American Association of Birth Centers

America's Birth Center Resource

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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 largest Medicaid budget expenditure.[2,3] For commercial payers, whose enrollees include the Medicare population, maternity care is also a considerable expenditure. Despite these expenditures, 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 hospital 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]

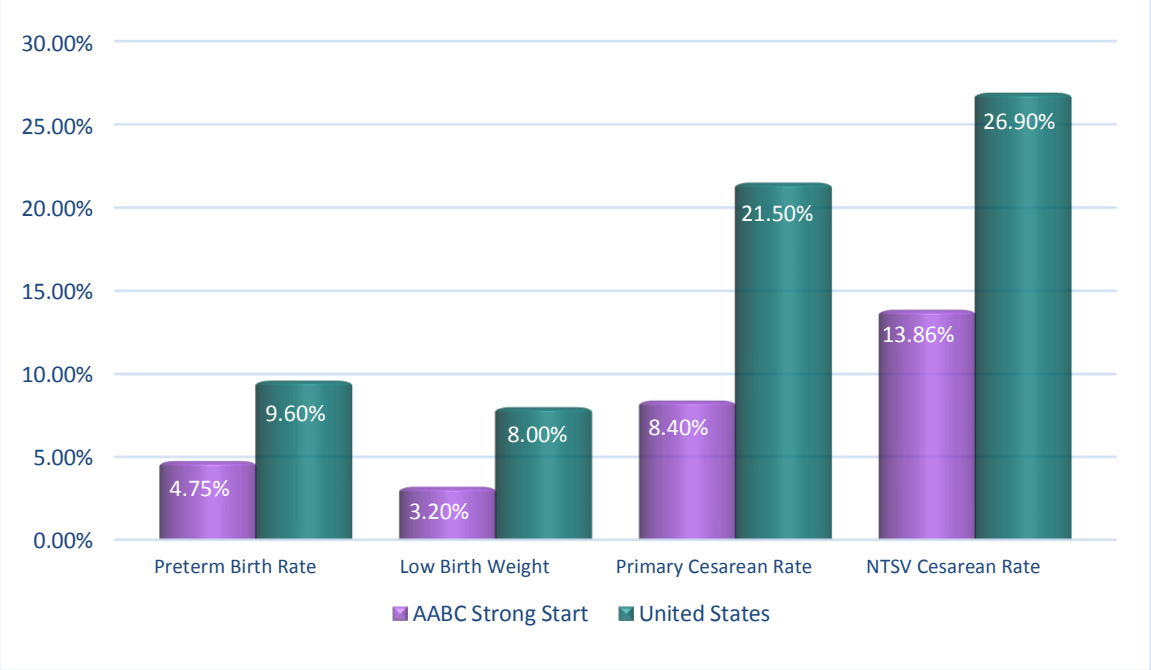
Birth center care leads to improved health outcomes, cost savings, and increased patient satisfaction when compared to hospital-based maternity care for women with similar risk status.[7,8,9,10,11] Key outcomes of birth center care include an average 6-9% cesarean birth rate (compared to national rate 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] Though the percentage of women who currently give birth in birth centers is low, it is increasing[17,18,19] and a quarter of women who gave birth in hospitals stated in a national survey that they would consider a birth center for their next delivery.[6]

Midwives are the care providers in the majority of birth centers. Relationship-building and time-intensive prenatal care reduces 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 Newborn 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 services 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.[16,20] Preliminary data show that AABC Strong Start participants enrolled in the study experienced a preterm birth rate of 4.75%, a low birth weight rate of 3.2%, and a primary cesarean rate of 8.4% for the first 4700 births.[16] National rates for these indicators are 9.6% for preterm birth, 8% for low birth weight, and 21.5% for primary cesareans 21.5%.[17]

Comparisons of Preterm Birth, Cesarean, and Low Birth Weight Rates [16,18,21,22]



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.[23] However, this number represents an increase of 75% in the past ten years.[24] According to the AABC, there are only 315 birth centers in the United States, limited in part by regulatory barriers and inadequate reimbursement or due to denials of coverage and contracting by Medicaid, Medicaid Managed Care Plans, TRICARE and other health plans, as well as a general lack of knowledge of the birth center model of care.

Alternative Payment Models in Freestanding Birth Centers

FSBCs have the demonstrated ability to reduce unnecessary medical interventions and the cost of maternity care for women who are medically low-risk, even if they have low socioeconomic risk status and a lack of social support. The birth center model of care meets the Triple Aim of quality healthcare, greater client satisfaction and cost savings.[25] The birth center care model should be integrated into APM planning to the fullest extent possible. AABC believes in a risk stratification of women eligible for low-risk care, with eligibility screening by the birth center or other low-risk midwifery provider at the beginning and throughout care. Birth centers operating under the AABC Standards utilize risk criteria that determine at the outset of care whether a woman is eligible for birth center care or not, and her risk status is tracked in AABC's Perinatal Data Registry (PDR) throughout the pregnancy. Because many birth centers are small, initial alternative payment arrangements need to focus on upside incentivized payments for the improved outcomes (and therefore lower costs) documented above, while greater volume birth centers would include upside and downside risk factors.

