



# Transforming Maternity Care

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## *A High Value Proposition*

**Priorities for Moving to a High Quality, High Value Maternity Care System from the  
Perspective of Health Plans, Private and Public Payors, and Liability Insurers**

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Health Plans, Private and Public Payors, and Liability Insurers Stakeholder Workgroup

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## **Introduction**

There are few working in health care today who would argue that the health care system functions well. The payors and purchasers represented in this stakeholder group, both public and private, have seen increasing costs and mediocre quality as a result of this poorly operating system. Maternity care, the leading cause of hospitalization in the United States, is costly and getting more so, and health plans and purchasers are not getting the value they expect for their dollars.

Liability insurers have seen rising malpractice judgments that drive up the cost of malpractice insurance and often do not reflect the actual quality of care delivered. They have also seen changes in the way physicians practice as they seek protection to prevent being sued.

Health plans and purchasers fund the majority of health care services and continue to see costs rise year over year. Far from expecting to see decreases in health care costs, at best, strategies are designed to slow the rate of rise. As purchasers focus increasingly on what they are getting for their money, they see results that are unacceptable and indefensible. Despite spending more on health care than any other nation, the United States has poorer health than most, including birth outcomes. The Milbank Report on “Evidence-Based Maternity Care: What It Is and What It Can Achieve” eloquently describes the gaps in maternity care and the many opportunities to improve processes likely to lead to better outcomes.

The evidence for what works and what doesn't in maternity care is significant. However, much more could be learned through a robust program of comparative effectiveness assessment to continue the work of identifying the most effective care options in complex treatment situations. It is equally important to do a better job assessing and meeting the needs and wants of individual patients. Childbirth Connection's national “Listening to Mothers” surveys suggest there is a disconnect for large segments of the childbearing population between their wishes and the care they receive. In addition, women of racial and ethnic minorities, lower socioeconomic status, or lower health literacy, have poorer birth outcomes. The system must evolve to address these issues and ensure high quality, cost effective outcomes for all.

Similar to many other medical specialties, there are few nationally endorsed, meaningful, easily obtained measures of the quality of maternity care. The stakeholders in this group have adopted divergent approaches to this problem – some use very few assessments of maternity care and wait for development of more nationally endorsed measures; others, especially in the Medicaid world where assessment needs are urgent, have developed their own measures. All are in agreement that we need a comprehensive set of nationally-endorsed performance measures to assess and improve maternity care and birth outcomes.

Payors and purchasers of care have a significant opportunity to influence and change care through payment policies and strategies. The spectrum of opportunities includes carrots (pay for reporting or pay for performance) and sticks (non-payment for non evidence-based services). Given the lack of performance measures, they have yet to take significant advantage of such tools for maternity care but are in favor of using payment policies to change behavior and improve outcomes. Within this stakeholder workgroup, there was a great deal of discussion, and no consensus, as to the best strategy for using payment reform to improve performance. While all agreed to the

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ultimate goal, the ideas on the specific path to get there differed. Especially between employers and commercial payors, and public sector payors, the influence on provider behavior and the ability to use payment policy to change provider behavior, varied greatly.

In developing these recommendations, the members of this stakeholder workgroup, representing their various constituencies, had animated and stimulating debate. All recognized the importance of this work and the urgency in improving maternity care quality assessment and outcomes. The group was also unanimous in the need to reform the liability system; balancing the need for societal transparency and continuous provider assessment with the need to give the provider a level of comfort, all while ensuring a mechanism for providing for the care of infants impaired from birth is a tall order and will require societal challenge.

The recommendations that follow are our attempt to answer the question of “Who needs to do what, to, for, and with whom to improve the quality of maternity care over the next five years?” What was very clear is that while Health Plans, Private and Public Purchasers, and Professional Liability Insurers can play a major role in improving the system, it must be done in partnership with all stakeholder groups and will take a concerted national effort to achieve our ultimate goal of improved birth outcomes.

## **Performance Measurement and Leveraging of Results**

### **Current Problems:**

- **We do not currently have a comprehensive set of nationally-endorsed reliable performance measures that can assess safety, timeliness, efficacy, effectiveness, quality and value across the full spectrum of maternity care.** Nationally-endorsed performance measures in OB/neonatology are limited. Of 62 identified measures, 38 are nationally endorsed and these do not cover the entire spectrum or all important aspects of maternity care. To be widely applicable, a measurement set should include measures of process, structure, outcome, access and patient experience. Filling gaps in the evidence about which processes lead to best outcomes must be a top priority.
- **The current coding system was designed for billing, not to measure performance; therefore it lacks specificity for administrative data collection.** This creates barriers to collecting information on how care practices are linked to outcomes and creates obstacles for payors trying to encourage optimal maternity care through performance measurement and value-based purchasing initiatives.
- **Purchasers and payors want to pay for value; to assess value they need an assessment of performance to determine optimal quality:cost ratios.** Comprehensive payment reform is needed. Payment reform may include paying more for services with better than expected outcomes or performance and little or nonpayment for poor outcomes or poor performance.

### **Recommendations**

**1. A comprehensive set of priority performance metrics for maternity care must be developed through collaboration of key stakeholder groups.** These should include measures of structure, process, and outcomes for preconception care, prenatal care, delivery, birth outcome and key neonatal milestones, as well as patient experience. To reduce collection burden and promote widespread uptake, a national standard approach to maternity care measure development should rely on the principle of parsimony to achieve the most concise set of measures possible, giving priority to those measures that are easily understood and most likely to have a broad impact. These comprehensive performance metrics should be used to measure maternity care provider performance consistently and universally.

a. Strategies:

Payors and purchasers should support and participate in the formation of a multi-stakeholder group to work together to develop important maternity care metrics. Metrics should address the performance of the entire care team, not just the physician. In addition:

- Measures should be evidence-based or evidence-informed. Top priority for measure development should be areas of maternity care where there is evidence of a gap in process or outcomes compared to best practice. Measures should focus primarily on what is important in improving birth and neonatal outcomes, and secondarily consider ease of measurement and data collection.

