# Using Alternative Payment to Transform Maternity Care, Address Disparities, and Improve Outcomes

## Introduction

Maternity care in the United States is in crisis: the rates of maternity-related mortality and morbidity have more than doubled in the U.S. in the past three decades. Mortality rates for non-Hispanic Black women are three to four times higher than for non-Hispanic White women[1] and American Indian and Alaskan Native (AIAN) women are two to three times more likely to die from pregnancy-related causes than White women.[2] These troubling statistics reflect the impact of structural racism and other systems of oppression on health care access and delivery, and clearly demonstrate the need for equity-centered alternative payment models (APMs) that incentivize and reward providers for providing appropriate, equitable care.

For APMs to address health equity requires that they incorporate specific model design elements, as well as specific operational goals and visions, to target the provision of equitable care. In June 2019, the Health Care Transformation Task Force (HCTTF or Task Force) released "Expanding Access to Outcomes-Driven Maternity Care Through Value-Based Payment," which details the ways in which public and private sector payers are designing and implementing APMs to drive changes in maternity care reimbursement and care delivery that evidence has shown could address the poor maternal health outcomes in the U.S. Among the findings, the report noted that APMs should seek to meet the following goals:

- Improved prenatal care utilization
- Reducing the rate of unnecessary cesarean births
- Improved healthy birth weight rates
- Healthy postpartum recovery for mother and baby
- Reduced racial and ethnic disparities in morbidity and mortality
- Improved screening and treatment for perinatal mood and anxiety disorders

After the report's release, the Task Force developed the Maternal Health Hub Learning Community, with support from The Commonwealth Fund, for maternal health stakeholders to share promising practices reflecting how both commercial and public sector payers are leveraging payment and reimbursement methods to achieve the goals listed above. This resource reflects on lessons learned during the Learning Community meetings, examples from literature, and from other entities and industry stakeholders pursuing the goal of health equity through changes in how care is paid for and delivered.

### Terminology

***Birthing persons*** is a term used to describe pregnant persons that is inclusive of all genders and gender identities. Not all birthing people identify as ***women*** or ***mothers***. This resource uses both gendered and non-gendered language such as birthing persons, pregnant people, mothers, and women to reflect the terminology used by various stakeholders and found in the referenced literature. Gender neutral language is used when not directly citing an external resource to be inclusive of all birthing persons.

*This resource synthesizes findings from the third trimester of the Maternal Health Hub Learning Community which explored utilizing alternative payment models to advance maternity care transformation.*

## Overview

The U.S. maternity care system is the world's most costly system, and yet it is ranked last for numerous standard performance indicators among developed nations.[3] There are several causes for this, stemming from a traditional model of prenatal care financing and delivery which prioritizes higher cost procedures, devotes 80 percent of the overall cost to the labor and delivery (*i.e.,* hospital-based) phase of care, and underfunds prenatal care, post-partum care, and limits non-clinical support and education for the birthing person. Reimbursement is low or unavailable for a broad compliment of maternity health workers with distinctive contributions, including midwives, doulas, and community-health workers.[4,5,6]

