CATALYST FOR PAYMENT REFORM

Catalyzing Maternity Care Payment Reform Through Purchaser Leverage

March 30, 2012

CPR's Approach

Shared Agenda

Demand payments be designed to cut waste or reflective of performance

- Track progress with National Scorecard
- 20% by 2020

Leverage purchasers and create alignment

- Model health plan RFI questions and contracts and dialogue with plans
- Alignment with CMS, e.g. HHS Partnership for Patients

Implement Innovations

- Price transparency
- Reference or value pricing
- Maternity care payment

Purchasers Have a Catalyst Role to Play

Coordinated Purchaser Action

Leverage Purchaser Power: Critical Mass

- Shared vision - payment reform framework & principles
- Aligned employer agenda - short term wins, longer-term bold approaches
- Clear signals to plans – RFIs and contracts
- Toolkit for local action – Market Assessment, Action Briefs, etc.

Environment Conducive to Reform

- Direct dialogue with HHS for alignment and influence
- National Scorecard on Payment
- Compendium of Payment Reform Efforts
- Analyze and raise visibility of provider market power and cost shifting issues

Critical Mass Starts With Active Purchasers

CPR Toolkit developed to create shared understanding of opportunities and to encourage actions that leverage payment to improve value.

Payment Framework
- Help purchasers understand range of payment models and associated benefits and challenges

Action Briefs
- Outline steps to implement payment reforms and ways to mitigate potential unintended consequences

Market Assessment
- Identify opportunities based on market conditions, health plan capacity, and delivery system organization

Sourcing Tools
- Support purchaser initiatives though standardized RFI/RFP language and contract modules

SPECIAL INITIATIVES
- **Maternity Care Payment**
- **Value Pricing**
- **Price Transparency**

Plus, a National Scorecard to monitor the nation's progress

Disturbing Trends in Maternity Care

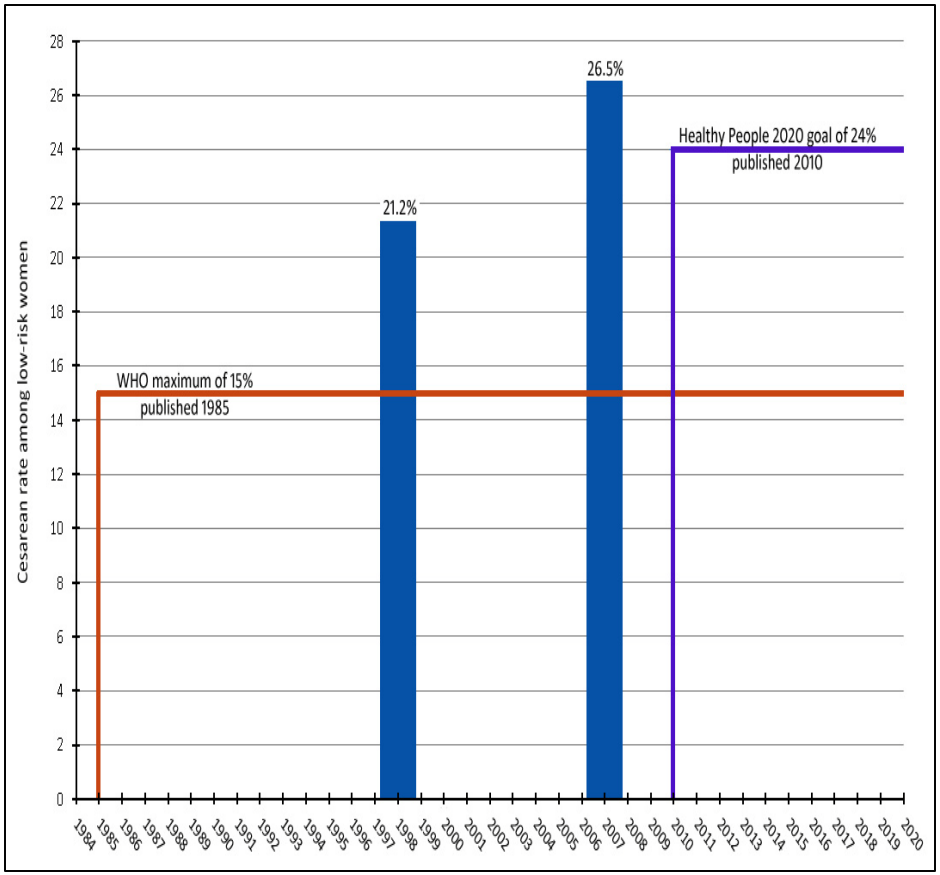
Unnecessary interventions are increasing costs and the incidence of complications among both mothers and babies, with no evidence of improved outcomes.