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- Metrics should include an assessment of consumer opinion on the experience of care through the entire pregnancy and birth. Metrics should also measure patient-centeredness of care.
  - To protect patients and to be fair to providers, outcome measurements must be risk-adjusted to account for differences in patient populations. Adjustment will require collection of variables such as race/ethnicity, socio-economic status, age, health literacy, insurance coverage, etc.
  - Metrics must address what is important, using data that can be gathered efficiently to minimize cost of data collection and the burden on the health care system. Ideally more robust clinical measures should be collected through widely disseminated Health Information Technology (HIT) system with fully integrated registries and performance measurement. Until HIT is widely available, measures must be administrative, based on claims data.
  - Health care processes and structures should be measured only when there is evidence linking the process or structure to outcomes or patient experience.
  - Metrics should be submitted to the NQF for endorsement as either best practices or consensus standards.
  - Start with measures already developed such as the NQF National Voluntary Consensus Standards for Perinatal Care and recommendations/metrics from maternity care delivery and professional organizations.
- b. Lead Responsibilities:
- The National Quality Forum (NQF) should be funded to call for this comprehensive set of performance metrics in maternity care. A single entity needs to take responsibility for convening the group and overseeing the development of the comprehensive measures.
- c. Challenges and Solutions:
- Developing these measures will require innovative thinking on how to gather data for important processes and outcomes without requiring expensive and burdensome clinical data collection. The establishment of data registries may be a possible solution although potentially costly and time consuming. Existing data sources of convenience will be insufficient to create some important measures. Updating billing codes is a possible interim solution that should receive attention.
- d. Mechanisms for Collaboration:
- There is currently no multi-stakeholder entity responsible for creation of metrics for maternity care; a group needs to be convened that includes all relevant representatives. Hospitals, health plans, purchasers including Medicaid, and consumers should be included. These metrics could/should be developed, at least in part, by the multi-stakeholder group developing the recommended scope of maternity services (see scope of services recommendations).

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- e. Timeline for achievement:
  - The NQF should call for comprehensive measure set in 2010 with measures released in 2011. The coalition of stakeholders developing the scope of services recommendations for maternity coverage (see scope of services section) should be charged with ensuring that the measure set is comprehensive and covers all important aspects of maternity care.

**2. In the short term, strategies to improve the availability and collection of administrative data to measure quality of care need to be advanced.**

- a. Strategies:
  - Payors and purchasers should join other stakeholders in urging the American Medical Association (AMA) to convene a group to review Current Procedure Terminology (CPT) codes for maternity care. As HIT is being more widely disseminated, relevant maternity measures should be incorporated into the automated systems for data and performance analysis. Minimally, modifications to the current coding scheme need to facilitate claims-based identification of individual prenatal visits, of induced labor, and of scheduled c-sections. Delivery claims should also note the gestational age of the newborn.
- b. Lead responsibility:
  - Representatives of health plans, providers, hospitals, and the Center for Medicare and Medicaid Services (CMS) must collaborate with the American Medical Association (AMA) to ensure that coding schemes best meet everyone's needs.
- c. Challenges and solutions:
  - Current billing systems are built around existing codes; if coding strategies are not carefully thought out, new codes will be ignored or misused. Currently used code sets may not lend themselves to coding gestational age. Problems can be resolved by having each constituency that will be affected by code changes represented in the discussion and by thoroughly testing proposed solutions in demonstration projects across different environments.
- d. Mechanism for collaborating:
  - The AMA should convene a multi-stakeholder group.
  - Study coding innovations in the Alternative Billing Concepts (ABC) coding system, produced and maintained by ABC Coding Solutions, for possible inclusion
- e. Timeline for achievement:
  - The group could be convened as early as 2009 with final recommendations and action in 2010.

**3. Data collected through enhanced performance measurement should be reported to all relevant stakeholders and leveraged through a variety of strategies**

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**to improve maternity care.** The relevant stakeholders include: 1) maternity care providers who should use the data to improve their performance and maintain certification; 2) consumers who can use the data to choose providers and make decisions regarding their care; 3) public and private purchasers and payors to assess individual provider and systemic performance and success in improving in maternity care delivery 4) policy-makers in government and public health agencies to determine how to spend resources related to maternity care; and 5) researchers to identify and close gaps in the evidence behind maternity care.

a. Strategies:

- The data from performance measurement should be combined, where possible, and reported in aggregate. Fragmented data collection and reporting, i.e. by various payors, is confusing to providers and leads to inconsistency. A strategy for a national data registry for maternity care, with uniform requirements for data collection by providers should be thoroughly explored. This registry could be housed with maternity care professional organizations; or with a government entity, or other private entity.
- In the absence of a national registry, or until one can be developed and implemented, payors should report performance measurement data to providers. All reporting should be done in a uniform format that encourages/enables action to improve results.
- Performance measurement and process improvement should be built into training programs for all maternity care providers as well as ongoing certification programs.
- Once there is comfort with the validity and reliability of performance measures, results should be made public to consumers in a format that is appropriate to the consumer's level of health literacy, such as a consumer report card, that will allow consumers to make informed choices when choosing providers (clinicians or facilities) or choosing between therapeutic alternatives. This may include the identification of overall higher performing providers. This can be done by the registry agency, or in the absence of a national registry, by health plans/payors.
- Researchers should use performance measurement data to develop a maternity care agenda that allows ongoing process improvement to fill in gaps in research and determine comparative efficacy.

b. Lead Responsibilities:

- A single entity should take the lead for coordinated data collection and reporting. Until that can be developed/established, individual purchasers or payors should use performance measures to encourage better practice. Regional Certified Value Exchanges, which are working to pool data from multiple payors, may take the lead locally in promoting the use of maternity performance measures.
- Policy-makers at government agencies, including CMS and public health agencies, must take overall responsibility for collecting data and convening groups to develop system-wide strategies to improve birth outcomes.

