Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Reimbursement for Births Performed at Birth Centers

October 15, 2016

As required by Second Engrossed Substitute House Bill 2376, Chapter 36, Laws of 2016, 1st Special Session, Partial Veto, Section 213 (1)(qq)

Reimbursement for Births Performed at Birth Centers

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Executive Summary

Second Engrossed Substitute House Bill (2ESHB)2376, Section 213 (1) (qq), directs the Health Care Authority (HCA) to review reimbursement methods and rates for births performed at birth centers and report on recommendations for (1) adjusting reimbursement methods and levels, (2) improving access to care, (3) improving cesarean section (C-section) rates, and (4) savings options for utilizing birth centers. This one-time report, Reimbursement for Births Performed at Birth Centers, utilizes Medicaid claims, Medicaid encounters and birth certificate data to identify utilization trends, access barriers, C-section outcomes, and opportunities for potential cost savings and return on investment through increased deliveries at birth centers.

Birth center deliveries account for a small proportion (1.1%) of Medicaid covered births. Given that Medicaid pays for over half the births in Washington, there is likely an opportunity for greater utilization of this care setting. However, clients' access to birth centers is currently limited by the absence of Medicaid-approved birth centers, along with other factors.

Washington State has made notable strides in improving maternity care over the last several years through a variety of policy and quality improvement efforts. Further advancement of activities that leverage existing work may include: additional implementation of Robert Bree Collaborative Obstetrics Care report recommendations, expansion of the *Obstetrics Clinical Outcomes Assessment Program*, implementation of the *Safe Delivery Patient Assessment,* and broadening the reach of the existing hospital delivery statistics reporting.

After reviewing the current Medicaid rate schedule for birth centers, HCA recommends adjusting the birth center reimbursement method for Medicaid by increasing the birth center facility fee to $1,742. Under fee-for-service, the increase may be financially offset if 22 deliveries move from a hospital location to a birth center setting each fiscal year.

Many factors may contribute to a client's chosen birth setting, including the proximity of birth centers, provider outreach, social and demographic trends, and the client's personal preference. The cost impact of adjusting the reimbursement method will depend, in part, on the volume of clients that move from hospitals to birth centers. Improved access to birth centers and heightened awareness of their availability among Medicaid clients may further clients' ability to give birth within such centers, should they prefer to deliver in this setting. In addition to the existing hospital-based option, birth centers offer a high-value alternative for maternity services.

Background

Second Engrossed Substitute House Bill (2ESHB) 2376, Section 213, (1) (qq) states:

> *To further the goals of better care, better health outcomes, and reduced per capita costs of health care, the authority shall review its reimbursement methods and rates for births performed at birth centers. The authority shall report to the governor and appropriate committees of the legislature by October 15, 2016, with recommendations for adjusting reimbursement methods and levels, improving access to care, improving the cesarean section rate, and savings options for utilizing birth centers as an alternative to hospitals.*

The American Association of Birth Centers describes a birth center as a "homelike facility existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth. Birth centers provide family-centered care for healthy women before, during, and after normal pregnancy, labor, and birth." The American College of Obstetricians and Gynecologists (ACOG 2015) used the same definition for birth centers in their consensus paper on maternal care. The ACOG consensus paper offered the following guidance: Birth centers provide "peripartum[1] care to low-risk women with uncomplicated singleton term pregnancies with a vertex presentation[2] who are anticipating an uncomplicated birth. Cesarean delivery and operative vaginal delivery are not offered at birth centers." In the same consensus paper, ACOG recognized birth centers for the first time as appropriate birth settings for low risk women.

Birth centers have played an official role in the Washington State maternity care system since 1986 when Washington State began licensing birth centers. State statute defines a birth center as any health facility, not part of a hospital or in a hospital, that provides facilities and clinical staff to support a birth service to low risk maternity clients (RCW 18.46). The state Medicaid agency initiated reimbursement for delivery services provided at birth centers the following year.

The Affordable Care Act (ACA 2010) requires that states provide Medicaid reimbursement for birth center facilities and for birth attendants' professional fees. This section of the ACA added freestanding birth center services and the professional services of birth attendants in birth centers as a new category of "medical assistance" under section 1905(a) of the Act. Freestanding birth center services are identified as one of the services mandated by section 1902(a)(10)(A) for Medicaid-enrolled pregnant women.

Birth centers play a small, but expanding, role in the deliveries of Medicaid populations. Within the existing framework of the maternity care system in Washington, this report will explore the potential role of birth centers related to access and value for Medicaid clients.

[1] The period shortly before, during and immediately after birth.

[2] Head-first position of fetus.

National and State Trends

In the United States, a small but growing number of births are occurring outside of hospitals. In 2012, 1.36% of U.S. babies were born outside a hospital, up from 0.87% in 2004. Two-thirds (66%) of these births occurred at home and another 29% occurred in freestanding birth centers. During that time period, Washington was one of only six states in which more than 3% of births occurred outside a hospital. In contrast, the percentage of out-of-hospital births was less than 1% for southeastern states from Louisiana to Georgia, as well as for a few other states throughout the country (MacDorman 2014).

Washington State has demonstrated similar patterns to the U.S., with increasing numbers and proportions of out-of-hospital births in recent years. In Washington State, the proportion of births within a birth center increased from 0.9% in 2003 to 1.3% in 2013, representing a 44% increase over that time period. In 2014, 1,195 births in Washington State occurred in birth centers, representing 40% of all out-of-hospital births (Washington Department of Health). In State Fiscal Year (SFY) 2015, 1,241 deliveries occurred at fifteen birth centers across the state. The proportion of total birth center deliveries to Medicaid women was 39% overall, in comparison to Medicaid representing 51% of all Washington births. The percentage of Medicaid clients delivering at individual birth centers ranged from 24% to 65%. (For more information, see Appendix A.)