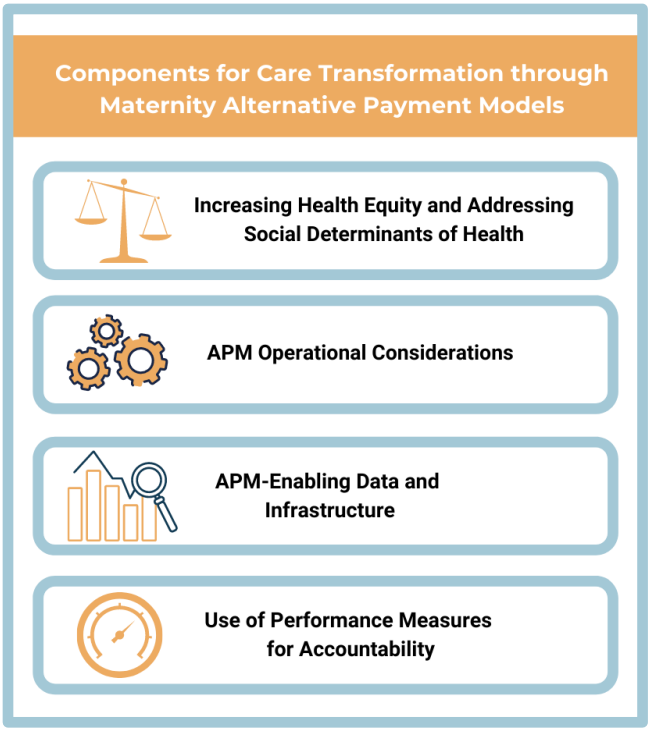
Patient-centered maternity APMs are a powerful tool to make progress toward the goal of improved care, as long as they are designed with the following in mind:

- meaningful engagement of birthing people and families
- commitment to a culture of health equity
- meaningful care coordination to reduce fragmented care and provide access to needed non-clinical community-based services
- inclusion of a full spectrum of risk levels for both the birthing person and the infant in the population
- twelve months of post-partum care
- use of impactful quality performance measures that truly reflect accountability and support population-level interventions
- reimbursement for midwives, doulas, and community health workers
- Use of upside and downside risk for providers

Taking this model further into the realm of a maternity care home model would include a focus on community and social supports and care navigation in a way that integrates clinician workflow seamlessly with community services and overall communication and coordination across the care team.

The Hub Learning Community highlighted efforts to transform care via payment by commercial organizations **Anthem**, **Blue Cross Blue Shield of North Carolina** (BCBSNC), and the **Purchaser Business Group on Health** (PBGH); and for the Medicaid populations in Colorado (through **Health First Colorado**), Tennessee (through **TennCare**), and the **Washington State Health Care Authority** (HCA). This resource reflects the learnings shared by these organizations – as well as efforts being done by other states, and covered in recent literature – across the following topic areas:

- Increasing Health Equity and Addressing Social Determinants of Health
- APM Operational Considerations
- APM-Enabling Data and Infrastructure
- Use of Performance Measures for Accountability

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## Increasing Health Equity and Addressing Social Determinants of Health

There are a number of ways that alternative payment models can serve as a lever to address inequities in maternity care, including reimbursement for midwives and doulas, and creating goals for health equity (based on utilization rates for various services) as a gateway to receiving shared savings.

### Midwifery and Doula Reimbursement

Studies have shown the benefit of doulas[i] and midwives[ii] being present during a birth and that these maternity care support services provide great opportunity to address health equity. According to a pooled analysis of many clinical trials, doula support reduced the relative risk of cesarean birth by 39 percent.[7] Similarly, another study found that birthing persons who received doula support had lower preterm and cesarean birth rates than Medicaid beneficiaries regionally: 4.7 vs 6.3 percent and 20.4 vs 34.2 percent, respectively.[8] For midwives, women who give birth at a hospital with more midwife-attended births have lower odds of giving birth by cesarean section and of having an episiotomy.[9] The Strong Start evaluation also found lower rates of pre-term birth and low-birth weight associated with midwifery-led prenatal care. While doulas and midwives are beneficial for all birthing individuals, they tend to have a larger positive outcome among women who are low income, socially disadvantaged, or who experience cultural and/or linguistic barriers to care.[10] Given the vast research evidencing the benefit of doulas and midwives in decreasing negative outcomes and increasing equity in maternity care, it is imperative doulas and midwives are reimbursed for their services.