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c. Challenges and Solutions:

- This will be a significant challenge that will require data that is reliable, reported consistently and accurately. Providers will be naturally suspicious and concerned about making any less-than-perfect data public. Liability reform must accompany payment reform to remove provider's fear of increased liability exposure from public reporting of outcomes. Consumers will have to be educated on how to interpret and use publicly reported performance data. Data aggregation efforts should be encouraged. A data registry strategy should be accelerated. Foundation funding can be pursued for projects addressing a specific research need or quality gap as identified through a collaborative process involving the above stakeholders. Developers might look to successful programs use as the Northern New England Perinatal Quality Improvement Network (NNEPQIN) or the European Union's PERISTAT project for best practices.

d. Mechanisms for Collaboration:

- Work with maternity certification organizations to facilitate performance measurement and reporting that will enable Maintenance of Certification (MOC) efforts to be coordinated with measurement efforts and enable MOC reporting to be used by multiple constituents.
- NCQA and The Joint Commission could use maternity performance measurement in accreditation and certification programs.

e. Timeline for achievement:

- Data aggregation pilots can start after robust measures are developed in 2010. Provider and consumer reports can be pilot tested in 2010-2011. A nation-wide maternity improvement plan can be developed starting in 2010.

## **Payment Reform to Align Incentives with Quality**

### **Current Problem:**

- **Most current payment systems reward high intervention, high-tech, maternity care regardless of medical outcomes, creating a perverse payment incentive system.** Providers do not receive an incentive for appropriate processes and improved outcomes, and payment is tied only to procedures. Due to this reimbursement system, outcomes such as perinatal, neonatal, and maternal mortality; low birth weight; and cesarean rates have suffered when compared with other nations. The national cesarean rate has increased annually from the mid-1990s and has reached a record level each successive year to date. Payment systems must be modified to reward appropriate care that is evidence-based, but to achieve this long term goal, a variety of payment mechanisms must be tested and evaluated. As all payor-purchaser markets are, practically speaking, regional and local, such pilot reform efforts are best carried out at this level.

### **Recommendations**

**1. Promote quality initiatives in purchasing/reimbursement for maternity care services.** These quality initiatives would utilize agreed upon performance measures for high-quality evidence-based care and test diverse approaches for modifying payment systems.

a. Strategies:

- Establish provider/facility level value-based purchasing initiatives that focus on quality of care provided (for example, episiotomy rates, birth trauma rates, etc.). State or regional Medicaid agencies and private insurers should collaborate with key providers and managed care organizations to decide on indicators, targets, and incentives/disincentives.
- Establish managed care level value-based purchasing initiatives that focus on service availability and utilization (for example, access to prenatal care in the first trimester, use of behavioral interventions such as smoking cessation, preventive dental care, etc.).
- Individual Medicaid programs and private insurers should consider which necessary prenatal services are not reaching the population and incentivize the delivery of these services.
- Design and begin implementing payment reform pilot projects with interested and capable maternity providers to test new systems that improve quality and reduce cost.<sup>1</sup>
- Encourage coordination of care among primary care and maternity providers by improving ability to share information and discouraging payment for fragmentation or duplication of services.

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<sup>1</sup> Network for Regional Healthcare Improvement, From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs, Executive Summary, Recommendations of the 2008 NRHI Healthcare Payment Reform Summit, 3.

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- Value-based purchasing measures could be based on aggregate data, publicly available and published in consumer report cards. Consumers should be educated on the need for value-driven maternity care.
  - Provider groups should develop a culture that encourages and supports routine and comprehensive performance measurement. Specialty boards should require performance measurement and reporting as part of certification maintenance.
  - Payment systems should not reimburse for provider errors or avoidable adverse events.<sup>2</sup>
- b. Lead Responsibilities:
- Medicaid agencies, private insurers, managed care organizations. The advisory role of the Medicaid and CHIP Payment and Access Commission (MACPAC) should be expanded to include maternity care since Medicaid pays for 43% of births.
- c. Challenges and Solutions:
- Obstetric care providers have not historically measured performance and outcomes. Performance measures must be valid and reliable for providers to feel comfortable. Providers should have the ability to review and appeal or if applicable correct any performance measurement data they believe to be incorrect or incomplete.
  - Data for desired indicators may be difficult to obtain or monitor without changes in coding.
  - For state Medicaid programs with managed care, it may be programmatically difficult to make direct incentive payments to providers and a mutually agreeable mechanism must be established. Using incentives rather than disincentives may be more beneficial for Medicaid programs, which have difficulty maintaining adequate provider networks.
- d. Mechanisms for Collaboration:
- Public and private insurers should work with advocates and providers including hospitals, physicians, and midwives.
  - The National Perinatal Information Center (NPIC/QAS) has offered to contribute data from close to a million perinatal discharges per year for use in value-based purchasing and payment reform demonstration projects
- e. Timeline for achievement:
- Encourage insurers to implement value-based initiatives by 2011 once uniform performance measures are developed.

**2. Adjust payment within existing systems to reward evidence-based practices that are the lowest appropriate level of intervention.** For example, pay more for vaginal births than non-emergency scheduled cesarean sections; do not pay

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<sup>2</sup> Miller, Harold D. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. September 2007, vii.