Addressing Access to Care

Access to comprehensive, quality health care services is important for the achievement of health equity. This report focuses on Medicaid clients' access to birth centers and their use of birth centers to meet their maternity health care needs. Factors this report will address regarding access include the presence or absence of resources within a given geographic area and trends in utilization of birth centers.

Over the past thirty years, Washington state laws, regulations, and policies, along with collaboration between midwives and physicians, have fostered a maternity care system that includes diverse birth settings (Cawthon 2013). While births at home and in birth centers accounted for just 2% and 1.4%, respectively, of total births in Washington State in 2014, the numbers and percentages of out-of-hospital births in Washington are rising.

For women with low-risk pregnancies, the birth center model of midwifery care can be a high-quality care option that often has lower costs than hospital births. Birth center care is characterized as providing substantial education and psychosocial support along with low rates of medical intervention. The birth center model of care is increasing in popularity in the U.S., and is associated with higher rates of spontaneous vaginal birth and lower rates of assisted vaginal and cesarean birth when compared to hospital care. Outcome data from more than 84,000 women demonstrate that birth centers are a safe model of care for low-risk women when associated with a health system that can provide higher level care as needed (Alliman and Phillippi 2016).

Medicaid covers births in all settings (hospital, birth center, and home) and with all licensed providers who have birth attendance in their scope of practice. Currently, Medicaid clients are offered Maternity Support Services (First Steps). Both birth center and midwife-attended-birth are identified as available options for all appropriate candidates on Medicaid. Medicaid clients are made aware of their options for birth setting and birth attendant choice through the HCA website, as well as brochures and booklets that explain coverage of services for pregnant women. Most Medicaid clients are enrolled in managed care plans which are required to offer the same coverage and choice of provider as fee-for-service coverage. Medicaid clients may choose their health care provider for women's health services, including pregnancy care.

Washington state law limits access to birth centers, based on medical criteria, to a specific population of pregnant women. Only women who meet certain "low-risk" criteria are candidates for delivery at birth centers. Washington State Medicaid does not cover planned home births or births in birth centers for women with certain health conditions, such as previous cesarean section; current alcohol or drug addiction or abuse; serious disease or illness; multiple gestation; breech presentation in labor with delivery not imminent; or other significant deviations from normal as assessed by the provider (WAC 182-533-0600).

As noted previously, Medicaid clients give birth less often in birth centers than the general state population. This report identifies several potential factors that may contribute to this difference.

One reason that Medicaid-enrolled women do not choose birth centers more often may be lack of access to a birth center within a reasonable distance from their homes. Currently only nineteen birth centers have contracted with Medicaid. (See Appendix C for a list of Medicaid-certified birth centers.) 28 out of 39 counties do not have a Medicaid-approved birth center, including several with relatively large populations such as Clark, Yakima, Benton, and Cowlitz counties. Lengthy travel distances are a critical factor affecting women's access to care at birth centers, since a long drive is prohibitive when a delivery is imminent.

Existing reimbursement policies may be another factor, limiting the number of birth centers that accept Medicaid clients and consequently affecting women's access to care at birth centers. The Department of Health and Human Services initiative, *Strong Start for Mothers and Newborns*, aims to improve maternal and infant outcomes for pregnancies covered by Medicaid and the Children's Health Insurance Program (CHIP). The program evaluation for years one and two notes that certain reimbursement policies create potential barriers and limit birth centers' ability to participate in the Medicaid program (Hill et al. 2014), including:

- Inadequate Medicaid reimbursement for birth centers.
  Key informants reported that Medicaid reimbursement often does not adequately cover the cost of birth center care and may impact birth centers' willingness to care for a greater proportion of Medicaid enrollees.

- Contracting with Medicaid managed care organizations (MCOs).
  Contracting with managed care organizations adds significant administrative burdens.

- Lengthy Medicaid application processing times.

According to representatives of the Midwives Association of Washington State, financial costs are a significant barrier that affects birth centers' ability to serve Medicaid clients. Potentially, this may influence the number of Medicaid clients who are able to seek care in a birth center setting. "The expenses of running a facility are heavily subsidized by private insurance payments" (Sasson and Levin, personal communication, 2016). A review of reimbursement policies, along with recommendations for potential changes to these policies, is included later in this report.

Another possible barrier is that women may not be aware that a birth center delivery is an option for them. This barrier could be addressed through a coordinated outreach campaign by Medicaid managed care organizations and associated stakeholders to further advertise this service to appropriate candidates during the beginning of pregnancy. Materials developed to highlight birth centers as a setting of care should adhere to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

Access may also be improved by ensuring that all licensed birth centers that are contracted with HCA are also contracted with the MCOs that cover the vast majority of Medicaid births. Encouraging MCOs to provide equitable contracts to licensed midwives and birth centers may lead to more birth centers contracting with them.

It is worth noting that two new birth centers are awaiting licensure from the Department of Health (DOH). This demonstrates that, within certain communities, there is a perceived demand for birth center care in the current health care environment. There are many factors that contribute to what type of provider (physician or midwife) a woman sees during her pregnancy and where she chooses to deliver (home, birth center, or hospital). For women with coverage through Medicaid, cost should not be a concern since they may choose any of these options without out-of-pocket expenses.