Private sector organizations, such the Purchaser Business Group on Health (PBGH), and their partner Qualcomm, are beginning to look at covering midwives in payment reform. This raises its own set of challenges, though, as midwives and doulas must fit into the benefits and claims active in a payer's sphere. Further, Blue Cross Blue Shield of North Carolina raised several other challenges payers face related to coverage of community health workers – especially doulas. Supply and demand remains an issue in doula care, with a limited number of credentialed doulas serving as a barrier to organizations contracting with doulas. While credentialing is a means to prove the validity of a doula, credentialing also creates a barrier for many lower-income, minority communities. This presents a significant issue for hospitals that seek to incorporate more community-based care.

A few state Medicaid programs have begun to take action in this area, with four states currently covering doula services as part of their Medicaid program: New Jersey, Indiana, Oregon, and Minnesota.[11] However, challenges remain in the sustainability of these Medicaid programs year after year. For example, the Indiana doula program recently lost funding after it was removed from the budget in 2019. As the benefits of doulas receive more national attention, some states

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[i] Doulas act as an advocate for the birthing individual to ensure that the birthing person's preferences are prioritized before, during, and after birth. Birth doulas are generally characterized as providing non-clinical informational, emotional and comfort measure support around the time of birth, and in some instances providing support during pregnancy and in the postpartum period as well (in some situations, such as hospital-based programs, a woman may meet her doula for the first time during labor).

[ii] Midwives are trained clinicians that provide care during pregnancy, postpartum, inter-conception, and reproductive health care. Midwives may help birthing individuals give birth during low-risk pregnancies, either at a hospital, in a birth center, or in a home birth setting. Many midwives (and statutes) distinguish midwifery from medical care.

are starting to look at expanding coverage to include these services.[12] Notably, New York began a Doula Pilot Program in 2019 to cover doula services for Medicaid fee-for-service and Medicaid Managed Care enrollees. The pilot is initially working in one New York country to enroll doulas as Medicaid providers. This pilot is using a phased-in approach, so the second phase will begin once provider capacity in the first county is reached.

While states are slowly incorporating midwifery and doula services into their Medicaid programs, there has been no reflection of this in existing Medicaid APMs for maternity care. In Tennessee's retrospective bundle, the system relies on claims data to reimburse providers. Since midwives cannot be identified by claims data, it is difficult to incorporate midwifery care into the model. Similarly, Colorado's retrospective bundle does not explicitly include midwives in the bundle, but if a midwife chooses to participate, there is nothing preventing the participating physician from sharing the savings with said midwife. Colorado and other states continue efforts to eliminate challenges to including midwifery care in bundled payment models and APMs.

## Health Equity "Gateways"

Colorado's Medicaid maternity APM provides a strong example of designing and implementing a model to improve health equity. During the design period, Health First Colorado led an intensive stakeholder engagement process to design a model in which providers are not eligible for shared savings if their claims data indicates a statistically significant difference in utilization between White and non-White Medicaid patients. To continuously improve and assess health equity in their model, the Colorado team also created a Maternity Advisory Committee comprised of Black, Indigenous, and People of Color (BIPOC) birthing people who were covered by Medicaid when they gave birth. While still a new initiative, the Advisory Committee will be actively engaged in the development of future health equity measures.

Similarly, other practices are available to integrate health equity into payment adjustments.[13] strategy is to provide a larger upfront payment to providers who care for disproportionately higher-risk populations; the second uses a multiplier so that organizations serving a population with greater social risk would receive larger rewards for an equivalent outcome. While adjusting for payments, models should also offer a payment to safety net providers to invest in the necessary infrastructure to address social needs (*i.e.,* health IT, community care coordinators, etc.).

Another equity-focused element of model design is creating and disseminating performance measures that can be stratified by race, ethnicity, and other key demographic variables to identify and track any segments of the population experiencing inequitable health outcomes and provide incentives to improve and eliminate gaps. While organizations can disaggregate measures that currently are collected, they can also develop their own performance metrics, or develop standardized measures that can be adopted nationally by all providers and health plans.