Delivery Trends

- Cesarean delivery rates for the privately insured have now risen to over 32% in the U.S. (up from less than 20% in 1996)
- Induced labor has doubled since 1990 to about 20% of all deliveries

Payment Trends

- Perverse incentives: *cesarean delivery reimbursement averages 50% more than that for spontaneous vaginal birth*



US is moving farther away from recommended benchmarks

2011 Leapfrog Hospital Survey Data

- Since April 1, 2011, 757 hospitals have reported on the elective deliveries measure
- Of those hospitals, 39% reported an elective delivery rate of 5% or less. Only 30% of hospitals were able to meet this target last year
- 65% of hospitals that reported in 2010 and then again in 2011 reported a reduction in their rate of elective deliveries

The national average rate has improved from 17% in 2010 to 14% in 2011

Some states have had impressive improvements

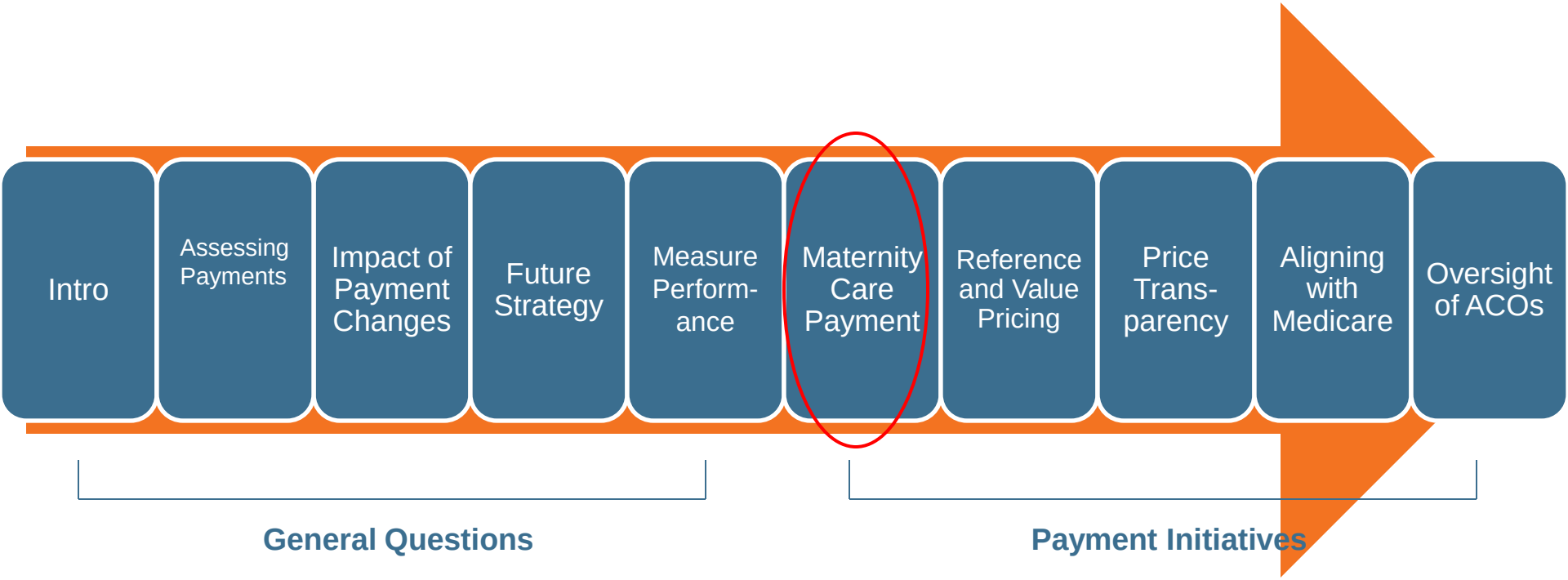
Source: The Leapfrog Group

Sample of State Rates of Elective Delivery

State	*2010 Elective Delivery Rate*	*2011 Elective Delivery Rate*
Arizona	32.2%	**19.5%**
California	14.7%	**11.2%**
Florida	20.9%	**13.2%**
Illinois	17.7%	**13.7%**
Indiana	26.5%	**11.3%**
Massachusetts	14%	**9.6%**
Michigan	14.3%	**9.2%**
New Jersey	15.7%	**11.7%**
New York	22.8%	**19.8%**
Ohio	14.2%	**7.6%**
South Carolina	27.8%	**19.4%**
Tennessee	19.0%	**14.9%**

