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# Realizing the Transformational Potential of Maternity Care Payment Reform

Executive Summary and Recommendations



Excerpted From: [Realizing the Transformational Potential of Maternity Care Payment Reform](#), 2024

## Executive Summary

Among high-income nations, the United States is the most dangerous place to give birth, and crucial outcomes are trending in the wrong direction. Communities of color, and especially Black and Indigenous families, disproportionately bear the brunt of this crisis, along with rural and low-income families. The vast majority of this harm is preventable. However, achieving equitable, high-quality maternity care will require a significant transformation of how maternity care is provided, who provides this care, and how to pay for the care that childbearing families need and want.

Health care payment reform – and especially alternative payment models (APMs) that tie payment to performance – are widely believed to be an important lever for achieving crucial quality improvements. Theoretically, maternity care episode payment programs and maternity care homes, which have been in place for more than 15 years, have the potential to support needed care delivery transformation. Given the ongoing maternal health crisis, an assessment of the actual impact of these models is urgently needed to inform the evolution and implementation of maternity care payment reform programs, including those developed within the just-announced Transforming Maternal Health (TMaH) Model of the Centers for Medicare and Medicaid Services.

We investigated the extent of maternity care episode payment and maternity care home program adoption, key design features of operating and in development models, and available evidence of impact. Our analysis was informed by the Health Care Payment Learning and Action Network’s Health Equity Advisory Team’s (HEAT) *Theory of Change for How APMs Advance Health Equity*, which we adapted to the maternity care context. Grounded in this framework, we interviewed birth justice leaders, program managers of maternity episode payment and maternity care home programs, and payment reform thought leaders, and compiled key program features in program profiles to enable analysis. This report summarizes what we learned from birth justice leaders about how our maternity care system needs to evolve, interprets what we learned about maternity care episode payment and maternity care home APM programs, and provides recommendations for the key stakeholder groups on how to improve APM programs to more effectively advance maternal health equity and excellence. It also includes an appendix identifying recommended performance measures for these programs as well as those that are often used but have a limited potential for impact. A companion report, *Technical Supplement to Realizing the Transformational Potential of Maternity Care Payment Reform*, details the project methodology, describes current program design features, and provides profiles of the studied programs.

Interviews with birth justice leaders centered our project on challenges and solutions identified by the communities most adversely affected by the ongoing maternal health crisis. Although those leaders were not strongly focused on health care payment reform, the issues they identified align closely with the adapted HEAT framework and support leveraging payment reform for these aims. Interviews with payment reform thought leaders helped with analyzing program attributes and impacts.

We identified 20 maternity care episode payment programs that are operating (17) or under development (3) and interviewed program managers of 17 of those programs. We interviewed program managers of all four operating maternity care home programs that we identified. We estimate that the episode programs care for just 3 percent of the nation’s childbearing families, and the maternity care home programs support even fewer.

The older legacy programs did not prioritize advancing equity. While they aimed to improve quality and reduce costs, program managers provided little evidence of impact in either area. Our analysis finds that the limited impact, even at small scale, reflects weak designs. While we were unable to assess the markets in which they operated, it is important to recognize that market constraints can also play a major role. Newer programs, and especially those with the greater leeway of Medicaid agencies, have more intentional emphasis on advancing equity and mitigating the maternal health crisis, as well as stronger designs. However, it is too early to understand whether these “2.0” programs will make a tangible difference in the lives of childbearing families.

The paucity of these programs, limited voluntary uptake, and limited use of stronger design elements reflect the absence of a clear central policy signal that is strong enough to set impactful design standards and foster maternity care practice culture change: working together toward shared aims with a commitment to steady improvement over time. The Transforming Maternal Health Model is designed to send such a signal.