Alternative payment models can be utilized to enhance certain services that potentially advance health equity such as telehealth and community-based models. It should be noted that telehealth services raise equity concerns when reimbursement is only offered to providers who communicate via audio and video, since certain communities lack access to the proper bandwidth to sustain video calling. Offering reimbursement to providers who communicate over audio-only calls is a step in the right direction. Alternative payment models should also incentivize care teams that include community-based organizations and health workers. For maternity care,

including doulas and midwives in service payments increases birthing individual's access to culturally competent care that is tailored to what matters to them.

# APM Operational Considerations

## Mandatory vs. Voluntary Models

An APM can either mandate participation in the model or allow providers to voluntary participate. A large concern with voluntary models is that by allowing providers to choose whether to participate in a model, only those who are best set to achieve success (*i.e.*, achieving quality metrics and receiving shared savings) are likely to join. The threat of selective participation could exacerbate disparities in care as providers who see patients with a greater range of social needs and risk factors may opt out of model participation. Mandatory models avoid the selective participation issue and if equity-focused elements are baked into the design, equity concerns could be mitigated.

The Health First Colorado initiative has chosen to keep their program voluntary. Due to its implementation during COVID-19, a smaller number of providers were able to dedicate energy to learning about and participating in a new model given most focus was on mitigating effects of the pandemic. After operating the voluntary models for three years, Colorado plans to make their model mandatory in 2023. This allows time to learn from the initial model design before mandating participation and implementing it across a greater number of providers.

## Payment and Reimbursement Structure

There are two payment structures used in APM design. Prospective payment offers upfront payments to providers which is used to cover all services needed by the patient in the bundle's time frame. Reconciliation occurs after the bundle ends to determine if the provider stayed within the bundle cost; if the cost target was exceeded, the provider is responsible for the shared losses. Retrospective payment pays providers under the typical fee-for-service paradigm. They then face a reconciliation period at the end of an episode to see how they fared against a pre-set benchmark, and shared savings or losses are awarded based on their performance.

Prospective payment is the desired gold standard as it allows providers to fully move away from fee-for-service and invest in infrastructure to place the patient at the center of their care. However, for both public and private payers, retrospective payment is currently the most common bundle type. Blue Cross Blue Shield of North Carolina, Anthem, Washington State Health Care Authority, TennCare, and Health First Colorado all use retrospective bundles to improve maternal health outcomes. Only one organization who presented during the Maternal Health Hub learning community, PBGH, uses prospective payments. Their bundle is newly implemented – as of January 2021 - in partnership with United HealthCare and Scripps at one of their member organizations, Qualcomm in San Diego.

## Direction and Accountability for Risk Bearing

The most cited challenge to model implementation was provider hesitation of moving into a model with downside risk. To mitigate some of this difficulty, TennCare worked with providers from the beginning to familiarize them with the bundle of care, holding numerous meetings with stakeholders to address provider concerns. At the start of the model's implementation, the majority of provider feedback was protesting the model and calling for it to not go live. Now six

years later, the state notes that providers have acclimated and when called upon to provide feedback, offer operational tweaks designed to evolve, rather than end, the program.

Achieving buy in from participating entities is only one piece of the puzzle. For payers, another challenging aspect is deciding which entity will take on the risk. Before signing a value-based contract with a provider, Blue Cross Blue Shield of North Carolina will evaluate who is ready and capable to take on risk. Typically, those organizations ready to take on risk are those with tools already in place, which speaks to the need for investment in infrastructure for smaller providers and those that operate in underserved urban or rural locations, to enable them to participate in risk-sharing models.

For small and/or safety net providers, taking on risk can be a daunting task. In acknowledgement of this, BCBS NC acts as a convenor to bring smaller maternity care practices into value-based care models. This partnership allows risk to be transferred in incremental steps, so the participating providers get familiar with the concepts before moving into full risk. To achieve these partnerships, BCBS NC is working with Wildflower Health, a digital health and value-based care company, to share the risk.