Source: The Leapfrog Group

Health Plan Sourcing Tools: RFI Questions



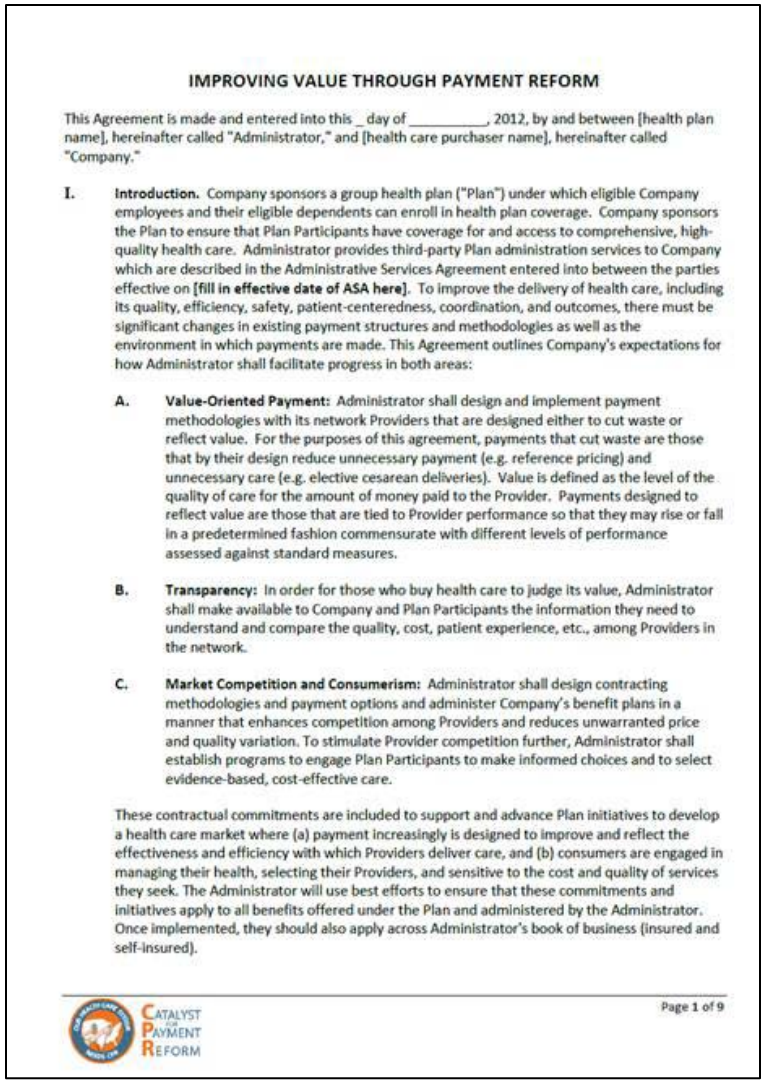
RFI developed through a comprehensive, well-vetted and multi-stakeholder process

Distribution of the RFI is made possible through the support of Aetna Inc. and the Aetna Foundation.

RFI Questions: Maternity Care Payment

- The incidence/rate of and use of performance measures on:
  - ✓Cesarean delivery
  - ✓Births electively induced prior to 39 weeks
  - ✓Vaginal births after cesarean delivery, etc.
- Strategies employed to address the rising rate of cesarean deliveries and inductions
  - ✓Payment
    - Bundled payment
    - Blended payment for cesarean and vaginal deliveries
    - Payment incentives or penalties
    - Payment to midwives
  - ✓Education
  - ✓Policy

Model Contract Language: Maternity Care Payment Provisions



IMPROVING VALUE THROUGH PAYMENT REFORM

This Agreement is made and entered into this _ day of _____, 2012, by and between [health plan name], hereinafter called "Administrator," and [health care purchaser name], hereinafter called "Company."