This quality and equity-forward assessment of maternity care episode payment and maternity care home programs surfaced critical shortcomings as well as clear recommendations for how to achieve the potential for mitigating the maternal health crisis. These recommendations reflect five overarching principles that apply across the relevant stakeholders:

- Integrate a comprehensive set of equity-forward design elements into existing and future maternity APM models.
- Lead with quality on program design, implementation, and evaluation; improved outcomes and cost savings will follow (e.g., achievable reductions in rates of cesarean birth, preterm birth, newborn intensive care unit admissions, mental health conditions, and unmet social needs, as well as increased breastfeeding).
- Start with maternity APM designs that are feasible within current systems and with modest accountability that is acceptable to providers; steadily add more robust, impactful elements and targets.
- Create a culture of shared learning and collaboration for better maternal health practice, with a commitment to continuous evaluation, refinement, and steady improvement over time.
- Provide a central policy signal (e.g., from the Innovation Center of the Centers for Medicare and Medicaid Services) to advance equity and overall quality by setting impactful design and participation standards and fostering maternity care practice culture change.

We invite the relevant stakeholders to consider our detailed recommendations for federal administration policymakers, state policymakers, developers and implementers of the two types of APMs examined here, health care benefits purchasers, the National Committee for Quality Assurance, and researchers and evaluators; as well as an appendix with higher-impact performance measures. Paying for what works and what birthing families need and want will go a long way toward ending our maternal health crisis.



## Recommendations for Leveraging Maternity Care Episode Payment and Maternity Care Home Programs to Improve Health Outcomes and Equity

Tackling the nation's maternal health crisis requires changing how care is delivered, which requires different ways of paying for maternity care. Episode payment programs and maternity care homes are the two types of APMs with the greatest potential for transforming maternal-newborn care delivery, improving the quality of care, and narrowing persistent racial, ethnic, and other structural inequities that undermine our nation's future. Policymakers, purchasers, payers, and providers must take bold action now on the design, implementation, evaluation, and refinement of these APMs, and their proliferation, to achieve a more equitable, accessible, and higher-performing maternity care system that supports childbearing families.

All stakeholders should follow five key, overarching principles to design, recalibrate, and scale maternity care episode payment and maternity care home programs so that they reach their potential to improve maternal health outcomes and achieve equity:

- Integrate a comprehensive set of equity-forward design elements into existing and future maternity APM models.
- Lead with quality on program design, implementation, and evaluation; improved outcomes and cost savings will follow (e.g., achievable reductions in rates of cesarean birth, preterm birth, newborn intensive care unit admissions, mental health conditions, and unmet social needs, as well as increased breastfeeding).
- Start with maternity APM designs that are feasible within current systems and with modest accountability that is acceptable to providers; steadily add more robust, impactful elements and targets.
- Create a culture of shared learning and collaboration for better maternal health practice, with a commitment to continuous evaluation, refinement, and steady improvement over time.
- Provide a central policy signal (e.g., from the Innovation Center of the Centers for Medicare and Medicaid Services) to advance equity and overall quality by setting impactful design and participation standards and fostering maternity care practice culture change.

Specific recommendations are organized by stakeholder groups. “Maternity care APMs” is intended to reference maternity episode payment and maternity care home programs.

## FEDERAL ADMINISTRATION POLICYMAKERS SHOULD:

- Continue to develop **supportive environments for impactful Medicaid maternity APMs**.
  - Provide Medicaid agencies with the necessary **resources to create and administer APMs**, including collecting race, ethnicity, and other demographic data to support measuring and improving health equity and building capacity to support providers through technical assistance, infrastructure development, and actionable reports that enable and foster improvement.
  - Develop and apply **actuarial models that take into account and reward providers for full reasonable cost savings** that would accrue over time from such outcomes as reduced rates of preterm birth, cesarean birth, NICU admission, perinatal mental health disorders, and unmet social needs, as well as increased breastfeeding.
  - Develop and apply **actuarial models that reward and do not penalize high-performing providers and birth settings**, including midwives and freestanding birth centers.
  - Continue to provide **pathways for states to make community-based perinatal support and care services** and **supports for social needs** available to Medicaid beneficiaries.
  - Address the **harm of low Medicaid payment rates** overall and for beneficiaries with greater needs for services.