## APM-Enabling Data and Infrastructure

To improve maternal health outcomes, all individuals in the care team must work together to put the childbearing family at the center of their care. It is also not atypical for a birthing individual to have a primary care provider, OBGYN, midwife and/or doula on board for their care. To ensure care is coordinated, value-based models should ensure/enable secure data sharing – with the patient's consent - between individuals, their caregivers, care teams, providers, payers, and community-based organizations.

Anthem is currently working to address the issue of data sharing by partnering with another organization, the U.S. Women's Health Alliance. A national organization of women's health care practices in the U.S., the U.S. Women's Health Alliance serves to effectively unify resources, knowledge, and experiences to help private practices thrive in a health care environment while delivering high quality and affordable health care to women. The partnership between these two organizations allows Anthem's providers to facilitate data capabilities while Anthem works to improve their own data analytics. Other organizations (BCBS NC and PBGH) acknowledged that a lot of work is needed in this space, both in terms of collecting better data in the first place and then allowing this data to be shared among providers. A common concern that must be urgently addressed is lack of access to complete and accurate information about race, ethnicity and other identities that are often associated with inequitable care, experiences and outcomes.

Health First Colorado seeks to address data interoperability in their model by gathering Electronic Health Record (EHR) data from Medicaid Managed Care Organizations (MCOs) in the state. This allows the team to look beyond the global billing used to see if there is any difference in prenatal services delivered between different sub-groups of the population.

At the federal level, Congress and the Administration are pushing transparency from a hospital perspective. Beginning January 1, 2021, under the Hospital Price Transparency Rule, each hospital in the United States is required to provide clear, accessible pricing information online about the items and services they provide. Health systems can join this effort by advocating for similar policies related to data sharing.

## Use of Performance Measures

Alternative payment models seek not only to reduce costs but also to improve quality of care for patients. Measuring quality is a critical step in APM development, yet it is difficult to find an ideal set of measures to use. Across the commercial and public sectors, there are a range of measures being utilized, with the most common measures being HEDIS, HCAHPS or Press Ganey. Although these measures are standardized, they are very broad and do not provide the level of granularity needed to see improvements in maternity care. Acknowledging the broadness of quality measure sets, TennCare selected their own quality measures to analyze, focusing on: HIV screening, Group B Strep screening, and cesarean births. TennCare uses these measures to calculate shared savings, while also using a broader set of measures, including gestational diabetes screening, asymptomatic bacteriuria screening, hepatitis C screening, and Tdap vaccination, for internal informational purposes.