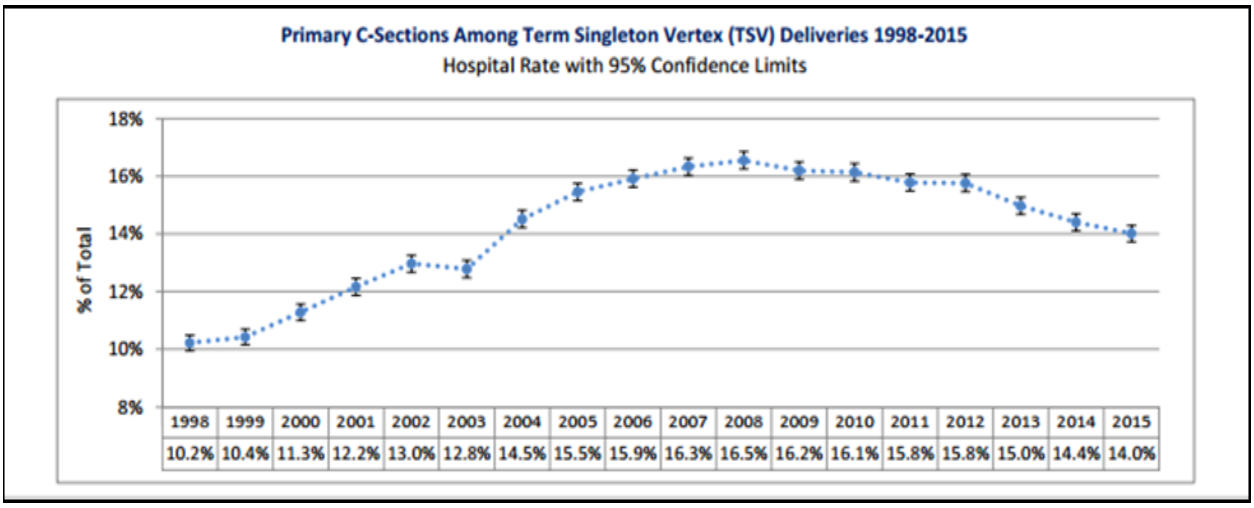
All Medicaid clients should be able to access the birth setting and provider of their choice. Although access, medical criteria and personal preference may limit the increased utilization of birth centers, birth centers should be recognized as a high-value option for maternity care and delivery alongside the existing hospital-based system.

Improving the Cesarean Section Rate

Cesarean delivery (C-section) is now the most common operation in the United States, with rates increasing dramatically since 1970. While cesarean delivery may be life-saving for mothers and their newborns in certain emergencies, the overall surge in C-section rates in the past forty years has not led to significant improvements in neonatal morbidity or maternal health (Blanchette 2011).

Rising cesarean delivery rates in the U.S. are the result of changes in the practice environment, including the widespread use of electronic fetal monitoring, the decrease in both vaginal breech deliveries and operative vaginal deliveries, and reduced availability of vaginal birth after cesarean (VBAC) (ACOG 2010). Other studies have attributed much of the increase in cesarean deliveries over the past twenty years to an increase in elective inductions (2009; Martin et al. 2015). Strategies to reduce unnecessary cesarean delivery include changes in labor management and hospital-based interventions that target physician or maternal behavior (Spong et al. 2012).

Results Washington's Healthy and Safe Communities includes a measure that addresses rates of cesarean delivery—decreasing the Primary Term Single Vertex (TSV) Cesarean section rate. The baseline rate for the Results Washington measure was 15.4% (SFY 2013).The target for 2016 was 14.7%; it was exceeded in 2014, when a rate of 14.4% was achieved.



Source: Cawthon, L. Delivery Statistics Report Washington State Non-Military Hospitals, Department of Social and Health Services Research and Data Analysis Division.

The Primary C-section rate in Washington peaked in 2008 with a rate of 16.5% and has decreased steadily since then, with the largest decreases in 2013-2014. Since 2014, the rate of decline appears to have slowed. Comparing Cesarean rates for low risk women in 2009 and 2015, Washington was among 18 states with declines in the range of 10%–19% (Hamilton et al. 2016).

A large body of evidence shows that substantial variation in cesarean section rates exists across the country, as well as within Washington State. Unexplained variation may indicate lack of adherence to evidence-based standards and result in poorer health outcomes for both mothers and babies. Significant effort has been made over the last several years to reduce the cesarean section rate in Washington. Appendix D outlines the state's maternity care quality improvement activities.

Studies indicate that birth centers may have a role to play in reducing the C-section rate. Nationally, the C-section rate for low-risk women who chose to give birth at a birth center was 6%—compared to the overall C-section rate of 27% for low-risk women (Stapleton et al. 2013; Osterman and Martin 2014). Additionally, evidence demonstrates that midwives are less likely than obstetricians

to use procedural interventions that may have higher risks when performed without definitive medical necessity (Yang et al. 2016). Midwife-led delivery care has shown reductions in the use of epidurals, with fewer episiotomies or instrumented births (Sandall et al. 2013). The birth center model of care is well-aligned with noted evidence-based practices such as continuous labor support and alternatives to pharmacologic pain management during labor (King et al. 2013).

Reimbursement Review

There are two portions of the reimbursement for Medicaid deliveries, one to the professional and one to the facility. The birth attendant (midwife or physician) at a birth center is currently reimbursed at 100% of the professional fee rate. The facility fee includes all room charges for the client and baby, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, newborn hearing screens, lab charges, ultrasounds, other x-rays, blood draws, or injections, which may be billed separately. This review will not address the newborn facility fee, which is currently not paid in a birth center setting.

The reimbursement rate for the facility fee is based on a percentage of the professional payment rate for procedure code 59409 (obstetrical care – delivery only). The reimbursement rate for 59409 is based on relative value units (RVUs) and the maternity conversion factor. The current facility fee is $605.

HCA recently sent a survey to other Medicaid states requesting their facility fee rates for birth centers. Four states responded to the survey. Florida pays a facility fee of $842.88 and Minnesota pays a facility fee of $2,138. Vermont responded that they do not have birth centers outside of hospitals and Missouri does not pay a facility fee to birth centers.