Episode of Care. The episode of care (EOC) for mom and baby commences upon confirmation of pregnancy at mom's initial visit to her provider or 270 days prior to her date of delivery when she is accepted as low-risk into midwifery care at the Birth Center and continues through her prenatal care, labor and delivery and including her 6-week postpartum care visit. The newborn's EOC continues through 28 days of life. The site of the delivery in the EOC could be either the birth center or hospital and the delivery supported by either a midwife or a physician. It should be noted that some women transfer care into or out of birth center care partway through pregnancy due to events of relocating, change in employment or insurance coverage, or if they learn about the option of FSBC later in pregnancy.

Women accepted as low-risk, and who continue their prenatal care under the midwifery model of care, in accordance with the standards adopted by American Association of Birth Centers, are deemed eligible for a birth center delivery so long as they are healthy, full term, with a single fetus in vertex position; these are estimated at 70-85% of pregnant women[26] In either event of a delivery at the birth center or hospital, the birth center is the accountable provider for the EOC.

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 an Ob/Gyn

or maternal-fetal medicine specialist, then the birth center part of the episode of care would end, unless the mother was approved to return to the care of the providers at the birth center. In the event of transfer of care at any time during the EOC to an Ob/Gyn or maternal-fetal medicine specialist for said high-risk complications which are considered exclusions from the EOC, in which delivery occurs at the hospital, then the provider who delivers the mother at the hospital will be the provider accountable for the EOC.

Clinical Episode of Care. The objectives of the clinical episode of care would be outcomes of increasing vaginal births, increased full term births, decreasing cesarean sections, decreasing pre-term babies, decreasing unnecessary medical interventions and complications resulting therefrom, providing support for women to choose their care providers and site of delivery, coordinating maternity care among providers in all settings, and creating a safe and comfortable environment for women to birth that is family-centric.

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] Services would include enhanced prenatal care, discussion of options for birth, nutrition, patient navigation, care coordination, childbirth and parenting preparation education, doula services, prenatal and postpartum lactation consultation, prenatal and postpartum depression and mental health screening, social support, smoking and drug abuse cessation education, and support to avoid preventable complications. Bilingual staff would be hired if there is a significant need in the population served. Women with risk factors or emerging risk status would receive consultation by a collaborating obstetrician or maternal-fetal medicine specialist. Ultrasound for dating of pregnancy and level II study may or may not be included in the services provided in the EOC depending on local factors. Lab testing for normal prenatal care may or may not be included, depending on factors such as ability to contract with labs to accept capitated or discounted payment as similarly reimbursed by health plans.

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. When primary care providers are the practitioners who confirm that a healthy woman is pregnant and that she meets low-risk criteria for birth center delivery, then she could be advised of enhanced prenatal care and an alternative childbirth experience at a birth center. There is a high level of satisfaction by women choosing a birth center model of care because it promotes shared decision-making, open access to medical records, and discussion of her birth plan.

Episode of Care Payment to Accountable Entity and Risk. FSBCs are typically small facilities and will vary in their tolerance of risk based on size and the population served, whether self-paying, commercially insured, Medicaid, or Medicaid Managed Care. Small birth centers might include fewer than 100 births per year or a majority of its patients are Medicaid beneficiaries, and therefore it would not be feasible to accept downside risk. These centers would benefit from incentivized payment for improved costs, better outcomes and confident, prepared, and satisfied parents (HCP-LAN Category 2c or 3a).[27] 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. Ideally, the base reimbursement for the EOC in each region would be sufficient to cover the costs of these enhanced services, the facility fee for the mother and newborn at the birth center, and care during the postpartum period. If the base reimbursement is not inclusive of the costs for these enhanced services, then there needs to be an incentive based on the improved outcome historical data so that results are rewarded continuously for providing and coordinating high quality services.

Small birth centers would receive an upfront incentivized payment at the commencement of pregnancy care for the enhanced prenatal services. The base reimbursement for birth center care would be paid at the end of the EOC and should be sufficient to support services provided and adequate numbers of midwives and support staff. Like other facilities, FSBC operating costs vary in different regions of the US depending on rents and overhead, liability insurance and cost of living for staff.

Large volume FSBCs will be able to accept upside and downside risk (Category 3 or 4) and would design its bundled payment to additionally include basic imaging, routine lab tests, consults with obstetricians or maternal-fetal medicine specialists, and professional services of the delivering provider, whether midwife or obstetrician at either the birth center or hospital. Included in the bundled payment

would be home visits and pediatric services for well-baby visits through Day 28. All facility fees for the birth center would be payable within the bundled payment, excluding any facility, technical or professional fees charged by the hospital.

