Payment Policy Levers to Address Maternal Health Disparities

When it comes to maternal health, the U.S. stands out as an anomaly: as the global rate of maternal mortality has declined significantly, the rate of pregnancy-related mortality has more than doubled in the U.S. in the past three decades. Maternal health outcomes in the U.S. have long signaled systemic inequities for pregnant and birthing persons of color, with Black and Indigenous people two to three times more likely to die in childbirth than white people. Policymakers can take key actions to enact evidence-based payment policies to address maternal health as a top priority.

1. Extend postpartum coverage

It is essential for women to have insurance coverage for the 12 months following birth. In states that have not expanded Medicaid to low-income adults, birthing persons that become eligible for and enroll in Medicaid during their pregnancies can lose coverage after 60 days postpartum. Extending Medicaid coverage for low-income pregnant people to a full year postpartum has the potential to help at least 200,000 people per year gain coverage during a critical window for new moms and babies, as more than half of deaths occur after birth and in the postpartum period.

States can individually take this action through waivers or financing extended Medicaid coverage on their own, or Congress could take up legislation to update federal statute. With state budgets already constrained due to COVID-19, it is important for Congress to address additional actions to increase the federal match rate for expanding postpartum coverage.

> If enacted, the Helping MOMS Act of 2020 (which passed the House in September) would allow states to provide one year of postpartum coverage under Medicaid and CHIP.

States and the federal government should also take immediate action to support continuous coverage for low-income women and birthing people during the COVID-19 pandemic, which has exacerbated existing health disparities. As part of the Families First Coronavirus Response Act, women cannot be disenrolled during the public health emergency, as that legislation put a freeze on Medicaid disenrollment and required continuous coverage tied to an enhanced federal matching rate. Many states have also made it easier for Medicaid eligible beneficiaries to enroll in coverage – a practice that should remain after the pandemic is over.

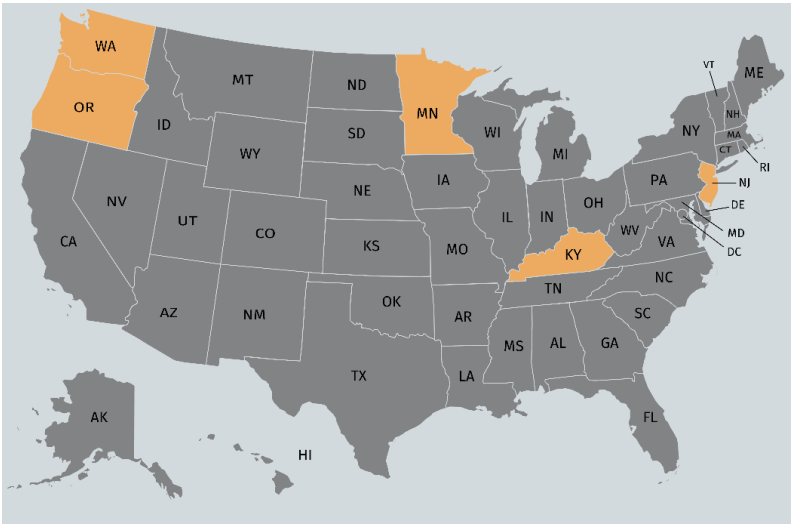
2. Implement pay parity

Nurse midwifery care provided in birth centers and perinatal support services such as doulas, childbirth educators and peer supports are proven models of maternity care, and there is strong evidence that access to midwifery-led care and a full complement of birth workers can reduce disparities and improve health outcomes. Yet these important components of the maternity care system are inadequately reimbursed – if at all.

The CMS Strong Start for New Mothers and Newborns demonstration found that Medicaid beneficiaries who received enhanced prenatal care in birth centers had lower rates of preterm, low birthweight, and C-section births. For women aligned to Strong Start Birth Centers, costs were $2,010 lower through birth and the year following for each mother-infant pair.

The average cost of a vaginal delivery at a birth center is 50 percent lower than a hospital, in part because birth centers use medical interventions less frequently than hospitals and do not perform cesareans. However, the cost savings can also be explained by inadequate rates of reimbursement for midwives, doulas, and other perinatal support workers.