I. **Introduction.** Company sponsors a group health plan ("Plan") under which eligible Company employees and their eligible dependents can enroll in health plan coverage. Company sponsors the Plan to ensure that Plan Participants have coverage for and access to comprehensive, high-quality health care. Administrator provides third-party Plan administration services to Company which are described in the Administrative Services Agreement entered into between the parties effective on **[fill in effective date of ASA here]**. To improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes in existing payment structures and methodologies as well as the environment in which payments are made. This Agreement outlines Company's expectations for how Administrator shall facilitate progress in both areas:

A. **Value-Oriented Payment:** Administrator shall design and implement payment methodologies with its network Providers that are designed either to cut waste or reflect value. For the purposes of this agreement, payments that cut waste are those that by their design reduce unnecessary payment (e.g. reference pricing) and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the Provider. Payments designed to reflect value are those that are tied to Provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

B. **Transparency:** In order for those who buy health care to judge its value, Administrator shall make available to Company and Plan Participants the information they need to understand and compare the quality, cost, patient experience, etc., among Providers in the network.

C. **Market Competition and Consumerism:** Administrator shall design contracting methodologies and payment options and administer Company's benefit plans in a manner that enhances competition among Providers and reduces unwarranted price and quality variation. To stimulate Provider competition further, Administrator shall establish programs to engage Plan Participants to make informed choices and to select evidence-based, cost-effective care.

These contractual commitments are included to support and advance Plan initiatives to develop a health care market where (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which Providers deliver care, and (b) consumers are engaged in managing their health, selecting their Providers, and sensitive to the cost and quality of services they seek. The Administrator will use best efforts to ensure that these commitments and initiatives apply to all benefits offered under the Plan and administered by the Administrator. Once implemented, they should also apply across Administrator's book of business (insured and self-insured).

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Administrators must:

- Remove the established financial incentives for medically unnecessary intervention in labor and delivery
- Measure and report results
- Educate network about what constitutes high-quality, safe, cost-effective maternity care
- If successful, consider applying payment approach to other areas where care is not evidence-based

Moving Understanding to Action: Maternity Care Payment Action Brief

- Use health plan RFI & contract language
- Remove perverse incentives for intervention in labor and delivery
- Push for hard stop policies on elective births <39 weeks
- Include maternity metrics in P4P contracts
- Educate consumers, doctors and hospitals
- Credential midwives
- Stand by your plan
- Implement benefit design and shared decision making tools that support smart choices

CATALYST FOR PAYMENT REFORM

Maternity Care Payment

ActionBrief

Labor and delivery account for nearly a quarter of all hospitalizations for many employers,[1] and costs associated with pregnancy and its complications are a driving factor in the rising costs of health care. Cesarean deliveries, elective labor inductions and scheduled deliveries before 39 weeks are also the rise. The growing use of medically unnecessary interventions is increasing costs and the incidence of complications among mothers and babies, with no evidence of improved outcomes.

MATERNITY CARE PRACTICE IS MOVING AWAY FROM THE EVIDENCE

Maternity practices that were developed to treat specific problems are now applied routinely to all pregnant women regardless of their risk, and many obstetrical practices have become standard without scientific evaluation of their effectiveness.[2] As a result, medically unnecessary interventions, such as elective cesarean deliveries, episiotomy and electronic fetal monitoring, are increasing the cost of maternity care and worsening the health outcomes of both infants and mothers. However, many less-invasive approaches, such as continuous labor support, nonsupine positions for giving birth, delayed cord clamping, and vaginal birth after cesarean (VBAC), continue to be underutilized.[3] The areas of greatest concern in the growing gap between evidence-based practice and current US practice patterns are the increasing rates of preterm births, cesarean delivery, and elective induction.

WHAT IS DRIVING THESE TRENDS?

This trend is driven by both expectant mothers and providers.[4] Expectant mothers sometimes request deliveries at convenient times, and the use of anesthesia, which has increased, has been shown in some cases to interfere with the progression of labor.[5] While there have been recent efforts to educate pregnant women about the potential risks of elective pre-term delivery and elective inductions and cesareans, many women may not be aware of the added risks of intervention.