According to a Kaiser Foundation Medicaid data report, many states reported paying for birth centers using a variety of reimbursement methodologies. California, Connecticut, Florida, Georgia, Iowa, and several other states use a global payment rate or fee-for-service methodology. Alaska, Kentucky, North Carolina, Texas, and South Carolina pay based on a percentage of the professional physician rate and/or hospital reimbursement rate for vaginal delivery without complications. (Kaiser Family Foundation 2012).

HCA has identified two options for adjusting reimbursement methods for birth centers.

Option #1 for adjusting reimbursement method:

- Pay 100% of the professional payment rate for procedure code 59409. This option would increase reimbursement rates by $164 from $605 to $769. According to a Kaiser Foundation Medicaid data report, three states reported paying birth centers based on a percentage of the professional physician rate (Kaiser Family Foundation 2012).

Cost Impact: In SFY 2015, there were 58 fee-for-service (FFS) births in a birth center. (See Appendix B for details.) At the current rate of $605, total facility fees paid under FFS would be $35,090. If Washington Medicaid paid birth centers at 100% of 59409 at $769, total facility fees would be $44,602. This would increase expenditures by $9,512 for the FFS population per fiscal year. For Medicaid MCOs, there were 430 births in a birth center. If we assume that MCOs use our current reimbursement rate for birth centers, total facility fees would be $260,150. Under the option of paying $769, total facility fees would be $330,670. This would increase expenditures by $70,520 for the MCO population per fiscal year.

Option #2 for adjusting reimbursement method:

- Pay 90% of the average FFS hospital delivery facility cost for a vaginal birth. Currently, we are assuming a cost of $1,936 for the facility component for a non-complicated delivery with a one day inpatient hospital stay. If Washington Medicaid were to pay birth centers a facility fee at 90% of the hospital facility rate, the new rate would be $1,742. That is an increase of $1,137 from the current rate and would exceed the rate for the actual delivery professional fee (procedure 59409). Based on a Kaiser Medicaid data report, three states reported paying birth centers based on a percentage of the hospital reimbursement rate for vaginal delivery (Kaiser Family Foundation 2012).

Cost Impact: If the FFS facility fee was increased to $1,742, based on 90% of the average hospital facility rate, total facility fees would be $101,059 for 58 FFS births. Under this new reimbursement method, it would increase expenditures by $65,969 for the FFS population per fiscal year. If we assume that MCOs would pay the same rate, total facility fees would be $749,232 based on 430 births. Under this new reimbursement method, expenditures for MCOs would increase by $489,082 per fiscal year. The MCOs typically benchmark their reimbursement rates against the fee-for-service rate schedule, therefore it is assumed any change in rate will also be applicable to birth center deliveries paid for by the MCO. However, there is no contractual requirement that MCOs do so.

Savings Options for Utilizing Birth Centers

The proportion of Medicaid births currently performed at birth centers is small compared to total Medicaid deliveries (486 out of 42,503 births). However, using either of the options described above to increase birth center reimbursement rates may open up opportunities for increasing use of birth centers by low-risk Medicaid clients. Ultimately, the increased reimbursement rates may be offset by potential savings realized if more Medicaid clients choose to deliver in birth centers rather than hospital settings.

- Under option #1, for FFS, the estimated added cost for the fee increase of $9,512 could be offset if three additional women covered by Medicaid FFS gave birth in birth centers instead of hospitals each fiscal year.

- Under option #2, for FFS, the estimated added cost for the fee increase of $65,969 could be offset if 22 additional women covered by Medicaid FFS gave birth in birth centers instead of hospitals each fiscal year.

- For managed care, if the birth center facility fee is increased to either $769 (option #1) or $1,742 (option #2), then those fees will remain below that of an uncomplicated inpatient hospital delivery. We are assuming a cost of $1,936 for the facility component for a non-complicated delivery with a one day inpatient hospital stay.

This financial analysis compares a birth center delivery to an uncomplicated vaginal birth in a hospital setting. Savings are assumed if increased access—achieved as more birth centers find it financially worthwhile to serve Medicaid clients—results in more Medicaid-enrolled women choosing to deliver at birth centers instead of hospitals. However, it is not certain if simply increasing the facility fee paid would, by itself, increase the number of Medicaid deliveries within a birth center setting. Many additional factors may play a role, including the geography of birth center locations noted in this report, social and demographic trends, provider outreach, and clients' personal preferences. As noted, the cost savings impact will depend on the volume of clients that move from hospitals to birth centers. Although deliveries in birth centers have been on the rise, there is no guarantee this trend will continue. Also, it is not clear if women are currently being turned away from birth centers due to low Medicaid reimbursement. Currently, there is no available data to confirm if this occurs or any estimates on how many women might move from a hospital to a birth center setting if facility fees are increased.

Recommendation

HCA supports option #2, increasing the birth center facility fee to $1,742. As noted throughout this report, birth centers have been shown to provide high-value maternity care. The birth center facility fee, even with this proposed increase, would remain below that of an uncomplicated inpatient hospital delivery. As previously identified, the estimated added cost for this fee increase could be offset if 22 additional women covered by Medicaid FFS gave birth in birth centers instead of hospitals.

This recommended rate is comparable to the typical Medicaid birth center reimbursement, falling within the mid-ranges of that paid by several other states. Washington Medicaid currently pays $605 for a birth center facility fee, which is $99 less than the fee the program paid in 1999. Low rates have been identified as a significant barrier which affects birth centers' ability to serve Medicaid clients. Increasing the reimbursement level for Medicaid women, who comprise 51% of the (non-military) births in the state, would help ensure access to birth centers for low-risk women. Along with the quality improvement activities outlined in Appendix D, maintaining birth center access helps to ensure a robust and comprehensive maternity care system for our state.