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for, or pay reduced rates for, non-medically necessary labor induction prior to 39 weeks; pay equitably for midwives and physicians; remove the barriers to care that high co-pays/coinsurance and deductibles can create for preconception, prenatal, and postpartum care visits. This may include the reduction or elimination of co-payments, coinsurance, or deductibles for prenatal care and related services.

a. Strategies:

- Build consensus around the evidence that induced labor and scheduled cesarean sections are harming mothers and babies. Based on that consensus: 1) establish specific recommended payment reform targets and recommended relative payment rates (for vaginal vs. cesarean) for target procedures; 2) identify procedures that should not be covered under any circumstances, or only under certain circumstances; and procedures that should be covered as part of routine prenatal care which are not typically covered.
- Modify maternity related billing codes and practices to enable collection of more meaningful clinical information through claims data: 1) unbundle CPT codes for prenatal visits or create an option to bill for a single visit; 2) separate codes for scheduled cesarean sections, emergency cesarean sections, and cesarean sections following induction; 3) separate codes for spontaneous and induced vaginal births; 4) identify codes for indicating trimester of pregnancy, maternal risk stratification, and gestational age of the newborn at delivery.
- Develop mechanisms to encourage providers to bring women into care earlier, such as paying more for prenatal visits in the first trimester.

b. Lead Responsibilities:

The Quality Alliance Steering Committee (QASC) could be asked to sponsor a multi-stakeholder maternity care workgroup for this purpose, with participants including:

- Public (Medicaid) and private purchasers and insurers
- The AMA and ACOG to implement billing code changes
- Health professionals and hospitals to establish payment reform targets
- The AQA Alliance and the Hospital Quality Alliance (HQA) to engage in dialogue with consumers, purchasers and health plans around ways to improve the quality of care
- Clinical groups collaborating with Advisory Committees of the AMA's CPT Editorial Panel to develop and approve needed CPT codes

c. Challenges and Solutions:

- Many of the recommended payment changes are based on the conclusion that unnecessary intervention in physiologic birth leads to poorer outcomes, and there must be an effort to build consensus on this among stakeholders.
- When reimbursement changes are implemented, care must be taken not to inadvertently limit care that is necessary and appropriate for some women, including high-risk women.

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- Recommended billing code changes would facilitate not only payment reform but would enable relatively inexpensive collection of large amounts of data about birth processes and outcomes.
- d. Mechanisms for Collaboration:
  - Advocacy, clinical groups (health professionals/hospitals), state and federal government, insurers. Example: Maryland Hospital Association collaborated with the state public health system, and all hospitals agreed not to allow voluntary scheduling of cesareans prior to 39 weeks. This model could be duplicated by other states, including other evidence based limitations on providers.
- e. Timeline for achievement:
  - Consensus on appropriate strategies to adjust payment by 2010. Adjusted pay by 2011.

**3. Develop and refine payment mechanisms to improve the retention and development of OB resident skills in evidence-based maternity care practices to support safe physiologic childbirth and skills to avoid unnecessary repeat cesarean section: e.g. vaginal breech delivery, vaginal twin deliveries, use of forceps and VBAC.**

- a. Strategies:
  - Review Graduate Medical Education (GME) funding rules to ensure there are no obstacles for payment to midwives for supervising and training residents. Midwives may not currently be deemed ‘faculty’ and therefore would not be allowed to receive GME funds.
  - Engage Midwifery associations, the Accreditation council for Graduate Medical Education (ACGME), ACOG, medical schools and specific training programs to discuss ways to promote GME training in evidence-based maternity care and low-intervention delivery.
  - Once payment is aligned to reward evidence-based practices at the lowest level of intervention (recommendation #2), medical schools, and specifically OB-GYN departments, should re-evaluate resident teaching practices to align with quality, including revision to faculty payment formulas.
- b. Lead Responsibilities:
  - A multi-stakeholder group that has identified retention of skills among OB residents as a problem would have the credibility needed to convene the entities that could address this: CMS, states, ACGME, ACOG, Midwifery Associations and Midwifery Training institutions.
- c. Challenges and Solutions:
  - GME funding is complex and many cross subsidies of care may be implicated in proposing changes to GME funding. Changing funding could be seen as a threatening “scope of practice” issue by physicians and/or midwives.
  - The solution lies in focusing on the goal—finding ways to ensure that new obstetricians are adequately trained in low-intervention deliveries

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rather than being wedded to a particular mechanism for addressing the problem.

d. Mechanisms for Collaboration:

- Engage Midwifery associations, ACGME, ACOG, medical schools and specific training programs to discuss ways to promote training in evidence-based low-intervention delivery. Some medical schools currently use this model, which could be shared and implemented by other schools.

e. Timeline for achievement:

- Begin discussions in 2009 with a goal to make adjustments by 2011. Medical schools and OB-GYN departments should begin evaluating residency teaching programs to align with new payment system by 2011 (recommendation #2).

## **Improved Functioning of the Liability System**

### **Current Problems:**

- The current tort system tends to discourage providers from reporting adverse events and “near misses” due to fear of litigation, thus making it difficult if not impossible to learn from these events.
- Lay juries are currently required to interpret complicated medical information from dueling experts in order to decide whether or not there was liability in a case.
- There is currently no effective system to coordinate and pay for care of neurologically impaired infants without need to access the tort system, whether or not the impairment was caused by preventable error.
- Providers often practice defensive medicine due to fear of litigation. This is felt to contribute to 5-9% of health care spending and may perversely increase the risk of harm to the patient.
- The current tort system does not adequately compensate injured patients in a timely and fair manner, improve patient safety, or weed out “bad” providers. A significant amount of money is spent on the tort system itself rather than helping injured patients.