Community-based doula programs are uniquely positioned to bridge the health system and community support system for low-income women and women of color to reduce health disparities. Currently, only five states cover doula services. Furthermore, while the ACA required Medicare to pay midwives the same amount in physicians' fees as they would pay clinicians at a hospital, this impacts a small percentage of births and has not been uniformly implemented for other payers. State Medicaid programs and private payers can take immediate steps to improve reimbursement rates for midwifery care and birth center facilities to improve outcomes for birthing persons, in line with recommendations from MACPAC.



The Commonwealth Fund, & Center for Health Care Strategies, Inc. *State Policies to Improve Maternal Health Outcomes, State by State Comparison*. 2020.

Pay equity for high-value birth workers and investments in a culturally diverse workforce are a health equity imperative. Policymakers can also foster improved maternity care workforce composition by supporting workforce development opportunities, reducing regulatory barriers to practice, expanding cross-state licensing (like New York did in response to the pandemic) and addressing scope of practice restrictions on advanced practice nurses.

3. Utilize value-based payment and care delivery models

The predominant fee-for-service model of reimbursement creates misaligned incentives based on volume and acuity of services. Public payers should accelerate adoption of alternative payment models for maternity care that hold the health system accountable for cost, outcomes, and reducing health disparities.

CMS can serve an important role by helping states transform how maternal health care is delivered. A recent State Medicaid Director letter provides helpful guidance about how states can advance value-based care across their systems, including to improve maternal health. The Center for Medicare and Medicaid Innovation can also design and test a holistic alternative payment model that explicitly incorporates improvements in health equity as an objective.

The IMPACT to Save Moms Act introduced in March 2020 would direct CMS to establish a Perinatal Care Alternative Payment Model Demonstration Project to allow states to test payment models for maternity care, including postpartum care, under Medicaid and CHIP.

Prior to the pandemic, only 19 state Medicaid programs reimbursed for telemedicine services delivered to the patient in their home, which limits the opportunities to expand telemedicine approaches to provide care to pregnant patients on Medicaid.

But reforming the underlying fee schedule can be a first step to paying for high-value care, especially during this public health emergency. Expanding coverage and pay parity for birth workers is also a way for Medicaid programs to support healthy pregnancies during the COVID pandemic and beyond by adequately covering telehealth for an expanded set of services like behavioral health, remote patient monitoring, and group prenatal care. This can mitigate barriers that existed pre-pandemic – such as access to childcare and transportation necessary to attend in-person appointments – while updating arcane clinical protocols to better reflect the quality rather than frequency of prenatal and postpartum visits.

4. Advance health equity

While payment reform is an important lever, incremental approaches to value-based payment and pay parity for birth workers alone cannot address the impact of institutional racism and implicit bias on maternal health outcomes. Unrooting systemic racism and economic inequalities that continue to drive racial disparities in maternal health outcomes in the U.S. requires an all-of-government approach.

California lawmakers passed legislation requiring all perinatal health providers to receive implicit bias training and improve data collection to understand pregnancy-related deaths, aimed at reducing maternal mortality among Black women.

Systemic racism and implicit bias upholds inequitable systems, structures, and norms throughout the health care system – including in the administration and evaluation of payment models – that contribute to unacceptable disparities in patient care outcomes. States including Michigan, New Jersey, and California have moved to implement policies to require that health care providers undergo implicit bias training, and others have taken steps to advance health equity in Medicaid by targeting health disparities when measuring and incentivizing quality performance.

The federal and state governments can improve data collection to include race & ethnicity information upon Medicaid enrollment, and standardize birth and death certificate data to better identify racial health inequities. Patient experience surveys and patient-reported outcomes that ask birthing persons about their childbearing experiences, whether the care provided was respectful and aligned to their preferences should inform equity-centered quality and safety improvement initiatives.

The Maternal Health Pandemic Response Act of 2020 if enacted would require the CDC to coordinate, collect, and publicly post data related to COVID-19 and pregnancy disaggregated by race, ethnicity, and state.

Conclusion

The health of birthing persons and babies impacts all of us. Policies and payment changes to improve maternal health outcomes and sustain high-value maternity care throughout the pandemic and beyond should be prioritized by states and the federal government as a critical mechanism to address the ongoing maternal health crisis.