- To catalyze the transition to value-based maternal and newborn care, the CMS Center for Medicare and Medicaid Innovation (CMMI) should implement its recently announced Transforming Maternal Health (TMaH) Model to support states to inaugurate or further develop **high-impact, transformational maternity care episode payment programs for all Medicaid and CHIP beneficiaries**.
  - Offer grants to support practices least able to develop **needed infrastructure**, to build capacity for data collection and sharing, technical assistance for quality improvement, and other purposes.
  - Incorporate **impactful population-level performance measures**, with expectations of increasingly stringent targets reflecting progressive quality improvement over time.
  - Disaggregate performance data, initially by race and ethnicity, require programs to measure and track performance, and **hold providers accountable for advancing equity**.
  - Offer gainsharing financial incentives and require contracting entities to reserve a portion for administrative costs and **distribute the majority of shared savings to members of the care team**.
  - Design programs with payment and performance systems that **support and do not penalize providers caring for high-acuity patients and high-performing providers** (e.g., midwives and birth centers).
  - Support perinatal quality collaboratives to **provide continuing technical assistance to enable quality improvement** and success with APM measurement goals.
  - Work with states to engage hospitals by providing the same Medicaid reimbursement for vaginal and cesarean births – **blended case rates** – and by similarly aligning provider reimbursement.
  - **Begin with feasible designs**, help providers succeed in accountable care, and **transition expeditiously to more impactful designs** such as including the baby, paying prospectively, and including downside risk.
- To catalyze the transition to value-based maternal and newborn care, the CMS Center for Medicare and Medicaid Innovation (CMMI) should implement its recently announced Transforming Maternal Health (TMaH) Model to support states to inaugurate or further develop **high-impact, transformational maternity care home programs for Medicaid and CHIP beneficiaries**.
  - Offer grants to support those least able to develop **needed infrastructure and convenience services**, including integration into clinical workflows and electronic health records, directory of social services, and capacity for televisits, 24/7 telephone consultation, and evening and weekend visits.
  - Incorporate **impactful population-level performance measures**, with expectations of increasingly stringent targets or benchmarks reflecting progressive quality improvement over time; include measures that align with clinical aims and those specific to aim of maternity care homes.

- Disaggregate performance data by race and ethnicity, require programs to measure and track performance, and **hold providers accountable for advancing equity**.
- Experiment with per-member, per-month, and other **ways of paying for maternity care home expenses** and financially rewarding program personnel success.
- To **learn and scale what works**, establish clear robust standards and assess, refine, and scale over time.

## STATE POLICYMAKERS SHOULD:

- Continue to develop **supportive environments for impactful Medicaid maternity APMs**.
  - Medicaid agencies without maternity care episode payment and maternity care home programs should **establish, implement, and evaluate maternity APM programs** with supportive infrastructure and impactful designs, ideally as participants in the new Transforming Maternal Health (TMaH) Model.
  - Medicaid agencies with maternity care episode payment and/or maternity care home programs should **take stock and strengthen their maternity APM programs**, ideally as TMaH Model participants.
  - In Medicaid managed care states, Medicaid agencies should **incorporate clear expectations in contracts with Medicaid managed care organizations** with the aim of developing impactful maternity APMs and generating extensive provider participation and reach to childbearing families, ideally as TMaH Model participants.
  - **Remove statutory barriers to increased access to midwifery care and birth center care in all states**, including licensure and Medicaid reimbursement of midwives holding all three nationally recognized credentials and of birth centers, as well as removal of unnecessary restrictions in midwifery practice acts and birth center licensure acts.
  - **Remove regulatory barriers to increased access to midwifery care and birth center care in all states** in the form of unnecessary restrictions on midwifery practice and birth center regulations.
  - Establish **doula services as a covered benefit** in all states through Medicaid (both fee-for-service and managed care), CHIP<sup>1</sup> and commercial plans by pursuing regulatory pathways offered by the Centers for Medicare and Medicaid Services.
  - Provide **access to community-based perinatal support and care services and assistance with meeting social needs** for Medicaid beneficiaries by pursuing regulatory pathways offered by the Centers for Medicare and Medicaid Services.

## APM DEVELOPERS AND IMPLEMENTERS, INCLUDING PAYERS AND PURCHASERS, SHOULD:

- Intentionally integrate **health equity** design elements into new APMs and modify existing ones to comprehensively and systemically combat current inequities.



