatal care and shares the financial risk or reward if the cost of care is above or below a designated threshold. To address concerns that providers may withhold necessary services, payments are often tied to provider performance on quality measures, such as cesarean section rates, HIV screening rates, and postpartum visit rates (Arkansas BCBS 2017, Ohio OHT 2017, Smith and Hanlon 2017). The quality measures selected are generally those linked to payment so they can be monitored through claims analysis.

Arkansas, Ohio, and Tennessee have implemented bundled payments for perinatal care in their Medicaid programs. In each state, the episode is initiated retrospectively by a live birth, and covers all care provided to the woman 40 weeks prior to birth, labor and delivery, and for 60 days postpartum (HCP LAN 2017, Arkansas BCBS 2017). Payment for care of the infant following birth is not included in these models. While Arkansas and Tennessee exclude high-risk pregnancies, Ohio's bundled payment approach covers complications, and payment rates are adjusted accordingly.<sup>6</sup> New York also implemented a maternity care bundle beginning in 2014. It includes prenatal care, delivery, and 60 days of postpartum care for women with low- and high-risk pregnancies, as well as 30 days of newborn care post-discharge (NYSDH 2018).

The early results of perinatal bundled payments in these states are mixed. In Arkansas, spending on perinatal episodes decreased 3.8 percent compared to surrounding states, but quality of care did not improve (Carroll et al. 2018, ACHI 2016). In Tennessee, spending on perinatal episodes was 7.7 percent lower per episode than what the state would have been paid if payments had not been bundled. HIV screening rates increased, but there was no significant improvement in cesarean section rates (TennCare 2017). In contrast, in Ohio, early reports from a subset of providers receiving bundled payments found that costs were higher than expected. There are limited data on the quality measures linked to payment (Ohio DOM 2018). In all three states, reports did not include the administrative costs of monitoring data and processing payments. No additional information is available on New York's bundled payment approach.

## Blended payment rates

A blended payment for delivery consists of a single payment for a birth, regardless of mode of delivery. Payment rates for cesarean delivery are generally higher than those for vaginal delivery. By eliminating this discrepancy, a blended payment may reduce the financial incentive to perform cesarean sections or adopt practices that lead to cesarean sections (such as limits on time in labor, management of fetal heart tracings, and others).

In 2009, Minnesota's Medicaid program implemented blended payments for uncomplicated deliveries in both fee for service (FFS) and managed care, aiming to reduce unnecessary cesarean births. The policy blended payments for facility fees and professional perinatal care services for uncomplicated vaginal and cesarean births. An evaluation found that cesarean FFS deliveries decreased by about 3 percentage points; the cost of childbirth hospitalizations within three years after implementation also declined. However, internal data analyses conducted separately at the state level did not find a change in cesarean use rates following adoption of the policy (Kozhimannil et al. 2018).<sup>7</sup> Due to concerns that the policy did not account for the complexity of surgical births, challenges in maternity care delivery in rural areas, and



other factors, Minnesota's blended payment policy for uncomplicated vaginal and cesarean deliveries was rescinded in 2015.

Tennessee has also implemented a blended payment for all vaginal and cesarean deliveries in Medicaid managed care. At the time of its adoption in 2011, the vaginal delivery payment rate was increased by 17 percent, and cesarean delivery payment rates were lowered to match that new vaginal delivery rate. This payment differential was gradually lowered; by 2014, the blended payment rate was closer to rates paid for vaginal delivery rates prior to 2011 (Tennessee DFA 2016).

## Reduced payment and nonpayment

Some states reduce payments or do not cover procedures such as early elective deliveries, elective inductions, and cesarean sections that are not medically indicated, or other practices that do not follow clinical guidelines. For example, Montana Medicaid reduces payments by 33 percent for elective inductions prior to 39 weeks and non-medically indicated cesarean sections at any gestational age (Mont. Admin. R. 37.86.2801(7)(b)(C)(iii)(c)(i)). In Oklahoma, non-medically indicated cesareans are paid at the same rate as a vaginal delivery, which is approximately \$1,600 less than a cesarean section (Smith 2017).

Some states have implemented so-called hard stop policies for labor and delivery services that are not medically indicated. Under such policies, states withhold payment altogether for practices that do not follow clinical guidelines. In 2011, Texas became the first state to adopt nonpayment for early elective deliveries prior to 39 weeks. After the policy was implemented, the rate of such deliveries decreased by roughly 10–14 percent. Birth outcomes also improved, and gestational age and birthweight both increased slightly (Dahlen et al. 2017). Other states that have since implemented nonpayment policies for early elective deliveries include Georgia, Indiana, Michigan, New Mexico, New York, and South Carolina. Some states, such as Iowa, adopted policies specifically targeting nonpayment for medically unnecessary cesarean deliveries, regardless of gestational age (Iowa DHS 2013).

## Pay for performance

Under pay-for-performance (P4P) models, providers are given financial incentives to meet certain established quality measures, such as those included in the Healthcare Effectiveness Data and Information Set. States pay a standard rate to providers that meet these measures. For maternal and neonatal care, such measures include performance measures such as rates of low-risk cesarean sections, early elective deliveries, breastfeeding during neonatal hospitalization, and newborn screening. (AFMC 2016). Washington State passed legislation in 2010 establishing an additional percentage increase in Medicaid payment rates for non-critical access hospitals that meet benchmarks under the Medicaid Quality Incentive Program (ASTHO 2014). The benchmarks related to safe deliveries include the reduction of early elective deliveries and three measures of severe maternal morbidity. From 2010 to 2017, the early elective delivery rate dropped from 15.5 percent to 1 percent (WSHA 2018). Multiple factors may have played a role in decreasing this rate, since educational and awareness campaigns were simultaneously implemented on the national and state level (CMS 2018, Main et al. 2018, HCP LAN 2016).

