Robert Wood Johnson Foundation Payment Reform Evaluation Project
California Maternity Episode Bundled Payment
Pacific Business Group on Health

Executive Summary: August 2015 Report

Introduction and Context

The California Maternity Episode Bundled Payment Project is being implemented in a health care economy that is changing rapidly, both nationally and regionally within the state. The widespread national movement toward accountable care organizations (ACOs), value-based payment, and patient-centered care has stimulated experimentation with new models for payment.

Major stakeholders in the project are the Pacific Business Group on Health (PBGH), three quality improvement (QI) organizations, three health insurers, and three hospitals and their associated medical groups. Two of the insurers are piloting the maternity care case rate in four hospitals and medical groups in 2015. While the third has not concluded an agreement, it has been an important player in development of blended case rates and value-based payment for maternity care. CMMI's decision not to fund CalSIM was a setback for the PBGH maternity Project, since the initiative explicitly included the PBGH-sponsored Maternity Project as one of its four priority areas.

Project Objective

The project objective is to encourage appropriate choice between the options of C-section and normal vaginal delivery for singleton, full-term uncomplicated births. Widespread implementation of the approach is aimed at decreasing variation in C-sections across the state, resulting in better health outcomes for patients and in lower health care costs.

Approach

Payment reform. The core payment reform strategy is a combines a blended case rate for the hospital with a separate blended case rate for the physician organization. This general approach has been adopted by the two insurers, and is being adopted in different forms by each hospital and affiliated medical group.

Delivery system reform. The project is providing QI programs for the hospitals, medical groups, and nurses, and education and engagement for patients. The California Maternal Quality Care Collaborative (CMQCC) provides data to hospitals on key metrics and has developed a labor management bundle.

Project Progress

Results in the hospitals are mixed. Three of the four hospitals currently participating in blended case rate contracts have shown reductions in NTSV C-section rates, but it would be implausible to attribute those changes to the payment reforms because the decline began well before the blended case rates went into effect. While not necessarily driving the observed reductions in C-section rate and increases in VBAC rates, the new payment model appears to be supporting the changes initiated by the organization's QI initiatives. At the fourth pilot hospital, C-section rates initially had not declined post-QI, but in late 2014 and the first quarter of 2015 have declined.

Facilitators and Barriers

Facilitators.

- California's favorable market environment for testing new payment models.
- The PBGH's credibility and its understanding of the nuances in this state's environment.
- The September 2014 PBGH Maternity Care Summit introduced an expanded set of employers and provider organizations to the prospects for integrating QI and bundled payments for maternity care.
- IHA's initial leadership role in technical definition of episode-based bundle and defining key principles for bundled payment.
- Readiness among stakeholders to focus on maternity care.
- Reputation and active leadership role of the CMQCC and the California Maternity Data Center.
- Engagement of several insurers in the state.
- Increased consumer engagement. Support of American College of Obstetrical and Gynecological Surgery and other professional societies.
- Local physician and nurse champions and supportive administrators in participating hospitals.
- Changing climate in the purchaser community, which seemingly has passed a tipping point and is more engaged and sophisticated; employer support of QI initiatives in maternity care.
- Influence of social media

Barriers.

- Challenging logistics: many players to assemble at the same table, typically with competing priorities and varying degrees of interest and resources.
- The narrow perspective of several health plans despite general movement towards innovation
- It is difficult and slow to develop these programs and to negotiate with providers.
- Physician practice patterns unlikely to change because of new payment incentives of a single health plan with limited market share.
- Physicians seek control over the timing of delivery to mitigate its impact on their office practice and personal life.
- The challenge of changing culture of providers and payers.
- Difficulty in implementing a unified hospital and physician bundled payment, given incomplete integration of hospitals and physician organizations.
- Recognition by hospitals of the contribution of maternity care to the organization's bottom line is somewhat lacking.
- Challenges in convincing providers of the merit of bundled payment.
- Patient expectations of the "perfect baby" providing implicit encouragement for early induction and discouraging normal vaginal delivery.
- Competing priorities for attention, and "change fatigue" associated with multiple elements of health care reform.
- CMQCC leadership and supporting clinical experts are widely stretched; need for more resources and a more "scalable" QI model.
- Time and energy demands on providers from rapid movement toward increased adoption of electronic health record systems.
- Need for more vocal support from PBGH members and other employers.

- Hospitals’ perceived legal exposure when implementing C-section reduction programs.

Evaluation and Sustainability

Evaluation: There are several positive signs sustaining the project’s gains. The California Health Care Foundation continues its active support of the CMQCC and the Maternity Data Center. The results achieved at the first participating pilot hospital have attracted significant external and internal recognition and its efforts have included a feasibility study for expansion of maternity care innovation into another regional health system.

Sustainability. CMQCC’s receipt of a Merck for Mothers grant will assist with scaling up maternity care QI initiatives in the state, and it has developed a paid mentor system of physician-nurse champions. At a second participating health system, embedding maternity care measures into the EMR will be key to building maternity care improvement into the daily clinical work flow. The two private insurers with blended case rates in place express commitment to continuing the model, and one indicated that the health plan would emphasize hospital P4P and ACO development. The collective energy for improved maternity care seems strong; the movement toward bundled payment or (even) blended case rates seemingly has less momentum. Ultimately, sustainability will depend on positive proof of concept, including demonstration of value to hospitals and payers. Interviewees from the participating payers and provider organizations expressed commitment to the project, while acknowledging that sustainability for the long term is dependent on showing results to those constituencies.

Lessons Learned

California is a particularly difficult environment for implementing bundled payment because of the extensive hospital-physician consolidation in many parts of the state, and the significant penetration of capitated payment. Another challenge has been the fragmented private health insurance market.

Culture (of physicians, nurses, and the community) exerts significant influence. Heightened patient engagement is critical, and well-informed patient advocates have an important role.

Real-time, actionable data at the hospital and individual provider level have proven instrumental in addressing criticism and inertia from skeptics. Physician education regarding the evidence base on birthing and delivery is critical.

Particularly among employers with a large proportion of young employees, reduced costs of birthing and delivery and improved outcomes are a major issue, and that reality has brought them to the table with provider organizations and payers.

The principal factors driving improved maternal and fetal outcomes are the concerted efforts of selected QI organizations, health systems, hospitals, and provider organizations to change care, reduce unnecessary C-sections, and deploy high-quality and actionable data in driving better care. The strong pressure for organized health care purchasers has been a crucial catalyst in motivating these changes, and a much broader engagement of purchasers, health plans, and patients will be required to scale and sustain these improvements. At this juncture, rather than driving the change, the role of value based payment (a la the blended case rates) will be to align the financial incentives with the desired clinical changes.