In addition, the current fee-for-service payment mechanisms for labor and delivery create incentives for hospitals to perform complex, costly procedures. In the most recent comprehensive report on evidence-based maternity care, the "perverse incentives of payment systems" are listed as one of the pervasive barriers to evidence-based care.[6] Hospitals are generally paid a case rate for vaginal and cesarean deliveries, with provisions for

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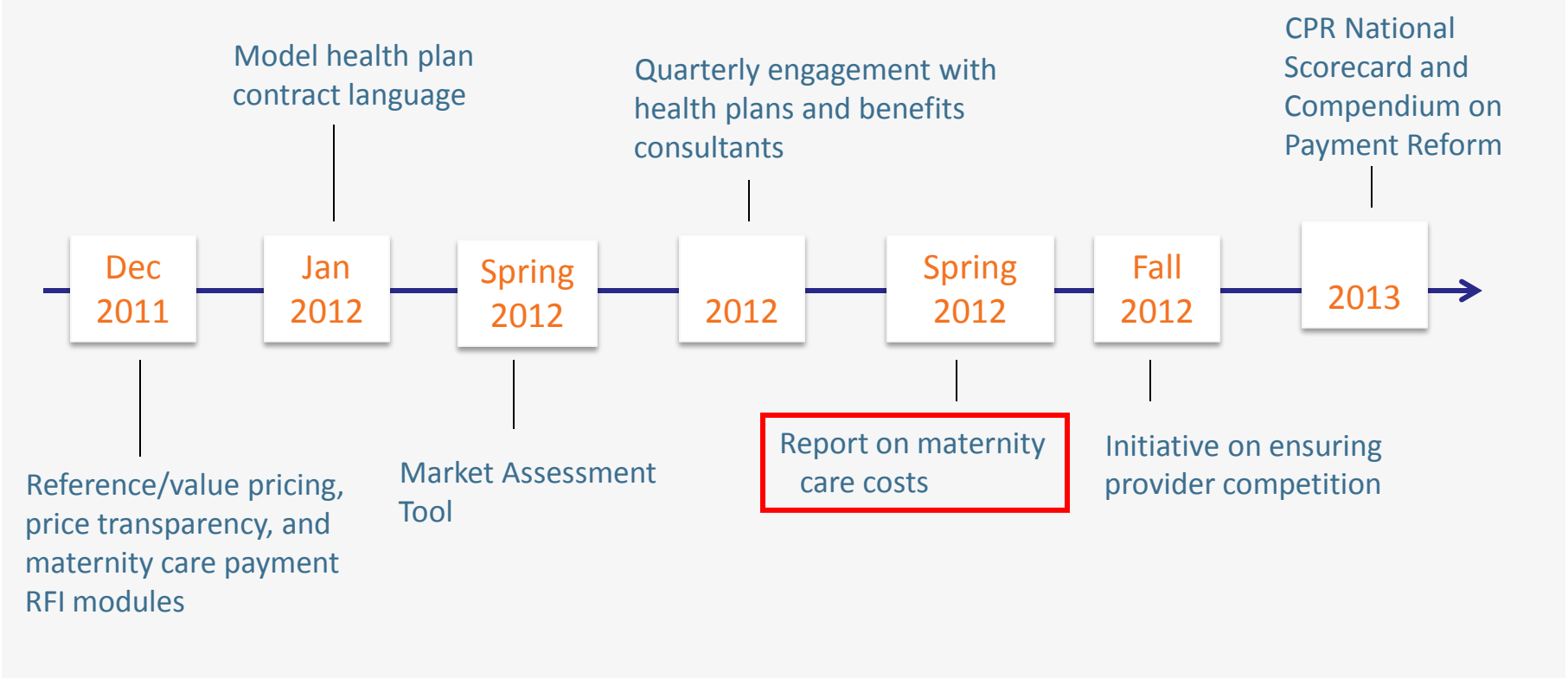
CPR Action Briefs detail options & steps purchasers can take toward positive reforms

Aligning Incentives to the Evidence: Examples of Payment Alternatives

- Financial incentives to eliminate elective deliveries <39 weeks
  - Creating a "do not pay" policy for elective deliveries prior to 39 weeks
- Blended payment for delivery
  - Providing one case rate for delivery, regardless of mode, removes the financial incentives for unnecessary intervention in delivery
- New bundled payments for pregnancy
  - Option 1: Bundle the hospital birth payment *and* the professional (obstetrician or midwife) fee for labor and delivery into a single payment
  - Option 2: Bundle the hospital delivery payment for both *mother and infant* into a single payment
  - Option 3: A comprehensive, single bundled payment for a maternity care "episode"

More to Come


Dec 2011
Jan 2012
Spring 2012
2012
Spring 2012
Fall 2012
2013
Model health plan contract language
Quarterly engagement with health plans and benefits consultants
CPR National Scorecard and Compendium on Payment Reform
Reference/value pricing, price transparency, and maternity care payment RFI modules
Market Assessment Tool
Report on maternity care costs
Initiative on ensuring provider competition

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