### **Recommendations**

**1. Establish a nationwide repository, similar to that used in aviation, to collect and evaluate occurrences in a non-punitive fashion, with the goal of assessing systems, trends, etc. and recommending strategies to improve patient safety and disseminate the information to providers.**

a. Strategies:

- Promote regional Patient Safety Organizations (PSOs) that can feed into a legislated national PSO or other national organization that can collect the aggregate, de-identified information for use by Physician Liability Insurance (PLI) carriers to both better assess risks as well educate their insured providers and facilities. This information can also be used by other interested parties for risk assessment and education.
- Promote use of the newly developed common format AHRQ Perinatal Patient Safety Event Report to report adverse events occurring during perinatal care.
- Make this information accessible within Health Information Technology (HIT) tools, including automated transmittal of adverse event information to providers and PLI carriers.

b. Lead responsibilities:

- Coalition of providers, provider organizations, private and public payors, liability insurance companies, advocacy groups, lawyers and others to lobby Washington for establishment of such a national entity
- Regional coalitions to establish PSOs

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- c. Challenges and solutions:
  - Acceptance of a uniform report form for use in reporting data
  - Acceptance of a uniform taxonomy
  - Need for establishment of additional regional PSOs
  - Objections of trial lawyers to any changes to the current system; outreach and education through their relevant professional associations (e.g., the American Health Lawyers Association and state Trial Lawyers Associations) may be productive
  - PLI carriers can use the information obtained to better educate their insured providers and facilities
  
- d. Mechanisms for collaboration:
  - Utilization of information obtained to educate healthcare providers and facilities on strategies to avoid system deficiencies that result in less than optimal outcomes
  - PLI carriers use this information in the development of patient safety/risk management seminars for their insured providers and facilities
  - PLI carriers use this information to better assess the risks of certain procedures
  - The Physician Insurer Association of America Data Sharing Project that collects closed claims information from member PLI carriers could do additional “mining” of data regarding obstetrical care to evaluate strategies that promote patient safety; this information can be disseminated to their insured providers and facilities on a regular basis.
  
- e. Timeline for achievement:
  - Accomplish legislation by 2010

**2. Improve the liability system by exploring alternative systems that separate negligence and compensation as well as systems that decrease administrative expense.** This will result in patients being compensated quickly and fairly, and remove waste from the system. It would also enable the system to deal more efficiently with negligent providers and better effect changes in their behavior.

- a. Strategies
  - Explore and pilot methods of alternative dispute resolution:
    - a) Health courts
    - b) Mandatory arbitration/mediation
    - c) Apology laws, which allow providers to discuss an adverse outcome and express regret or sorrow to a patient without fear that it will be admissible in court
  - Explore and pilot methods that deal with compensation and negligence in separate systems:
    - a) No fault administrative systems such as those in Sweden or New Zealand
    - b) A federal program modeled on the National Childhood Vaccine Injury Act of 1986, which created the National Vaccine

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Injury Compensation Program that has been operating under HRSA since 1988.

- Explore and pilot methods that relocate responsibility from individuals to systems:
    - a) Enterprise liability
  - Allow pilot programs for the establishment of neurologically impaired infant funds, similar to those in Virginia and Florida, but with improvements based on the lessons learned. This could include establishing a system to coordinate currently available resources, establishing a fund to help care for all neurologically impaired infants regardless of negligence. This could be done either through general revenue or a dedicated tax. It is not sustainable for this fund to be exclusively supported by health care providers.
  - Explore options for diversifying the assignment of liability insurance premium rates according to level of specialty, provision of segmental care, geographic and socio-demographic population risk factors, etc.
  - Encourage expert witness testimony that focuses on appropriate calculation of economic damages rather than testimony to determine negligence.
- b. Lead responsibilities:
- Coalition of providers, provider organizations, liability insurers, private and public payors, advocacy groups, lawyers, patients and other stakeholders.
- c. Mechanisms for collaboration:
- PLI carriers can collaborate with other organizations such as Common Good to explore and pilot alternatives to the tort system.
  - Pilot program experiences should be broadly shared with other states.
  - Coalitions and partnerships should work together to establish enabling legislation.
- d. Challenges and solutions:
- Need for enabling legislation on a state and/or federal level, and financing for some of these things to occur
  - Potential for increased expense if no fault systems and funds for neurologically impaired infants result in greater numbers of cases being compensated
  - Objection of trial lawyers to any change in the tort system
  - Requires a major culture change
- e. Timeline:
- Federal/state legislation that would enable pilot projects such as those noted could be brought forth in 2010. Pilots could launch subsequent to legislative approval.

**3. Promote use of best practices and evidence-based medicine in the courtroom and in clinical practice.**

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a. Strategies:

- Better define and promote best practices and evidence-based medicine in maternity care and reduce defensive clinical practices and unwarranted variations in practice.
- Legislate a “safe haven” for providers who follow evidence-based standards so that they are protected from legal action when established guidelines are followed.
- Develop and promote evidence-based standards and procedures that promote patient safety and discourage defensive clinical practices and unwarranted clinical variation.
- Improve communication and transparency when medical errors occur.
- Conduct research to explore the potential of the hospital “laborist” model (health professionals, either physicians or midwives, who provide hospital-based maternity care only) to improve safety and decrease adverse perinatal events.
- Work to establish apology laws.

b. Lead responsibilities:

- A coalition of providers, provider organizations, public and private payors, liability insurers, advocacy groups, lawyers and others to lobby for legislation to enable these projects

c. Challenges and solutions:

- Providers have traditionally been slow to adopt the best practices and evidence based medicine guidelines. Provider organizations, public and private payors and liability insurers need to find ways to better promote adoption of these practices now and as new ones become available.
- Need for comparative effectiveness research to demonstrate differences between treatments
- Need for more specific practice guidelines for high risk procedures and clinical scenarios
- Need for improved education in critical appraisal and uptake of evidence
- Need for continuous evaluation with updates done on a regular cycle and alerts disseminated rapidly
- Need for legislative change (for apology legislation and provider “safe haven”)
- Fear of increasing litigation due to disclosure (although insurers who have implemented disclosure policies report that they have not experienced this problem)
- Trial lawyer objections to any systemic change to the current tort system

d. Mechanisms for collaboration:

- PLI carriers can use these standards as a basis for risk management/patient safety seminars to educate their insured providers and facilities

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- PLI carriers should encourage disclosure instead of silence and provide education to their insured providers and facilities as to appropriate methods of disclosure.
- e. Timeline for achievement:
- Promotion of best practices and evidence-based medicine should begin immediately. Promotion and education regarding methods of disclosure should begin immediately. Apology and other enabling legislation to be introduced by 2010.

## **Disparities in Access and Outcomes of Maternity Care**

### **Current Problems:**

The current system of maternity care is not equitable for all women in the United States.