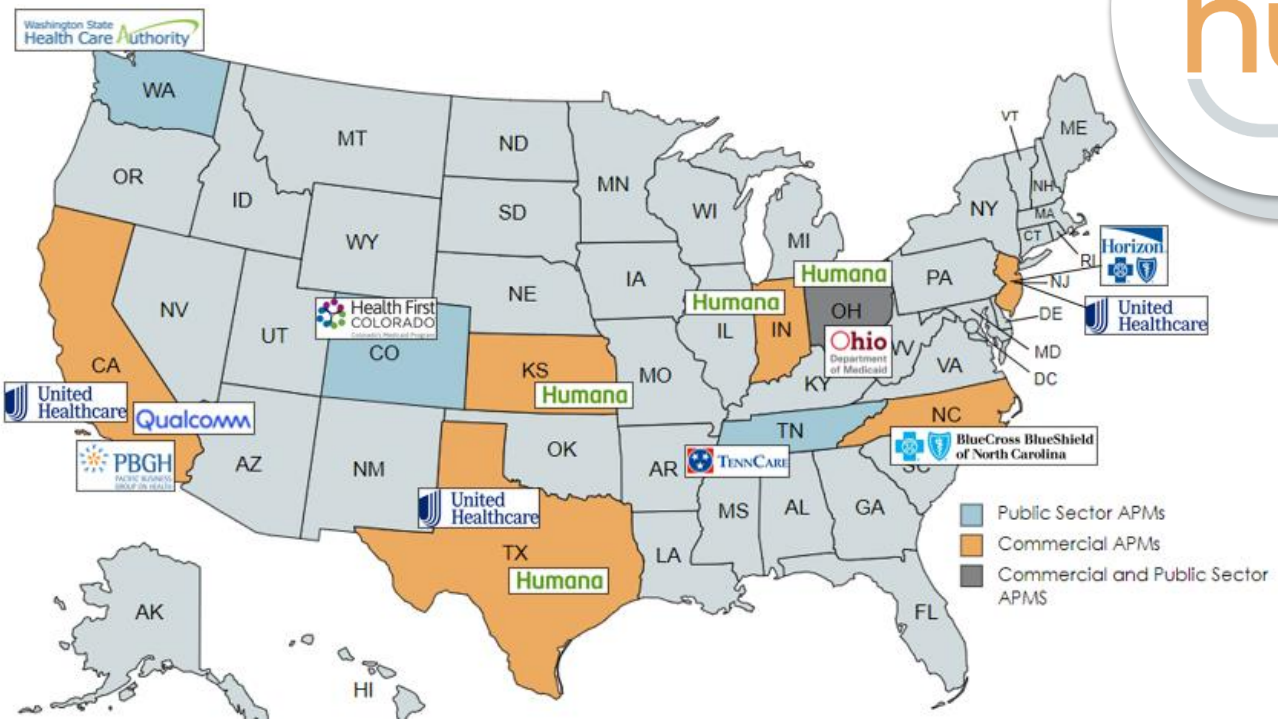
A major challenge in the creation of operational quality measures revolves around claims data. Some APMs rely solely on claims data to analyze the actions of provider, meaning quality measures must be tied to claims data. This gives little leeway to model designers who would like to focus on a greater number of clinical care areas, yet are tied to areas that are currently found in claims data.

Urgent priorities for meeting the quality improvement aims of APMs and addressing the nation's maternal health crisis are measures with the potential to impact childbearing families at the population level, measures that are stratified by race/ethnicity and other dimensions of inequity, and person-reported measures of the experience of maternal-newborn care and the outcomes of maternal health care.

## Conclusion

Payment policy reforms and innovations are a critical step toward transforming maternity care; they need to be implemented concurrently with workflow and culture change at the point of care to truly realize the Triple Aim goals of alternative payment models. As these models – in both the commercial and the public sectors – continue to mature, stakeholders will endeavor to explore how to merge the vision of the patient-centered, coordinated, community-based maternity model for pre-natal, labor and birth, and post-partum care, with innovations in payment.

# Alternative Payment Models in Maternity Care




## COMMERCIAL APMS

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|---|---|
| PBGH Pacific Business Group on Health; Qualcomm; United Healthcare | https://www.nationalalliancehealth.org/www/news/news-press-releases/2020-excellence-award |
| BlueCross BlueShield of North Carolina | https://www.bluecrossnc.com/sites/default/files/document/attachment/services/public/pdfs/medicalpolicy/guidelines_for_global_maternity_reimbursement.pdf |
| Horizon | https://www.horizonblue.com/members/health-programs/patient-centered-programs/episodes-care |
| Humana | https://press.humana.com/news/news-details/2018/national-value-based-model-for-maternity-care/default.aspx#gsc.tab=0 |
| United Healthcare | https://www.unitedhealthgroup.com/newsroom/2019/2019-05-09-uhc-bundled-payment-maternity-carehtml |

## PUBLIC SECTOR APMS

| | |
|---|---|
| Health First COLORADO Colorado's Medicaid Program | https://hcpf.colorado.gov/bundled-payments |
| Ohio Department of Medicaid | https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/payment-innovation/episode-based-payments/linked-to-payment |
| TennCare | https://www.tn.gov/content/dam/tn/tenncare/documents2/PERISumm2021.pdf |
| Washington State Health Care Authority | https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2021/01/Perinatal-Bundle-FINAL-2021.pdf |