- Include **care redesign** elements such as:
  - Providing families with access to community-based and -led organizations that can offer trusted, respectful, and often culturally congruent support and care.
  - Proactively providing access to high-performing underused care models (and community-based forms of these, when possible), including midwifery, community birth settings, doula support, and support and care from community-based perinatal health worker groups.
  - Requiring screening and follow-up for physical health, mental health, and social needs in a respectful manner that prioritizes confidentiality.
- Include **payment incentive** elements such as:
  - Paying providers prospectively, adjusted to account for physical health, mental health, and social risk factors of individual patients or their overall maternity patient population.
  - Using resources that measure levels of socioeconomic stress such as the Area Deprivation Index or the Maternal Vulnerability Index to adjust payment and provide funds needed for additional care and care coordination.
  - Providing one-time or periodic infrastructure support (both funding and technical assistance) to safety-net providers and providers that lack the resources of larger health systems to enable them to integrate APM functions into their practices and successfully participate in APMs.
- Include **performance measurement** elements such as:
  - Creating and implementing a system for collecting participants’ self-identified race and ethnicity, sexual orientation and gender identity, disability status, as well as their economic status and geographic location in a respectful manner that prioritizes confidentiality.
  - Selecting high-impact measures developed and vetted through consensus processes with the potential to have population-level impact.
  - Disaggregating performance measures, at minimum, by race and ethnicity.
  - Implementing performance measures of strategies for reducing inequity, such as screening for social needs and meeting identified needs.
  - Measuring, tracking, and assessing results, setting performance goals; providing technical support; and paying for progress and exemplary practice.
- Ensure that families receiving care through APMs have access to, and understand the value of, **high-performing care models** such as midwives, birth centers, and doulas and information about **adjacent health-promoting benefits**.
  - Intentionally include design elements to **increase access** to these forms of care by:
    - Developing contracts with midwifery practices, birth centers, and FQHCs designed to reward them for current high performance and welcome improvement.

- Incentivizing ob-gyn physicians to collaborate with high-performing care providers as a strategy to achieve success under risk-based contracting.
- Including preventive and population-focused performance measures to maximize desired outcomes and benefit from strengths of these models (e.g., fewer preterm and cesarean births, and increased breastfeeding and postpartum contraception).
- Providing technical assistance to help contracting providers understand how including high-performing care models can help them succeed in the APM.
- Reliably **inform participating childbearing families about health-promoting benefits beyond the APM program for which they may be eligible**, such as state Medicaid doula programs, state paid leave programs, and the federal Pregnant Workers Fairness Act.
- Use APM **performance measurement** to foster meaningful improvement in the care, experiences and outcomes of childbearing families.
  - Select measures developed through consensus processes that apply to a large segment of this population and have the potential to **generate population-level improvements**. While endorsed measures from the Partnership for Quality Measurement (previously the National Quality Forum) are optimal, consider other consensus-based measures as well, due to the many measure gaps in endorsed maternity measures.<sup>i</sup>
  - Set **benchmarks and/or improvement targets**, including those for advancing equity, and help providers understand their performance, improve, and succeed; reward progress.
  - **Over time, raise the bar** on benchmarks and targets, without penalizing high performers and with effective support to enable safety net, rural, and smaller providers to succeed.
  - Identify, measure, and track **stratified performance measures at the program level** to determine whether the overall program is achieving its goals for better, more equitable health.
- Use APMs to address the harmful **overuse of cesarean birth**.
  - **Incorporate accountability** for the reduction of cesarean births by setting meaningful targets for a cesarean birth performance measure<sup>ii</sup> together with a measure to protect against the potential for unintended consequences and possible reduction of cesarean rate beyond safe levels (i.e., the endorsed Unexpected Complications of the Term Newborn measure).
  - Develop maternity episode budgets using a **blended rate** for cesarean and vaginal birth, contracting with professionals and, when feasible, with hospitals as well, rather than projecting historical fee-for-service rates forward.

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i Appendix B identifies currently available measures that are best suited for maternity care APMs and those that are unlikely to foster needed improvement.

ii The nationally endorsed Cesarean Birth measure or total cesarean rate are options.