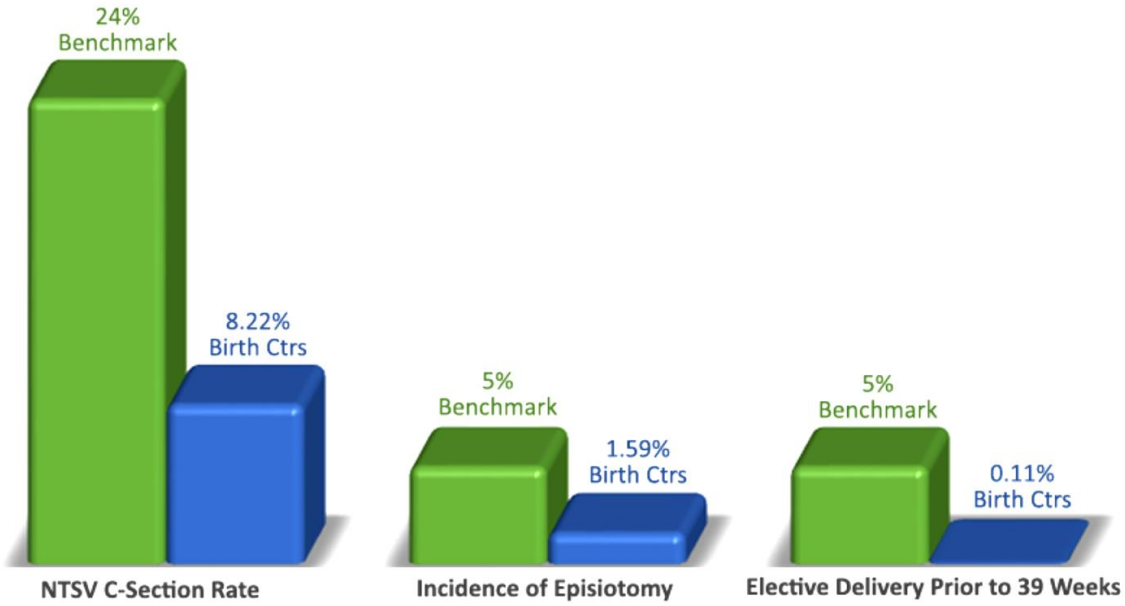
Bundled payment would flow to larger birth centers as the Accountable Entity for their acceptance of risk for an episode of care of low-risk women and newborns for the entire pregnancy, labor and delivery, and postpartum care, including the professional fee to the delivering provider whether at the birth center or hospital. The bundled payment would be set based on a negotiated price or formula to include costs of the EOC to achieve its goals and pay prospectively for its historical outcomes of decreased rates of cesarean sections, increased rates of full term babies, and other quality metrics.

There would be a set of high-risk complications and exclusions during which the EOC would cease or suspend unless the complication resolves and prenatal care resumes at the birth center. In some cases, care may resume during pregnancy, and in other cases, care would not resume until postpartum care, or not at all. However, exclusions would need to be carved out of the bundle or risk adjusted, such as hospital admissions, testing and ultrasounds performed in the care of an obstetrician or perinatologist for high-risk pregnancy, as well as admissions for increased length of stay and readmissions to the hospital for high-risk complications in pregnancy or birth. In regard to the newborn, exclusions would include admission to NICU and hospital admissions for complications arising in the postpartum 28 days.

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, readmissions, 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 below for an example of quality benchmark data from the Strong Start data set.[16]

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]

Birth Centers Exceed Quality Benchmarks [11,28, 29]



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. Base reimbursement for facility fees of birth center when EOC includes birth center delivery.
2) Bundled payment where FSBC is Principal Accountable Provider (PAP) (Accountable Entity/AE) managing EOC beginning at 270 days prior to delivery. Women are eligible for birth center care if they meet low-risk criteria at beginning of care and throughout care at birth center for entire pregnancy, labor and delivery, and postpartum care for 54 days for the mom and 28 days for the newborn. FSBC contracts with referral providers and the birth center is the PAP/AE even when women require transfer to hospital. Professional services of midwives and physicians are covered in EOC. Hospital charges are excluded from EOC.

3) 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 the 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 contract is 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 service fee. 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, and circumcisions). Reimbursement varies based on the contract; some contracts pay a reduced rate for a direct hospital admit and other contracts 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 an incentive 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. 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 Birth Centers 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 *AABC 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 seeks accreditation by the CABC, they are measured against the rigorous, national *AABC Standards for Birth Centers*. There are currently 104 CABC accredited birth centers.

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