Care delivery systems and payor models for maternity care are often:

- Provider-focused, not family-centered
- Not prevention focused, instead stressing care which starts too late in pregnancy to effectively prevent birth defects or ameliorate the effects of chronic conditions on birth outcomes
- Fractured, and are not comprehensive in considering the psychological and social-economic needs of women
- Inadequate to respond to the cultural and linguistic needs of women
- Exclusionary toward undocumented women
- Based on bundled payment systems and payment for interventions, creating incentives to “save” care for later pregnancy, assuming that more intervention will be needed at that point
- Not supportive of preconception care, early pregnancy education or inter-conception care in support of birth spacing
- Influenced by a fear of liability, leading to practice patterns that do not reflect standards of care. For example, fewer vaginal births after cesarean section are performed, and the rate of cesarean sections continues to climb with rates of over 50% present in some states.
- Influenced by consumer expectations for perfect outcomes
- Driven by economic motives rather than clinical data

### **Recommendations**

**1. Initiate and fund national research efforts to measure comparative effectiveness of all aspects of perinatal care in populations experiencing maternity care disparities.** Use the data to develop new perinatal performance measures that address unique needs of diverse populations. Perinatal measures should include performance reporting in subgroups of women where there are health disparities and poorer birth outcomes as a result.

a. Strategies:

- Develop comparative effectiveness (CE) research priorities: CE should prioritize subgroup analysis within vulnerable populations of practices that have demonstrated efficacy in randomized controlled tests (RCTs), and further research on practices that have demonstrated improved outcomes within minority groups. CE should start by testing these evidence-based practices within specific non-random populations that may have different attributes to determine effectiveness and identify gaps.

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- a) Example: Conduct further research on models of care delivery such as “CenteringPregnancy” group prenatal care, which demonstrated a 41% decrease in preterm birth in the African American sample population in a recent RCT.<sup>3</sup>
- State Maternal and Child Health [MCH] (Title V) public health programs should develop and test disparities-sensitive performance measures, and serve as measures sponsors to submit them for endorsement to the National Quality Forum (NQF).
  - State Medicaid plans should work with MCH (Title V) agencies to obtain their assistance in collecting and analyzing the data, and should adopt these perinatal performance measures in their state programs.
  - Performance against these measures by health care providers needs to be communicated to consumers in a clear, linguistically appropriate manner matched to their health literacy level via national and health plan websites and other mechanisms.
  - Performance related to perinatal measures needs to be reported in a way that specifically correlates outcomes on performance measures with relevant maternal variables that lead to disparities, such as the race, ethnicity and socioeconomic status of the mothers.
  - These data need to be collected in state and national public databases that track and monitor maternity care delivered and outcomes of care for all women and for relevant subgroups of women.
- b. Lead responsibilities:
- State MCH (Title V) and Medicaid agencies, Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB), CMS, and national quality assurance agencies should utilize federal funding made available for comparative effectiveness research via the newly signed federal economic stimulus package that stipulates that all research financed by the federal government shall include women and members of minority groups.
- c. Challenges and solutions:
- There are many entities that collect data, but not all data collected supports quality measurement or outcomes, thus developing a set of quality measures that meets everyone’s needs will be challenging.
- d. Mechanisms for collaboration:
- Involve all potential stakeholders and start with a few quality measurements. Partnering between MCHB, Title V, and CMS/state Medicaid agencies, would allow consistency of data collection and reporting.
- e. Timeline for achievement:
- MCH (Title V) public health programs begin identifying, researching and developing measures for testing by 12/09.
  - Prioritize measures for CE trials based on potential impact by 3/10.

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<sup>3</sup> Ickovics JR, Kershaw TS, Westdahl C, Magriples U, Massey Z, Reynolds H, Rising SS. Group prenatal care and perinatal outcomes: a randomized controlled trial. *Obstet Gynecol* 2007;110(2):330-39.

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- Reporting, tracking and consumer education to start as measures and become available over the next 5 years.

**2. Require development of and access to consumer education provided by payors that is linguistically appropriate and culturally relevant.**

a. Strategies:

- Enact national or state legislation that requires health insurance plans to provide plan members who have limited English skills with access to both written and spoken language assistance.
  - a) Example: the state of California recently enacted a bill (CA SB 853) with these requirements. This bill is designed to help alleviate the language barriers that members could encounter when accessing health care and understanding their health benefits.
- Public and private payors should collaborate at national, state and regional levels to develop joint workgroups to share communication strategies and co-develop materials on what constitutes quality maternity care for diverse groups of women and other key audiences.
- Fund expanded use of community health workers, care coordination and patient navigators to assist women in understanding, using and navigating through the system and ask for what they need.
- Utilize database of race, ethnicity, primary language, and gender that will be developed in response to the recommendation of the HIT policy committee as directed in the recently approved federal stimulus package. This data is critical to determining communication needs and targeting appropriate, relevant information.

b. Lead responsibilities:

- Insurance plans, both public and private, working with consumer advocacy groups, state insurance agencies and MCH (Title V) public health programs. MACPAC may serve as vehicle to make recommendations, including for funding.

c. Challenges and solutions:

- Current legislation such as that in California is very expensive and may not be achievable or sustainable. Finding a reasonable middle ground will be a challenge.

d. Mechanisms for collaboration:

- An existing resource is the National Center for Culture Competency. Also, the MCHB could support a mechanism for collaboration.

e. Timeline for achievement:

- Legislation enacted by 2011
- Public/private workgroups formed by the end of 2009
- Utilization of HIT database as soon as it is available

**3. Expand access to high quality care options addressing women’s maternity care needs throughout the reproductive years.**

a. Strategies:

- Initiate and fund national research effort to measure effectiveness of preconception care (PCC) and interconception care (ICC) interventions. There is a need to understand what works, what are the “critical periods” when interventions may be most effective, what drives healthy behavior choices, and what correlates directly with good health outcomes for women and their babies.
- Identify best practices for preventive care for all women starting in early adolescence and continuing throughout the lifespan and consider a variety of options for delivery of services such as schools, mobile vans, clinics in churches, etc.
- Expand maternity care options for women to include choices that meet the needs of an ethnically diverse population, especially in areas where there are significant health disparities.
- Expand network of midwives with nationally recognized credentials and birth centers across the country. Encourage health plans to provide robust access to these care models.
- Develop incentives for maternity care providers and care delivery systems to provide flexible care options:
  - a) Expanded in-home care
  - b) Home visit offerings for maternity care and post-delivery care
  - c) Extended clinic hours (evenings/weekends)
- Expand public support for maternity care providers and centers to serve vulnerable populations including undocumented women, in underserved areas.
  - a) Example: Target funding increases for Federally Qualified Community Health Centers (FQHCs) and increase federal Title V-MCH block grant funding for areas where many disadvantaged women seek care.
- Expand public support for school-based or -linked health services for adolescents to meet the needs of an increasingly ethnically and culturally diverse population at a time when preventive care can be initiated to reduce long term health disparities from such behaviors as smoking and substance abuse, hypertension and obesity.

b. Lead responsibilities:

- CMS and State Medicaid programs, private health insurers, HRSA Bureau of Primary Health Care and MCH (Title V) public health programs, maternity care facilities and their staff, medical schools, consumer education groups such as Lamaze International, Title X providers, etc.

c. Challenges and solutions:

- Matching payment regulations and requirements to cover “alternative locations” and models will be challenging and will require “out of the box thinking”. A federal agency, such as MCHB should support the

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identification of best practices, including funding mechanisms, and issue a report.

d. Mechanisms for collaboration:

- Engage maternity care provider organizations, quality research experts, and payors for discussions and consider pilot programs in areas of the country where known health disparities exist.

e. Timeline for achievement:

- Initiation of basic research to determine efficacy of PCC and ICC care practices by 2010
- Expansion of various maternity care networks and options by 2011

## **Scope of Covered Services for Maternity Care**

### **Current Problem:**

- **Lack of a standardized list of recognized, evidence-based maternity services; inadequate insurance coverage; and eligibility requirements create barriers to providing evidence-based models of maternity care that have been proven to lead to improved health outcomes.** Providers are not always aware of or reimbursed for effective routine and additional effective services, such as nutrition education and tobacco cessation, and women may not be aware of or able to access such services. Health care coverage and eligibility rules create barriers to pre-pregnancy and first trimester continuum of care, especially for the Medicaid population.

### **Recommendations**

**1. Create a standardized package of recommended evidence-informed routine maternity care services, plus indications for additional services, such as behavioral counseling (obesity, diabetes, substance abuse, etc.).** Services with periodicity schedules should be recommended for the preconception, inter-conception, prenatal, delivery, and postpartum periods. The service package should be comprehensive to include prevention and wellness oriented care, as well as recommendations for high-risk pregnancies and non-routine care. The service package needs to support equal treatment regardless of race, culture or income, and must provide for woman-centered care that is tailored to their needs related to such factors as language, access and socioeconomic status.

a. Strategies:

- Convene an independent advisory board comprised of diverse stakeholders to create a standardized package of recommended evidence-informed maternity services. The federally funded 'Bright Futures' pediatric standards workgroup can be used as a model for this effort.
- The advisory board should begin with The National Business Group on Health's (NBGH) *Investing in Maternal and Child Health: An Employer's Toolkit*. The best evidence for services should be compiled based on systematic reviews. Recommended services should be correlated with the best quality and cost effective outcomes, including birth outcomes, wherever possible.
- The board should address areas in the NBGH model that need further development, such as labor and delivery.
- This standardized package should address recommended frequency of services, which types of providers should be reimbursed for the provision of which services, medical necessity criteria, and preauthorization requirements.
- Recommendations should be made for service limitations.

b. Lead Responsibilities:

- A single agency or organization, such as NBGH, should take the lead to organize and convene the advisory board.

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- c. Challenges and Solutions:
    - The evidence base is not strong for many services. There needs to be a call for research to support specific services. The board should consider “evidence-informed” services in addition to evidence-based services, as discussed in the NBGH toolkit.
    - Availability of referral sources for expanded/ancillary services needs to be addressed.
  - d. Mechanisms for Collaboration:
    - Providers, professional organizations, advocacy organizations, state MCH (Title V) public health program staff, and public and private insurers should be represented on the advisory board.
  - e. Timeline for achievement:
    - Standard package of services completed by 2011.
- 2. Public and private insurance programs should modify and expand service packages in line with the standardized package recommended by the independent advisory board.**
- a. Strategies:
    - The independent advisory board should develop a strategy to widely distribute the recommendations through traditional and non-traditional media to public and private insurers.
    - Pilot projects with careful evaluations should be used to demonstrate to employers and other private insurers, policy makers, and Medicaid agencies the cost-effectiveness and improvement in health outcomes from increasing access to appropriate and preventive care.
    - Insurers should improve enrollee communication regarding available benefits, health and wellness tools and the importance of informed consent in decision making.
    - Private and public insurers should provide consumers with transparent information on the coverage and costs associated with benefit packages embedded in insurance products. They should also provide incentives for employers to purchase insurance products with maternity benefits.
    - If the package demonstrates cost effectiveness and improves health outcomes, states should require providers of individual health insurance products to offer the standard maternity care service package for all privately insured women at an affordable price point.
  - b. Lead Responsibilities:
    - Medicaid agencies and private insurers should work with provider groups to determine feasibility and appropriateness of modifying service packages.
  - c. Challenges and Solutions:
    - Medicaid budgets are strained in the current economic situation. Private payers are struggling to slow rising health care costs. A

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demonstration of how preventive services can be cost neutral, or cost saving, is needed.