Conclusion

The birth center model of care serves a small but growing number of clients in Washington State. While not all women are appropriate candidates, there may be particular benefits for low-risk women who give birth in this setting. Although Medicaid coverage includes birth centers as a delivery setting, barriers exists that limit access. Geographic proximity, specifically a lack of birth centers in the majority of counties, may hinder Medicaid clients' ability to choose this birth setting.

Improved maternity care in Washington State over the last several years may be attributed to a variety of policy and quality improvement efforts. New activities could leverage the work that has been done, such as implementation of Bree Collaborative recommendations, expansion of *Obstetrics Clinical Outcomes Assessment Program*, implementation of the *Safe Delivery Patient Assessment* and broadening the reach of the existing hospital delivery statistics reporting.

For this report, HCA reviewed the current birth center rates and proposes increasing the facility reimbursement for birth centers to $1,742. Any increase in facility fees should likely be accompanied by efforts to heighten awareness of the birth center option for appropriate candidates. All Medicaid clients deserve to experience delivery and birth in the setting of their choice. Improved geographic distribution of birth centers who accept Medicaid and heighted awareness of their availability among Medicaid clients may further clients' ability to make informed decisions regarding the setting they prefer.

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Appendix A: Birth Center Births (2010-2015)

Birth Center Births SFY2010-SFY2015

	SFY 2010		SFY 2011		SFY 2012		SFY 2013		SFY 2014		SFY 2015	
Facility	Total Births (N)	Percent with Medicaid-Paid Maternity Care (%)	Total Births (N)	Percent with Medicaid-Paid Maternity Care (%)	Total Births (N)	Percent with Medicaid-Paid Maternity Care (%)	Total Births (N)	Percent with Medicaid-Paid Maternity Care (%)	Total Births (N)	Percent with Medicaid-Paid Maternity Care (%)	Total Births (N)	Percent with Medicaid-Paid Maternity Care (%)
A	97	49.5%	124	43.5%	101	38.6%	129	38.0%	106	48.1%	73	47.9%
B	0	--	0	--	0	--	4	25.0%	1	0.0%	66	40.9%
C	49	40.8%	61	45.9%	89	37.1%	78	48.7%	88	33.0%	113	45.1%
D	0	--	1	0.0%	3	66.7%	12	58.3%	20	20.0%	49	28.6%
E	62	17.7%	77	24.7%	80	26.3%	78	19.2%	88	14.8%	77	35.1%
F	16	81.3%	16	75.0%	29	72.4%	21	61.9%	24	62.5%	23	65.2%
G	112	32.1%	140	44.3%	130	40.8%	152	37.5%	124	23.4%	123	41.5%
H	19	31.6%	8	12.5%	14	50.0%	12	8.3%	2	0.0%	0	--
I	0	--	22	59.1%	52	44.2%	62	37.1%	66	39.4%	78	35.9%
J	196	13.3%	182	22.0%	210	16.7%	204	16.2%	215	18.1%	228	23.7%
K	0	--	0	--	0	--	0	--	0	--	20	45.0%
L	23	13.0%	30	16.7%	27	25.9%	40	17.5%	36	36.1%	42	31.0%
M	19	26.3%	13	15.4%	6	16.7%	13	15.4%	12	33.3%	2	100.0%
N	38	60.5%	42	83.3%	64	51.6%	59	49.2%	76	68.4%	90	62.2%
O	18	61.1%	68	42.6%	65	35.4%	75	40.0%	88	44.3%	96	38.5%
P	109	26.6%	126	28.6%	112	26.8%	129	25.6%	126	28.6%	121	42.1%
Q	25	36.0%	46	43.5%	39	48.7%	46	58.7%	39	56.4%	40	40.0%
Total	**783**	**30.7%**	**956**	**37.2%**	**1021**	**34.0%**	**1114**	**32.8%**	**1111**	**33.5%**	**1241**	**39.2%**

Based on birth place and facility code on birth certificate.

Does not include delivery records with birth facility code whose value is the midwife's name or the name of a midwifery group.

DSHS Research and Data Analysis

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Appendix B: Birth Center Facility Fees

Birth Center Facility Fees	FY12		FY13		FY14		FY15	
Total Reimbursements								
FFS								
59409 -SU or -59	$39,811		$30,667		$27,491		$28,559	
Managed Care (shadow pricing)								
59409 -SU or -59	$206,667		$206,914		$224,953		$313,490	
S4005	$1,100		$2,108		$1,833		$2,933	
Managed Care (actual amount paid)								
59409 -SU or -59	$164,229		$166,006		$193,689		$263,609	
S4005	$1,100		$2,108		$1,833		$2,933	
Birth Center Facility Fees								
Average Reimbursement per Birth		N		N		N		N
FFS								
59409 -SU or -59	$594	67	$568	54	$491	56	$492	58
Managed Care (shadow pricing)								
59409 -SU or -59	$763	271	$744	278	$678	332	$712	440
S4005	$367	3	$351	6	$367	5	$367	8
Managed Care (actual amount paid)								
59409 -SU or -59	$615	267	$617	269	$600	323	$613	430
S4005	$367	3	$351	6	$367	5	$367	8
Total Delivery Reimbursement Paid by HCA								
Average Per Birth								
FFS (DRG/facility fee + professional fees)					$1,178			
Managed Care (DCR)					$5,961			

Notes: 59409 with modifier -SU or -59 is the facility fee paid to birth centers, including all room charges, equipment, supplies, anesthesia administration, and pain meds. S4005 is the interim labor facility fee paid when the client labors in the birth center and then transfers to a hospital for delivery. Fee-For-Service reimbursements represent the amounts HCA paid to providers. Managed care reimbursements (shadow pricing) represent an estimate of the amounts managed care plans paid to their contracted providers, outside of capitation. Managed care reimbursements (actual amount paid) represent the actual amounts managed care plans reported that they paid to their contracted providers, outside of capitation. DCR is the Delivery Case Rate paid by HCA to managed care plans and includes all costs related to pregnancy and birth, not limited the delivery costs.

