The Financing of Pregnancy and Newborn Care

OVERVIEW OF ALL PUBLIC, PRIVATE INSURANCE AND OTHER PAYMENTS FOR CARE PROVIDED TO U.S. MOTHERS AND BABIES

Disclosure

- Steve Calvin MD is a SACIM member who specializes in maternal-fetal medicine. He is the owner of the Minnesota Birth Center, a primary midwifery practice providing care in two accredited freestanding birth centers as well as in collaborating hospitals. He developed the BirthBundle®, an episode payment model covering comprehensive pregnancy and newborn services.

The Problem

- Despite being the world leader in development of life-saving pregnancy and newborn interventions, the U.S. spends more than any other country for maternal and neonatal outcomes that consistently lag those of other developed nations, AND that demonstrate persistent disparities based on race and geography.

Source of Payment for Delivery

National Vital Statistics Reports, March 2021

Medicaid

Total 42.1%

White 29.4%

Black 65.1%

Hispanic 59%

*Since Medicaid covers 2/3 of births to Black mothers, Medicaid reform is crucial to addressing outcome disparities.

Private Insurance

Total 50.2%

White 63.8%

Black 29.3%

Hispanic 30.5%

Self-pay/other

Total 7.7%

White 6.8%

Black 5.7%

Hispanic 10.5%

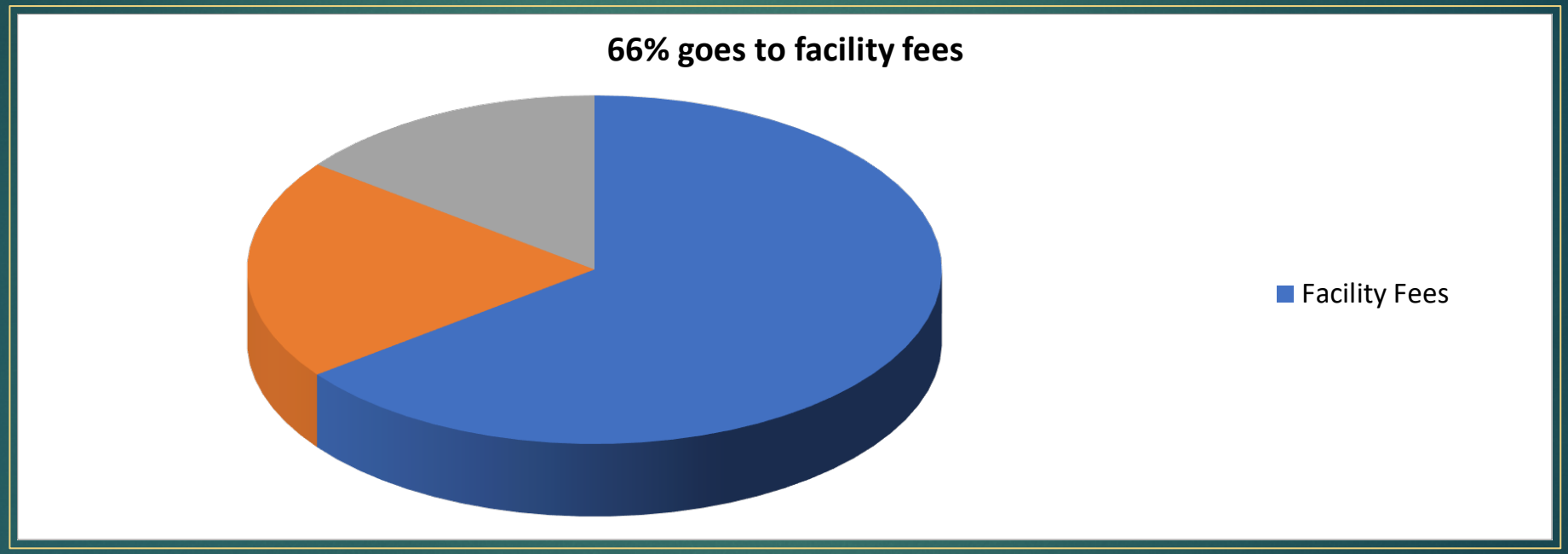
US Spending by Payer and Condition 1996-2016 JAMA 2020

- $143B was spent in 2016 on eight pregnancy related conditions that are among the one hundred most expensive analyzed
- #12 Pregnancy and postpartum care ($71.3B)
- #34 Preterm birth complications ($28.2B)
- #41 Well Infant ($17.4B)
- #57 Indirect maternal complications ($5.8B)
- #80 Hypertensive disorders of pregnancy ($5.8B)
- #82 Other maternal disorders ($5B)
- #98 Neonatal encephalopathy ($2.4B)
- #99 Other neonatal disorders ($2.2B)