*Up to date as of July 2021*

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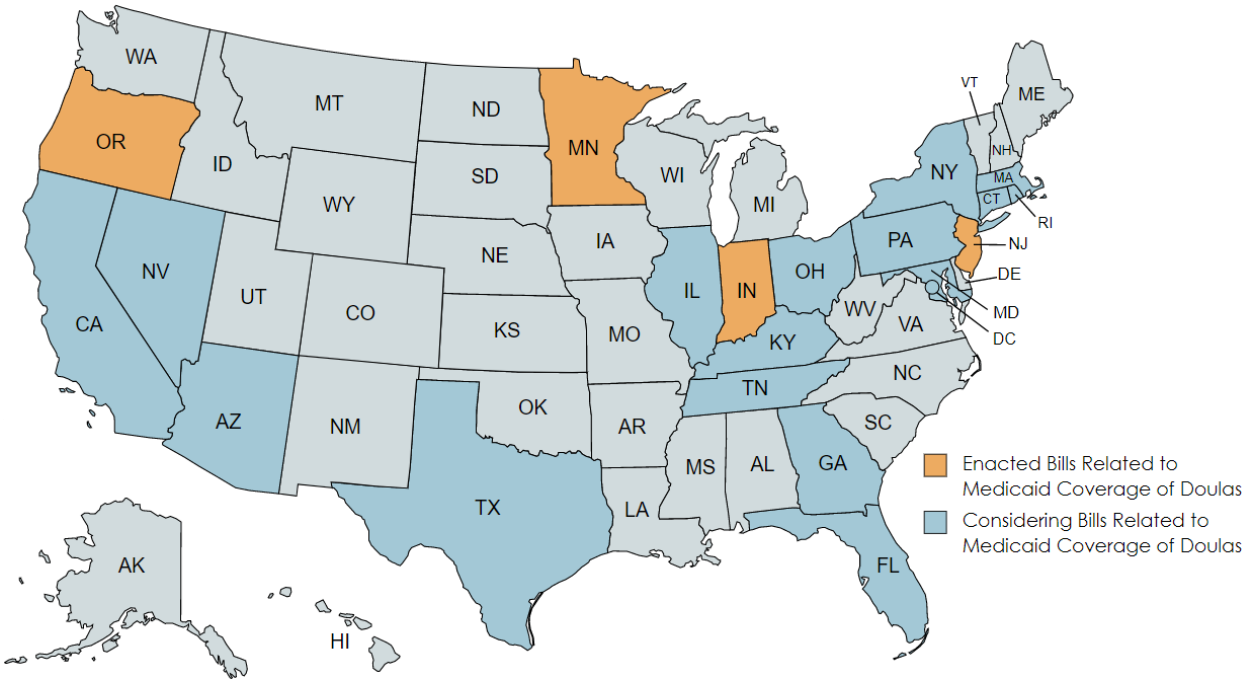
# Medicaid Coverage of Doula Services




| ENACTED BILLS RELATED TO MEDICAID COVERAGE OF DOULA CARE | |
|---|---|
| Indiana | https://legiscan.com/IN/bill/SB0416/2019 |
| Minnesota | https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-14-007.pdf |
| New Jersey | https://legiscan.com/NJ/bill/S1784/2018 |
| Oregon | https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0006.pdf |