DSHS Research and Data Analysis
2/3/16

Appendix C: Medicaid Approved Birth Centers

	Medicaid Approved Birth Center	County	Location
1.	Bellingham Birthing Center	Whatcom	Bellingham, WA
2.	Birthing Inn	Pierce	Tacoma, WA
3.	Birthright LLC	Spokane	Spokane, WA
4.	Birthroot Midwives & Birthing Center	Whatcom	Bellingham, WA
5.	Cascade Birth Center	Snohomish	Everett, WA
6.	Center for Birth LLC	King	Seattle, WA
7.	Eastside Birth Center	King	Bellevue, WA
8.	Greenbank Women's Clinic and Childbirth Center	Island	Greenbank, WA
9.	Lakeside Birth Center	Pierce	Sumner, WA
10.	Midwife Seattle	King	Seattle, WA
11.	Mount Vernon Birth Center	Skagit	Mount Vernon, WA
12.	Puget Sound Birth Center	King	Kirkland, WA
13.	Salmonberry Community Birthing Center	Kitsap	Poulsbo, WA
14.	Seattle Birth Center	King	Seattle, WA
15.	Seattle Home Maternity Services and Childbirth Center	King	Seattle, WA
16.	South Sound Midwifery	Pierce	Tacoma, WA
17.	Sprout Birthing Center	Snohomish	Mountlake Terrace, WA
18.	The Birth House	Thurston	Olympia, WA
19.	Wenatchee Midwife and Childbirth Center	Chelan	Wenatchee, WA

Appendix D: Washington State Maternity Care Quality Improvement Activities

In Washington State, quality improvement activities related to cesarean delivery began as early as 2008, with the recognition of unexplained geographic variation in Cesarean rates across the state (Starzyk and Campo, 2008). Improvement efforts have grown through the work of a broad array of public and private stakeholder groups.

In 2009, HCA implemented payment reform to align financial incentives by paying hospitals the same amount for an uncomplicated C-section as for a complicated vaginal birth. By 2010, a state perinatal collaborative (initially known as the Cesarean Section Workgroup) had been formed, strategies to reduce elective deliveries at one Washington hospital had been identified and published, and early elective deliveries had been selected as one of five Medicaid quality measures as part of the Safety Net Assessment (HB 2956). The first measurement year for the Early Elective Deliveries Medicaid quality incentive was 2011. The quality measures were subsequently expanded to include appropriate documentation for induction of labor in 2013. C-section rates and a more refined measure related to labor induction were added the following year.

In addition, the Washington State Perinatal Advisory Committee, the Department of Health, the Department of Social and Health Services, HCA, and the Robert Bree Collaborative are monitoring obstetric outcomes. Hospital-level reports of NTSV (nulliparous, full term, singleton, vertex presentation) C-section rates have been distributed to hospitals with obstetric services across the state, and hospital-level reports have been posted publicly on the HCA website since 2011. These feedback reports provided a foundation for current efforts to optimize C-section rates in Washington State. Leveraging this existing work by expanding provider and public distribution would likely enhance the use and benefits of the report.

At the same time, maternity care providers, policy makers, state agencies, and other organizations in Washington strive to improve the care and outcomes for the state's pregnant women, newborns, and infants. Since 2011, the Washington State Hospital Association, Washington State Perinatal Collaborative, and the HCA have focused on reducing unsupported variation in the primary C-section rate in low risk women. The collaborative effort, Safe Deliveries Roadmap, emphasizes best practice recommendations bundled for pre-pregnancy care, pregnancy care, labor management, and postpartum care. As these efforts move forward, the focus is turning toward prevention to bring the best results for mothers and babies. Consistent with the Healthier Washington Medicaid Transformation Waiver recommendation to reduce avoidable poor pregnancy outcomes and improve maternal and child health, completing a first prenatal patient visit assessment may help early risk factor identification and mitigation. Additional resources for the implementation of the *Safe Delivery Patient Assessment* would strengthen and build on these existing efforts.

The Robert Bree Collaborative chose to address maternity care and childbirth as their first topic in September 2011 due to the high variation in care identified. To improve obstetric care, the report recommended: greater collection, reporting, use of, and transparency of data; improved patient and provider education; and new models of payment (Bree 2012). There has been progress in implementing the Bree-identified recommendations, focused on aligning incentives, education, and coordination across existing programs. Additional efforts could more fully incorporate those recommendations into the provider community throughout the state.

In 2013, at the behest of the Legislature, the Improving Maternal & Neonatal Outcomes toolkit was developed in a collaborative effort by HCA, the Optimizing Birth Outcomes Workgroup, and the Center for Evidence-based Policy at Oregon Health & Science University.

The Toolkit aims to make maternal and infant care more evidence-based, transparent, consistent, and measured to reduce variation in care across Washington State (King et al. 2013).

Obstetrics Clinical Outcomes Assessment Program (OB COAP), midwives, physicians and hospitals work together to review clinical outcomes data and seek improvements in labor and delivery care. This quality improvement effort uses provider-specific, chart-abstracted data from labor, delivery and the postpartum period for analysis and discussion. Currently, almost one-third of the deliveries in the state are by providers participating in OB COAP. Expanding participation of providers in this quality improvement effort may help improve maternal and child outcomes, including C-section rates.