- Require contracting providers to understand and **implement quality improvement strategies** to reduce cesarean births by working with their state perinatal quality collaboratives and/or by using the California Maternal Quality Care Collaborative evidence-based toolkit.<sup>2</sup> (See also: next recommendation.)
- Support **hospital delivery system transformation** through APMs by:
  - Contracting with **teams that include clinicians and other personnel, at least one hospital, and ideally at least one birth center**.
  - **Including newborn and infant outcomes** with a glidepath to including care and costs of the newborn as well as the birthing person.
  - Developing approaches that foster **appropriate use of NICU services**.
  - **Incentivizing a team-based approach** that links the hospital phase of care with the prenatal and postpartum phases, particularly when the contracting provider is not employed or affiliated with a hospital. This may be done, for example, by requiring any shared savings to reach those providing care and incentivizing care team members in all phases of care to work toward shared performance targets in present and upcoming care phases.<sup>iii</sup>
  - Adopting a **blended facility and professional fee payment policy** for vaginal and cesarean births to remove incentives for cesarean births that do not confer benefits, or pay facilities *less* for some types of cesarean birth (e.g., those without medical indications or routinely scheduled repeat cesareans).
- **Engage all members of the maternity care team** to work together toward shared aims.
  - Require a substantial portion of any incentive payments or **shared savings be distributed to all members of the care team, including non-clinical members**, to encourage those providing care to work together toward shared goals.
  - Limit shared savings flowing to the contracting entity for **administrative costs** to a smaller proportion of overall savings.
- Establish **effective processes for meaningful engagement and shared learning among all stakeholders** as advisors throughout the entire APM cycle from planning through implementation, evaluation, and recalibration.
  - **Include as relevant key stakeholder groups:** clinicians and hospitals; advocates, beneficiaries, birth workers, and community-based organizations; state perinatal quality collaboratives; health plans; employer purchasers; and legislators and key state agency personnel.
  - Across the APM cycle, **center the role of the birth justice community and people who are most adversely affected** by the underperforming maternity care system.

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iii For example, the prenatal team can support targets relating to vaginal birth, breastfeeding, and contraceptive care.

- Implement **best practices** for respectful inclusive processes, collaborative problem-solving, good communication and feedback; and appropriate support for participants to help design, implement, and scale impactful programs.
- Incorporate **educational opportunities** for the stakeholders to learn about and inform evolving plans, processes, and progress.
- Address the **potential of population-based APMs** (such as Accountable Care Organizations, or ACOs) to mitigate the maternal-newborn crisis of quality, equity, outcomes, experiences, and costs.
  - Evaluate the impact of ACOs on maternal-newborn health quality, equity, and cost outcomes.
  - Investigate ways in which maternity episode and maternity care home APMs could be incorporated into larger population-based APMs with strong design elements for impacting maternal-newborn care and outcomes.

### HEALTH CARE BENEFIT PURCHASERS SHOULD:

- Create a **supportive environment for APMs** to thrive.
  - Contract with payers and third-party administrators with the capacity to develop and support **maternity care APMs with robust designs**, as described above.
  - **Design health benefits to encourage the use of high-performing forms of care**, such as midwives, birth centers and doulas, and provide access through APMs.

### THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) SHOULD:

- **Develop and test a standardized and robust maternity care home model** that benefits from central coordination and the incentives of a recognition program.
  - NCQA should expeditiously develop, implement, and refine a **maternity care home recognition program** that applies lessons learned about effective, equitable patient-centered medical homes in primary care settings to maternal-newborn care, through a comprehensive package of design elements that may include:
    - Integrating model processes into clinical workflows and electronic health records.
    - Developing and maintaining a directory of social and community resources.
    - Ensuring accessibility through extended hours, telehealth options, ability to speak with a team member 24/7, ability to be seen on the same day for urgent concerns, and communication in languages spoken by patients (e.g., synchronous discussion, signage, and website).
    - Screening at intake for social, mental health, and physical health needs; addressing identified needs; and repeating this at minimum after the birth in a respectful manner that prioritizes confidentiality.
    - Addressing the unmet needs of both childbearing women and their babies.

- Ensuring that personnel – which may include community-based perinatal health workers, nurses, social workers – are prepared, tasked, resourced, and held accountable for essential components of this model.
- Identifying and including metrics and targets that foster excellence and equity by disaggregating data and measuring, tracking, and tying results to payment, including metrics that align with clinical aims and maternity care home priorities.
- Continuously evaluating and refining the model to strengthen its impact.
- Promoting uptake of the designation to scale the model.

