Maternal care could be the next big healthcare expense targeted with bundled-payment models.

Bundles... of joy?

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Delivering new bundles to control cost of maternal care

By Elizabeth Whitman

Last year, Community Health Choice, a Medicaid managed-care organization, paid for the births of 21,194 babies along the Texas Gulf Coast. For those deliveries, it spent $41.6 million on providers, such as doctors and hospitals; $11.9 million on physicians providing prenatal care; and more than $75 million on babies who ended up in the neonatal intensive-care unit.

With two providers, it also quietly began testing a program aimed at saving money while improving care for pregnant women and newborn babies.

"Houston is still a very fee-for-service kind of territory," said Karen Love, executive vice president and chief operating officer. "We all know that the fee-for-service model really doesn't work. And so our thought was, where do we have the most ability to be an agent for change in our community?"

The model that Community Health Choice decided to test was a bundled-payment system, where providers receive a lump sum for all medical care in an episode instead of being paid per service. The model has gained popularity in Medicare in recent years as the CMS seeks to contain costs while maintaining or raising the quality of healthcare, two areas where maternity care is seen as holding perhaps the greatest potential for improvement. Yet obstetric bundled-payment programs are in their infancy, with only a handful of pilot programs across the U.S. Even advocates of bundled payment for maternity care warn that developing the best model is a complicated process that will require much more time before it can be implemented widely.

"It's absolutely a great potential direction to go in, but it's not easy," said Jill Yegian, senior vice president of programs and policy at Integrated Healthcare Association, an Oakland, Calif.-based organization that works to improve affordability and transparency in healthcare. "The devil is in the details."

Wrangling with those complexities is a task left to individual states, healthcare providers or payers that want to bundle payments for maternity care. They also must take the initiative to develop and implement models on their own, because no existing federal body has the regulatory authority to nudge them into doing so. As a joint federal-state program, Medicaid cannot broadly mandate maternal bundled payments across the country the way Medicare, which covers the elderly and disabled, has done for other medical procedures.

Design is one issue at the heart of the conundrum with bundled payments for maternity care. What should trigger the bundle? Does it begin with prenatal care? With delivery? When should it end, and whom should it include? How should providers—primarily hospitals, but sometimes birth centers—take on financial risk? Some models allow..."
high-risk mothers, such as those who are obese or have AIDS, or high-risk babies; others include only low-risk pregnancies.

“You start with the decision of what you’re doing in a perfect world,” said Dr. John Bulger, chief medical officer for population health at Danville, Pa.-based Geisinger Health System, whose bundled-payment program covers low-risk pregnancies and the mother only. From a payment perspective, low-risk pregnancies are more predictable and homogenous than high-risk ones, Bulger said.

Convincing insurers to take part is another challenge—sometimes an insurmountable one.

When the Pacific Business Group on Health, a San Francisco-based coalition of large employers, was coordinating a pilot program for maternity care, it initially hoped to expand the model from a blended case rate, which covers solely the delivery of a baby, into a full bundle spanning pregnancy to postpartum care.

But it hit a roadblock when health plans and hospitals participating in the pilot were supposed to agree on reimbursement fees. Some of the negotiations broke down entirely, said Brynn Rubinstein, senior manager of the employer group’s Transform Maternity Care program. Now, the blended case rate pilot is in place at three hospitals, but the Pacific Business Group learned hard lessons along the way.

For bundled payments to succeed in maternal care, “it has to come from a larger regulatory push,” Rubinstein said, because one-off contracts between providers and payers proved tedious and unreliable.

Hints of broader government support can be detected. Maternity care featured prominently, as one of three clinical episodes, in a new white paper on designing and implementing episodic payment models, as bundled payments are also called. Voluntary and mandatory bundled payments for Medicare patients are already in place for the other clinical episodes mentioned in the paper.

The paper was produced by the Health Care Payment Learning and Action Network, a federally sponsored collaborative that consists of payers, providers, employers, states, consumer groups and individuals enlisted to help pursue CMS’ goal of tying at least 50% of Medicare fee-for-service payments to value or quality by 2018 and broadly nurture the industry’s transition to value-based payment models.

With maternity care, “episode payment can potentially have a significant impact on both the short- and long-term health of a woman and her baby and on the health of American society,” the paper noted.

Its maternal mortality rate of 1 in 1,800 put it at 33rd out of 179 countries with the U.S. lagging behind all other countries that were top-ranked for education and economic status, according to a report by Save the Children last year. At the same time, U.S. women pay more to have a baby than women anywhere else in the world, according to the International Federation of Health Plans, a global network for health insurance companies.