Key Payment Insights

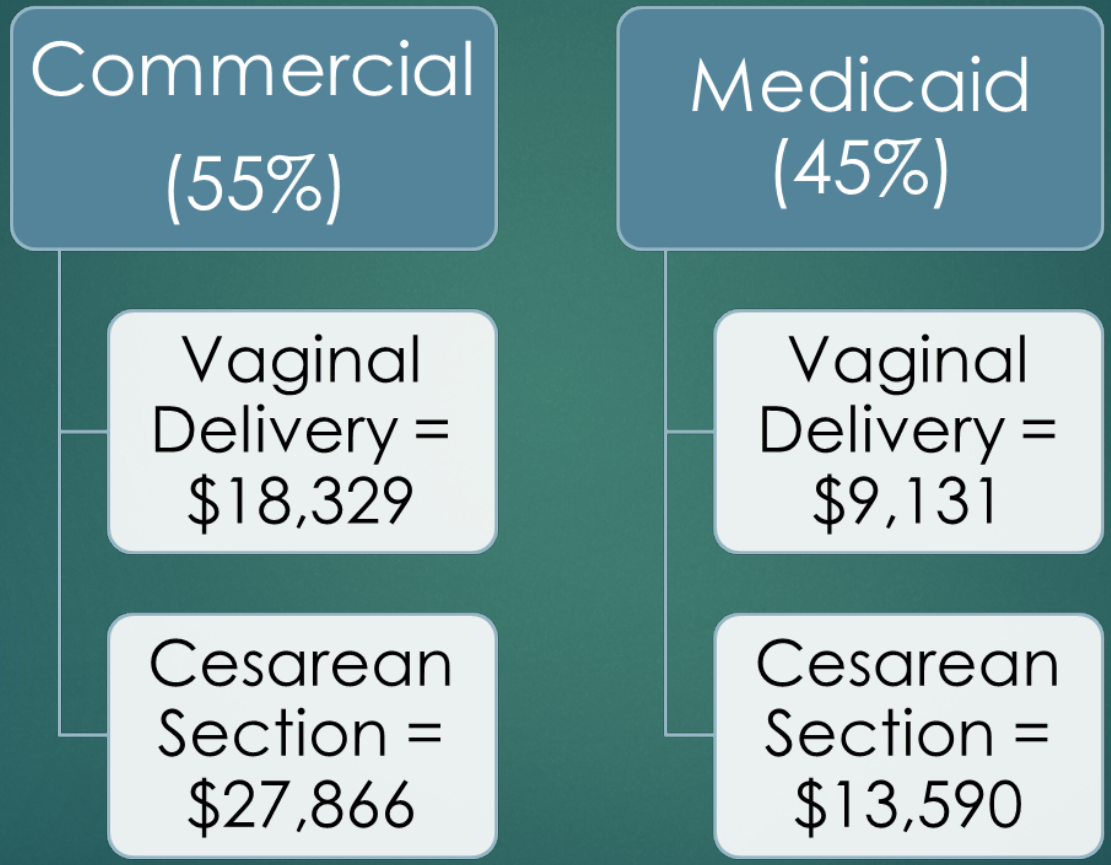
- 42% of all US births are paid for by Medicaid but 70% of all spending for pregnancy and newborn care is made by private insurance and out of pocket payments.
- There is significant private subsidization of public program pregnancy care

THE PREGNANCY CARE PIE (2013)[1]



1) The Truven Study commissioned by Childbirth Connection, Catalyst for Payment Reform, and the Center for Health Care Quality and Payment Reform, available at transform.childbirthconnection.org/reports/cost

THE COST OF HAVING A BABY IN THE US (2013)[1]



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The Medicaid Maternity Money Flow

Federal

Operating under federal guidelines beginning in 1965

Federal payments provide around 50% of Medicaid funding

State

Major expense in most states

50+ variations in Medicaid eligibility and implementation

Eligibility range is from 138% to 326% of federal poverty level

Accelerating transition from direct fee for service payments to contracting with managed care organizations (MCOs)

Medicaid MCOs

Currently provide 69% of Medicaid care nationally

Six Fortune 500 companies have almost 50% of the MCO market

All states make general capitated monthly payments to MCOs

Some states make monthly payments to the MCOs for the specific care of mothers and newborns until 1 year of age.

MACPAC: Value-Based Payment for Maternity Care in Medicaid 9/21

Episodes of Care

Focused on cost reduction with few quality measures

Retrospective payment with attribution to delivering provider

Focus on professional services and not on the major expense of facilities

Pay for Performance

Incentives to meet limited quality measures but not on cost goals

C/S rates are included but a major focus is on completion of risk and health screenings

Medical Homes

Focus on addressing clinical, behavioral and social aspects of care

Payment support for patient engagement, community supports and population health

The Solution – High Value Perinatal Care Requires:

Transparency

Detailed reporting of public program pregnancy and newborn care payment information.

Accountability

Regular detailed public reporting of perinatal outcomes and patient satisfaction scores.

Requiring financial and outcome data for MCO contract bidding and provider participation.

Innovation

Implement clinical models proven by CMMI (Strong Start)

Provide culturally competent patient-focused care by provider teams and facilities paid for value, not volume.

Transition to prospective comprehensive episode payments.

The Healthcare Confusopoly

"…the healthcare topic is confusing because that's how you keep margins high. If Congress or the public ever started to understand healthcare, we would know which buttons to push to lower the profit margins in the industry. But by keeping things complicated, no one can explain to anyone else what needs to be done for the public good."

Scott Adams – creator of the Dilbert Cartoon