P4P models also include penalties for providers or plans that do not meet quality thresholds. For example, Louisiana withholds a share of monthly capitation payments from managed care organizations that do not meet targets; however, managed care organizations have the potential to earn back the amount that was withheld if they meet established quality measures, one of which includes injectable progesterone to prevent preterm births (Mehta 2018). Prior to the implementation of the quality initiative, only 5 percent of eligible Medicaid beneficiaries received the drug in Louisiana (ASTHO 2015). After being included as a quality measure, 16.6 percent of eligible patients received the drug in 2016, although this did not meet the established target of 20 percent (CMS 2017).

## Medical homes

Medical homes may improve the quality of care by providing access to and coordination of services to address a woman's physical and behavioral health needs beyond pregnancy. Providers that participate in the medical home model may receive bonus payments for providing key services such as prenatal risk screening and postpartum care, or for achieving positive maternal and birth outcomes.

North Carolina launched a pregnancy-centered medical home in 2011, with the goal of reducing preterm births, unnecessary cesarean sections, and costs. These medical homes provide care coordination and targeted perinatal, physical, and behavioral health services, particularly for high-risk women, and receive a per-member, per-month payment based on the number of Medicaid pregnancies. The North Carolina model includes financial incentives to encourage the quality of care, such as an additional \$50 for prenatal risk screenings, \$150 for a postpartum visit, and enhanced payment for vaginal deliveries (MACPAC 2013). Between the program's inception in 2011 and 2014, the incidence of low birthweight infants covered by Medicaid in the state decreased by 6.7 percent (Berrien et al. 2015).

Wisconsin's Obstetric Medical Home Program aims to reduce racial disparities in maternal and child health through comprehensive, coordinated care targeted to high-risk pregnant women. Enrollees are required to attend 10 prenatal visits and a postpartum visit within 60 days of delivery. As an incentive to providers, Medicaid pays a \$1,000 bonus per enrollee who meets the enrollment criteria including early and adequate prenatal care, and an additional \$1,000 bonus for medical home enrollees who have positive birth outcomes (Wisconsin ForwardHealth 2017).<sup>8</sup> State external quality review reports found that in 2017, 93.9 percent of enrollees had a first medical home visit and enrollment within the first 16 weeks of pregnancy, and that 86.2 percent of enrollees had 10 or more prenatal appointments (Wisconsin DSH 2017b). A separate evaluation of the program found no effects on birth outcomes, although participating clinics were associated with higher likelihood of providing behavioral health care (Friedsam et al 2016).



## Endnotes

<sup>1</sup> This brief updates Chapter 1 of MACPAC's June 2013 report to Congress, *Maternity Services: Examining Eligibility and Coverage in Medicaid and CHIP*.

<sup>2</sup> Cesarean deliveries can pose intrapartum and postpartum risks to women, as well as risks to their subsequent pregnancies (by increasing risk of uterine rupture). Newborns delivered by cesarean section are more likely to have serious lung problems and are more likely to be admitted to the neonatal intensive care unit compared to babies delivered vaginally.

<sup>3</sup> Routine services include, but are not limited to, such services as complete blood counts and urinalysis. Other routine screenings include, but are not limited to, screenings for group B streptococcus, syphilis, and chlamydia (ACOG 2017). Progesterone treatment is an example of administered medication that is shown to reduce preterm birth rates (Romero et al. 2014).

<sup>4</sup> Adequate prenatal care is defined by the Kessner index as initiation of prenatal care in the first trimester and nine or more visits (MACPAC 2018).

<sup>5</sup> Bundled payments are also referred to as episode-based payments.

<sup>6</sup> Arkansas's episode of perinatal care is intended for low-risk pregnancies; Tennessee's episode includes low- to medium risk pregnancies. Bundled payment rates for these pregnancies may nonetheless undergo risk-adjustment based on factors that influence the cost of care. For example, managed care organizations in Tennessee risk adjust the perinatal episode payments for obesity (Arkansas BCBS 2017, TennCare 2018).

<sup>7</sup> Internal data analyses on the blended payment rate in Minnesota may have differed from the findings of the evaluation on the policy for a number of factors. While the policy applied to both payment rates in fee-for-service (FFS) and managed care, the evaluation only examined the effect on FFS births and the internal data analyses examined births covered by both. Thus, the policy effects may have been dampened in the internal data analysis when including births funded by Medicaid managed care since it is possible that the policy had the greatest effect on FFS births. Additionally, if the outcomes were not compared to control states, then the results of Minnesota's blended payment rates policy may also have differed between the two analyses (Kozhimannil et al. 2018).

<sup>8</sup> To receive the additional \$1,000 payment per eligible, enrolled member, members must be enrolled in the first 16 weeks of the pregnancy and remain continuously enrolled throughout the pregnancy; they must have attended a minimum of 10 prenatal care appointments with the provider; they must remain continuously enrolled during her pregnancy; and they must have had a postpartum appointment within 60 days of delivery (Wisconsin ForwardHealth 2017).

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