WASHINGTON STATE

	2000-02	2008	2009	2010	2011	2012	2013
Statistics for All Births to WA Residents							
Number of Births	79,810	90,334	89,291	86,588	87,107	87,543	86,304
Number of Births with Medicaid-paid Maternity Care	34,360	43,163	43,199	43,363	43,569	42,615	42,132
Births with Medicaid-paid Maternity Care (%)	43.1%	47.8%	48.4%	50.1%	50.0%	48.7%	48.8%
Grant women (TANF)	13.5%	13.2%	13.6%	13.8%	13.5%	12.9%	11.5%
Medical-only S women (citizens and legal aliens)	20.4%	22.5%	23.0%	25.5%	25.8%	26.0%	27.3%
Medical-only Undocumented Women	6.6%	9.8%	9.5%	8.0%	8.0%	7.1%	6.8%
Non-Medicaid	56.9%	52.2%	51.6%	49.9%	50.0%	51.3%	51.2%
First Trimester Prenatal Care	83.2%	68.6%	69.6%	72.3%	72.5%	73.5%	74.0%
Medicaid	73.3%	56.4%	58.9%	62.5%	63.6%	64.0%	64.1%
Non-Medicaid	90.4%	80.1%	79.7%	82.1%	81.4%	82.4%	83.3%
Late or No Prenatal Care	3.0%	7.1%	6.8%	5.9%	6.3%	5.8%	5.9%
Medicaid	5.2%	10.5%	9.5%	8.2%	8.5%	8.2%	8.4%
Non-Medicaid	1.5%	3.8%	4.2%	3.6%	4.1%	3.5%	3.5%
Obesity (pre-pregnancy BMI ≥ 30)	n/a	23.3%	24.0%	23.9%	24.7%	24.7%	25.2%
Medicaid	n/a	27.2%	28.4%	28.5%	29.9%	30.4%	30.9%
Non-Medicaid	n/a	19.8%	19.9%	19.3%	19.6%	19.3%	19.8%
Primary C-sections (TSV) - Non-Military Hospitals	12.0%	16.6%	16.3%	16.4%	15.8%	15.8%	15.2%
Medicaid	10.5%	14.4%	14.0%	14.3%	13.7%	14.1%	13.6%
Non-Medicaid	13.2%	18.9%	18.6%	18.6%	18.2%	17.7%	16.8%
LBW (singleton liveborn)	4.4%	4.7%	4.7%	4.8%	4.7%	4.6%	4.8%
Medicaid	5.2%	5.4%	5.5%	5.5%	5.5%	5.3%	5.6%
Non-Medicaid	3.8%	4.1%	4.0%	4.0%	3.8%	3.9%	4.1%
Statistics for Non-Military Births to WA Residents							
Total Births that occurred in WA State[1]	75,626	85,855	84,585	82,470	82,238	82,598	82,224
Total Number of Medical Birth Attendants[2]	2,034	1,798	1,779	1,833	1,805	1,901	1,908
Total Number of OB Providers[3]	1,804	1,582	1,577	1,639	1,654	1,737	1,719
Perinatology (MFM)	26	49	53	56	55	58	53
Obstetrics & Gynecology (OB/GYN)	533	554	568	604	630	642	674
Family Medicine/Family Practice (FM/FP)	978	725	683	704	683	737	684
Certified Nurse Midwives (CNM)	189	174	183	178	190	189	194
Licensed Midwives (LM)	77	80	90	97	96	111	114
Average Number of Births per OB Provider							
Average Number of Births per OB Provider	40.9	53.4	52.9	49.6	49.2	47.1	47.3
Average Number of Births per MFM	103.7	69.1	66.7	56.2	47.9	43.7	46.6
Average Number of Births per OB/GYN	91.7	104.9	100.6	93.0	90.8	89.7	85.5
Average Number of Births per FM/FP	13.5	18.3	18.7	16.7	17.1	15.7	16.0
Average Number of Births per CNM	40.5	46.1	43.8	45.9	39.5	41.3	40.6
Average Number of Births per LM	15.2	21.8	22.0	22.2	23.9	21.3	21.6

Number of OB Providers By Volume of Deliveries in 2013	**MFM**	**OB/GYN**	**FM/FP**	**CNM**	**LM**
>150 Deliveries	0	125	2	2	0
101-150 Deliveries	4	153	7	8	2
51-100 Deliveries	19	139	32	50	7
15-50 Deliveries	21	147	204	86	49
<15 Deliveries	9	110	439	48	56

[1] Total Births (presented by the county in which the birth occurred): all births to Washington residents, that occurred in Washington State at non-military facilities, including out of hospital deliveries, with any identified birth attendant (including birth attendants who were not medical practitioners).

[2] Total Medical Birth Attendants: all birth attendants identified as medical practitioners (MD/DO of any or unknown specialty, CNM, LM, nurses and other midwives). This excludes EMTs, dentists, chiropractors, health care assistants, family members and hospital administrators.

[3] Total OB providers: includes MDs/DOs with an identified specialty of MFM, OB-GYN, or Family Medicine/Family Practice; CNMs; and LMs.

Primary TSV = Hospital Births at non-military facilities to Women without a prior C-section, Term (≥37 weeks), Singleton, Vertex Presentation.

MFM = Maternal-Fetal Medicine.