| CONSIDERING BILLS RELATED TO MEDICAID COVERAGE OF DOULA CARE | |
|---|---|
| Arizona | https://legiscan.com/AZ/bill/SB1181/2021 |
| California | https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB65 |
| Connecticut | https://legiscan.com/CT/bill/HB06010/2021 |
| District of Columbia | https://legiscan.com/DC/bill/B24-0026/2021 |
| Florida | https://www.billtrack50.com/BillDetail/1325847 |
| Georgia | https://legiscan.com/GA/bill/HB727/2021 |
| Illinois | https://trackbill.com/bill/illinois-house-bill-354-medicaid-doula-services/2005997/ |
| Kentucky | https://legiscan.com/KY/bill/HB286/2021 |
| Maryland | https://legiscan.com/MD/bill/SB163/2021 |
| Massachusetts | http://malegislature.gov/Bills/192/H2372 |
| Nevada | https://legiscan.com/NV/bill/AB256/2021 |
| New York | https://www.nysenate.gov/legislation/bills/2021/S362 |
| Ohio | https://www.billtrack50.com/billdetail/1326602 |
| Pennsylvania | https://legiscan.com/PA/bill/SB360/2021 |
| Rhode Island | https://legiscan.com/RI/bill/H5929/2021 |
| Tennessee | https://legiscan.com/TN/bill/SB0650/2021 |
| Texas | https://legiscan.com/TX/bill/HB158/2021 |

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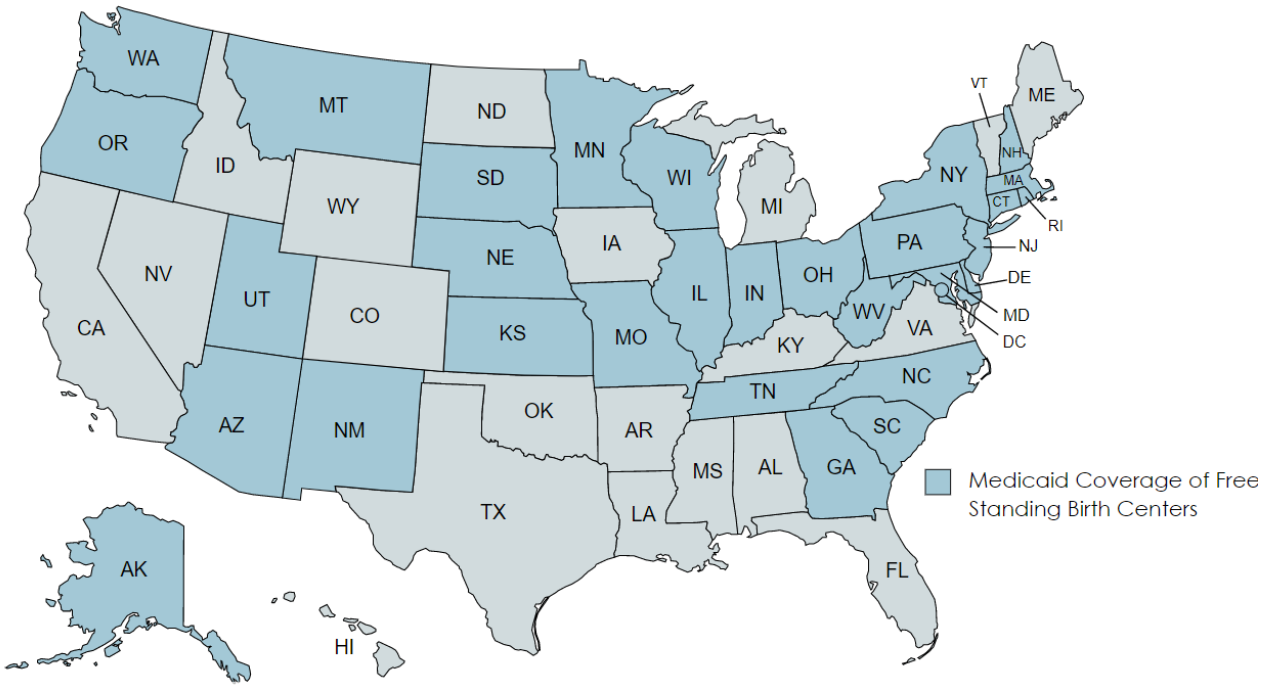
# Medicaid Coverage of Free-Standing Birth Centers





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