Medicare coverage is needed by beneficiaries under 65 only when they qualify because of a disability, but maternal care is a huge cost for Medicaid and commercial payers.

Childbirth is the most common reason for hospitalization in the U.S. in 2009, mothers and newborns accounted for 23% of all hospital stays in the U.S. Medicaid paid for 45% of the nation’s births in 2010, and that percentage has surely grown with the significant expansion of Medicaid eligibility under the Affordable Care Act.

The costs of giving birth are significant and vary depending on the payer. On average, in 2013, a cesarean section cost $27,866 with commercial insurance, while vaginal birth cost $18,329. Medicaid pays providers substantially less for births, reimbursing them $13,580 for C-sections and $9,131 for vaginal births, according to the Learning Action Network paper.

The higher price of C-sections, in addition to the convenience of being able to schedule them, creates an incentive for providers to encourage women to opt for C-sections over vaginal birth, said Harold Miller, president of the Center for Health Care Quality and Payment Reform, a policy center. Today, cesarean sections account for nearly one-third of all U.S. births, yet the procedure is generally riskier for mother and child alike.

Bundling payments may help recalibrate maternity care to focus on what’s best for the mother and child, smooth out these imbalances in costs and make prices more predictable, according to the model’s boosters. But they emphasize how much work needs to be done first.

“We don’t know the best approaches,” said Carol Sakala, director of Childbirth Connection Programs at the not-for-profit National Partnership for Women & Families. “It’s a time of great innovation and creativity.”

When the Providence Women’s Clinic in Portland, Ore., began designing its Pregnancy Care Package about four years ago, it drew on elements from other bundled-payment models.

“We didn’t feel like there was any bundle of best practices out there,” said Laura Durham, regional director of perinatal services for Providence Health & Services in Oregon, which the women’s clinic is part of.

The package pulled together two teams—one for each of its two loca-
Legal

Dignity’s transgender bias case could signal more religious freedom clashes

By Harris Meyer

A federal discrimination lawsuit against Dignity Health may foreshadow a legal effort by Catholic providers and other employers to seek religious freedom exemptions from federal requirements to cover transgender-related healthcare services.

So far the San Francisco-based health system is arguing a lawsuit filed by a transgender nurse should be dismissed not on religious grounds but rather by arguing that civil rights law does not require its self-insured employer health plan to cover care related to gender reassignment.

Dignity’s motion filed last month in response to the closely watched suit—one of the first of its kind in the country—says Title VII of the Civil Rights Act does not cover transgender status as a protected classification.

Dignity also argued that HHS’ May rule barring categorical exclusion of coverage for gender transition services did not require it to provide coverage for "sex transformation" treatment for the nurse because the rule does not take effect until Jan. 1, 2017. In addition, the system argued, the new rule doesn’t bar self-insured employer health plans from excluding benefits for services that are not medically necessary and "the medical efficacy of sex transformation surgery remains the subject of debate."

But lawyers for the American Civil Liberties Union who are representing nurse Josef Robinson say both Title VII and the new HHS rule interpreting Section 1557 of the Affordable Care Act clearly require employers and health plans to cover treatment related to gender dysphoria. That’s the name of the condition in which people feel they are not the gender they were assigned at birth.

Legal experts expect more such lawsuits following HHS’ issuance of the anti-bias rule in May.

Lisa deFilippis, an attorney at Jackson Lewis in Cleveland who counsels employers on benefits, predicted that Catholic and other religious groups will turn to the courts seeking a religious freedom exemption from the federal prohibition against discrimination relating to gender reassignment-related care. It will be similar to legal challenges against the ACA mandate to provide coverage for contraception. "I would not be the least surprised to see people waving the Hobby Lobby and Zubik cases, saying this is the same thing and we shouldn’t have to provide these services," she said.

Robinson was assigned the gender of female at birth but identifies as a man. He claims the self-insured health plan operated by Chandler (Ariz.) Regional Medical Center, the Dignity-owned hospital where Robinson works, denied him coverage for double mastectomy and phalloplasty operations, and he had to pay thousands of dollars for the mastectomy and hasn’t been able to afford the phalloplasty.

The Phoenix office of the federal Equal Employment Opportunity Commission found that the denial of coverage relating to gender reassignment by Chandler Regional’s plan was a Title VII violation and granted Robinson a notice of right to sue.

Dignity “is making an argument that’s been rejected over and over and is flatly inconsistent with controlling law in the 9th Circuit,” said Josh Block, a senior staff attorney at the ACLU’s LGBT Project in New York City.

The lead attorney for Dignity, Barry Landsberg, of Manatt Phelps & Phillips