Appendix E: Medicaid-Paid Maternal and Infant Services (FFS)

State of Washington - First Steps Database 2/2/2016/dsl

Medicaid Paid Maternal and Infant Services for Washington Births to Medicaid Fee For Service Mothers SFY 2014

	Birth Centers			Home Births w/Midwife			Hospital-Cesarean			Hospital-Vaginal		
Type of Service	(N)	%	$/Client	(N)	%	$/Client	(N)	%	$/Client	(N)	%	$/Client
MATERNAL SERVICES												
Prior to Initial Assessment												
Outpatient	69	93.2%	$ 176	101	95.3%	$ 138	3,199	93.5%	$ 142	8,414	92.9%	$ 132
Inpatient	0	0.0%	-	0	0.0%	-	0	0.0%	-	1	0.0%	1,190
Prenatal Visits; OB Services	67	90.5%	1,261	104	98.1%	929	3,294	96.2%	2,448	8,702	96.1%	2,345
Maternity Support +	25	33.8%	384	38	35.8%	275	2,155	63.0%	347	5,600	61.9%	337
Case Management +	10	13.5%	124	12	11.3%	110	995	29.1%	144	2,508	27.7%	127
Prior to Delivery +												
Outpatient	46	62.2%	422	53	50.0%	311	2,884	84.3%	859	7,587	83.8%	799
Inpatient	0	0.0%	-	0	0.0%	-	149	4.4%	6,447	306	3.4%	5,940
Delivery	63	**85.1%**	**1,178**	84	**79.2%**	**1,058**	2,705	**79.0%**	**6,261**	7,461	**82.4%**	**4,114**
Postpartum +												
Outpatient	46	62.2%	370	63	59.4%	389	2,842	83.0%	884	6,958	76.9%	857
Inpatient	0	0.0%	-	0	0.0%	-	43	1.3%	7,105	51	0.6%	5,590
Unknown												
Outpatient	44	59.5%	237	46	43.4%	232	3,107	90.8%	319	7,747	85.6%	292
Inpatient	0	0.0%	-	0	0.0%	-	8	0.2%	5,391	18	0.2%	5,750
TOTAL MATERNAL	74	100.0%	**$ 2,942**	106	100.0%	**$ 2,370**	3,423	100.0%	**$ 9,566**	9,053	100.0%	**$ 7,589**
INFANT SERVICES (Liveborn Infants)												
During the first year of life*												
Outpatient	71	100.0%	$ 3,000	101	100.0%	$ 2,443	3,428	99.2%	$ 4,319	8,801	99.3%	$ 3,915
Inpatient	5	7.0%	5,667	5	5.0%	2,056	2,571	74.4%	5,404	7,291	82.3%	2,483
Neonatal/Ped. Critical Care	3	4.2%	539	2	2.0%	347	557	16.1%	27,458	616	7.0%	13,956
TOTAL INFANT CARE	71	100.0%	**$ 3,422**	101	100.0%	**$ 2,552**	3,454	100.0%	**$ 12,737**	8,860	100.0%	**$ 6,902**

Limited to in-state births. **'Home births'** are planned home births with midwife attendant, not restricted to licensed midwife. Birth place, type, and attendant are determined by Birth Certificate designations. **Average payment per Client ($/Client):** Total Medicaid-paid dollars for each type of service divided by the number of clients with a payment (greater than $0) for that type of service. **Delivery services** include hospital or facility fees and professional fees paid to doctors and midwives. * **Infant Services** are limited to data available at the FSDB processing date for that cohort. **SFY**=State Fiscal Year.

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Appendix F: Birth Center Facility Fee Analysis

Financial Services Division

Professional and Hospital Rates

Birthing Centers Facility Fee Analysis

FFS Cost Analysis - Option #1		
Current facility fee		$605
Proposed new facility fee		$769
Increase in fee		$164
Estimated FFS birth center deliveries in SFY16		58
Cost at current facility fee		$35,090
Cost at proposed facility fee		$44,602
Difference (added cost per SFY)		$9,512
Fund split	GF-F	$5,545
	GF-S	$3,967

FFS Cost Analysis - Option #2		
Current facility fee		$605
Proposed new facility fee		$1,742
Increase in fee		$1,137
Estimated FFS birth center deliveries in SFY16		58
Cost at current facility fee		$35,090
Cost at proposed facility fee		$101,059
Difference (added cost per SFY)		$65,969
Fund split	GF-F	$38,460
	GF-S	$27,509

MCO Cost Analysis - Option #1		
Current facility fee		$605
Proposed new facility fee		$769
Increase in fee		$164
Estimated MCO birth center deliveries in SFY16		430
Cost at current facility fee		$260,150
Cost at proposed facility fee		$330,670
Difference (added cost per SFY)		$70,520
Fund split	GF-F	$41,113
	GF-S	$29,407
Assumption: MCOs pay birthing centers based on FFS facility fee rate.		

MCO Cost Analysis - Option #2		
Current facility fee		$605
Proposed new facility fee		$1,742
Increase in fee		$1,137
Estimated MCO birth center deliveries in SFY16		430
Cost at current facility fee		$260,150
Cost at proposed facility fee		$749,232
Difference (added cost per SFY)		$489,082
Fund split	GF-F	$285,135
	GF-S	$203,947
Assumption: MCOs pay birthing centers based on FFS facility fee rate.		

Break-Even Analysis for FFS - Option #1	
Average FFS birth center delivery cost for SFY14	$1,178
Average FFS hospital vaginal delivery cost for SFY14	$4,114
Savings in cost (birth center vs hospital)	$2,936
Added cost for proposed fee increase per SFY	$9,512
Number of births per SFY to break-even in birth center vs hospital setting	3
Birth center and hospital vaginal delivery cost includes professional and facility fees based on SFY14 data.	

Break-Even Analysis for FFS - Option #2	
Average FFS birth center delivery cost for SFY14	$1,178
Average FFS hospital vaginal delivery cost based on SFY14	$4,114
Savings in cost (birth center vs hospital)	$2,936
Added cost for proposed fee increase per SFY	$65,969
Additional number of births in birthing center per SFY to offset facility fee increase	22
Birth center and hospital vaginal delivery cost includes professional and facility fees based on SFY14 data.	

Note: MCO break-even analysis is not included because available MCO costs in birth centers/home births/hospitals includes the delivery case rate (DCR). The DCR and the cost at a birthing center are not directly comparable, given the additional services (prenatal, post-partum, etc.) and levels of acuity included in the DCR.