## RESEARCHERS AND EVALUATORS, SHOULD, WITH POLICYMAKER SUPPORT:

- **Continuously evaluate maternity episode payment and maternity care home APM models**, and use results to improve care, experiences and outcomes of childbearing families.
  - Include robust community input in evaluation and model evolution, and provide resources for community members and organizations to effectively contribute.
  - Include in any evaluation **data disaggregated by race and ethnicity**. Expediently develop capacity to collect data, and identify, track, and improve results by language, sexual orientation, gender identity, and disability status.
  - **Set a time frame for evaluation and recalibration that is long enough** (e.g., three years) to account for the relatively long timeframe of the childbearing cycle (from pregnancy through postpartum) and subsequent periods for data collection and assessment; provide improvement tools and **more frequent feedback and support for providers on their performance**; ensure that the program uses high-impact performance measures.
  - Medicaid programs should provide **full public transparency of APM performance** and define successful performance collaboratively with a representative sample of beneficiaries with recent birth experiences, providers, and other stakeholders, centering maternal-newborn quality of care, experiences, and outcomes.
- **Provide adequate funding for evaluation** of operating models **and wide dissemination** to develop knowledge of successes and challenges and develop more equitable and effective maternity models over time.
  - Include funding to support **community-based input and evaluation**.
  - All programs should **publicly report results and trends for high-impact performance measures** to help clarify effective and ineffective practices and move toward a culture of collaboration and quality improvement.
- Support **learning collaboratives** that enable those grappling with the distinctive challenges of using APMs to advance maternal and infant health, spend wisely, and transform the culture of practice.

- Examine challenges and successes via **shared learning and teaching and mutual support**.
- Provide access to **continuing education** on relevant topics.
- **Identify, model, and test new design elements** for potential inclusion in future maternity APMs.
  - Develop and test methods to reduce the inappropriate overuse of **NICUs** by lower-risk infants, and conversely avoid withholding NICU care from babies who may be expected to benefit,<sup>3</sup> including the use of stand-by payments.<sup>4</sup>
  - Enable maternity care providers to participate without reservation in **episode programs inclusive of both childbearing people and newborns** (e.g., by including guardrails that protect against uncontrollable risk, collecting and keeping providers informed about relevant data, and providing technical assistance about how to succeed with the model).
  - **Adjust payments and, as appropriate, performance for social risks** and refine other elements to fairly support the participation of safety net and other providers and meet the varied needs of childbearing families.
  - Experiment with and evaluate **separate payments for each phase of maternity care** and other proposals from the Center for Healthcare Quality & Payment Reform that would encompass newborn and hospital care and prioritize access to birth center care.<sup>5</sup>
  - Pilot and evaluate **standby capacity payments to hospitals** to pay for the value of having services available in case of need and help address current challenges with maternity care access and appropriateness, including to:
    - Sustain rural hospital maternity units with inadequate volume to cover costs through conventional reimbursement.
    - Support availability of NICU services and appropriate NICU admissions.
    - Support availability of hospital maternity units as back up for birth center and home births.<sup>6</sup>
- **Conduct research** to inform the development, design, and implementation of future maternity APMs.
  - Conduct **business case analyses**, which might encourage greater development and uptake of maternity care alternative payment models.<sup>7</sup>
  - Conduct **analyses of true costs** (versus spending), e.g., to provide care to different types of childbearing women and newborns, and to operate labor and birth units and neonatal intensive care units to guide the creation of episode payment budgets.
  - Design, pilot, and evaluate **maternity care APMs based on purchaser direct contracting with providers**.
  - Study why **health plans and Medicaid agencies do not offer maternity care APMs** to understand barriers, challenges, and support needs.
  - Study why **providers do or do not participate in maternity care APMs** to understand experiences, including barriers, challenges, and support needs.

## Endnotes

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5. Ibid.
6. Ibid.; Center for Healthcare Quality & Payment Reform. "The Crisis in Rural Maternity Care," accessed October 15, 2023, [https://ruralhospitals.chqpr.org/downloads/Rural\\_Maternity\\_Care\\_Crisis.pdf](https://ruralhospitals.chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf)
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