- Resistance in individual market for mandatory maternity benefits.

d. Mechanisms for Collaboration:

- Professional organizations should educate providers about the standardized service package.
- Medicaid agencies and private insurers should convene stakeholder groups in their states to implement standard maternity care package.
- The Joint Commission could reinforce the standards set in the service package.

e. Timeline for achievement:

- Begin implementation when standard service packaged is released in 2011.

**3. Include additional services for current Medicaid populations and expand coverage to allow for a continuum of care to women of reproductive age.**

Many low income pregnant women are currently eligible for Medicaid coverage only during their pregnancy; federal legislation should be considered to permit women to be Medicaid eligible before pregnancy, at least for reproductive services. This could be accomplished through a “reproductive health package” or a “women’s wellness package.” Low-income uninsured women could be enrolled before they become pregnant and receive well-woman care in order to ensure preconception health. Services would also include prenatal and maternity care and family planning.

a. Strategies:

- States and advocacy organizations should encourage federal legislation to allow coverage of more women over the lifespan, rather than just during pregnancy or for post-pregnancy family planning.
- Federal legislation to change or remove family planning waiver regulations and allow states to expand family planning through State Plan Amendments.
- States and/or the federal government should remove requirements for an active re-determination process for family planning waivers.
- States should consider presumptive eligibility or expedited eligibility for pregnant women to ensure timely access to care for low-income women not enrolled in Medicaid prior to pregnancy.

b. Lead Responsibilities:

- State Medicaid programs, federal government, Centers for Medicare & Medicaid Services (CMS), Medicaid and CHIP Payment and Access Commission (MACPAC)

c. Challenges and Solutions:

- States have fiscal constraints to expanding eligibility. Federal legislation will be required to cover women up to or above 200% of the federal poverty level. States could potentially cover this population under an 1115 waiver. Budget neutrality or cost savings will be achieved by expanding family planning services to more women. In

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addition, healthier pregnancies as a result of preconception care and early pregnancy care will lead to healthier and less expensive birth outcomes.

d. Mechanisms for Collaboration:

- States should work with MACPAC to develop recommendations for federal legislation. Additionally, states should work together to develop strategies for covering more women over the lifespan, and advocacy organizations could provide research and policy support, as well as training and technical assistance to States.

e. Timeline for achievement:

- Begin exploring options in 2009 with goal to begin changes in 2010.

## **Decision Making, Patient Choice, Informed Consent and Refusal**

### **1. Public and private payors should offer benefits and develop payment policies that reward provider and consumer behaviors that lead to healthy pregnancies and high quality outcomes.**

a. Strategies:

- Create a national coalition of public and private payors to come to consensus on agreed sources for nationally recognized, consumer friendly, non-competitive information on quality and evidence in maternity care; consumer representatives and advocacy organizations should be included in the process.
- All payors and maternity care providers must enable patients to make confident, informed choices by providing access to these credible sources of information.
- Offer incentives that motivate women to select providers who have demonstrated consistent adherence to evidence-based medicine standards and high quality outcomes. Incentives could include coinsurance reductions, HSA contributions, co-pay waivers, etc.
- Create payment mechanisms that preferentially pay providers for supporting low intervention choices made by their maternity patients. Examples include practices that support physiologic labor, spontaneous full-term births, etc. (see Payment Reform recommendations).

b. Lead responsibilities:

- Public and private payors, self-insured employers, union groups, and others who purchase healthcare services in the commercial marketplace; providers; and relevant professional and quality improvement associations.

c. Challenges and solutions:

- Health plans can face conflict with physician providers of maternity care if they perceive that the plan is driving patients away from them to another source of care.
- Physician providers may not support preferential payments for low intervention maternity care. Synthesized evidence on the cost and quality benefits of low-intervention births may quell these concerns.

d. Mechanisms for collaboration:

- Payors, professional organizations, federal agencies (such as the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention), respected maternity care groups (such as Childbirth Connection and March of Dimes Foundation), consumer advocacy organizations and decision support systems (such as the Foundation for Informed Medical Decision Making) should work together to identify, develop, promote, and refine shared decision-making tools for women and their families.

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e. Timeline for achievement:

- Consolidation of, and consensus on, nationally recognized sources of consumer information on performance and quality data by 12/09
- Development of consumer and provider incentives for healthy pregnancy outcomes by 2011.

**2. Plans, purchasers, and providers must improve the way in which they communicate information on evidence-based maternity care, informed choice/refusal opportunities for mothers, risks associated with choices and tools available to support decision making.** Consumers are bombarded with conflicting information that is difficult to understand. As a result, they are not confident in their ability to make decisions and may look to unreliable sources for information.

a. Strategies:

- Fund the development of an electronic decision-support tool that is populated with probability data on the risk of interventions and that clearly communicates potential downstream effects of various birth choices.
- Garner national consensus on the validity of a decision-support tool from payors, health care providers and consumer advocacy groups.
- Publish consensus papers and make relevant tools available to the public via all stakeholder channels (health plans, providers, government agencies, etc.)

b. Lead responsibilities:

- Consumer advocacy organizations such as Childbirth Connection, Lamaze International, March of Dimes Foundation, and payors, purchasers, providers.

c. Challenges and solutions:

- Garnering support among payors for participation in the development of these tools may be difficult due to conflicting priorities. Having a neutral party, like an advocacy organization, facilitate may help.
- Funding for the development of the tool may be difficult due to budget constraints. Matching federal grants (to augment private contributions) is one opportunity to address funding challenges.
- Operationalizing “risk” and “safety” as components of consumer decision making is a complicated task. In the interest of transparency, it will be important to emphasize that data are imperfect; to discuss how values and preferences contribute to individual decision making; and to make comprehensive information on research methods available for women who want to know how risks were calculated.

d. Mechanisms for collaboration:

- National workgroup to develop, gain consensus, and disseminate information.

e. Timeline for Achievement:

- Workgroup recruitment: 9/1/09
- Tool development: 12/2010

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- Public announcement and distribution of tool: 3/2011