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Realizing the Transformational Potential of Maternity Care Payment Reform

Analysis and Recommendations



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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.



Introduction: Leveraging Payment Reform to Tackle the Maternal Health Crisis

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, especially Black and Indigenous families, disproportionately bear the brunt of this crisis, along with rural and low-income families. Despite broad recognition that the nation's maternity care system is deeply inequitable and fails to provide childbearing families with the services and supports they need to thrive, the maternal health crisis continues to escalate. In recent years, rates of maternal mortality and severe maternal morbidity have continuously risen.¹ Prenatal and postpartum depression and anxiety are prevalent and largely go untreated.² Technology-intensive, invasive practices, including high rates of cesarean births, prevail in childbirth and are frequently delivered regardless of need or preference.³ With the steady closure of hospital maternity units, more than one-third of U.S. counties are considered to be maternity care deserts.⁴ This large-scale harm, including an estimated 84 percent of maternal deaths, is largely preventable.⁵

THE QUALITY OF MATERNITY CARE IN THE NATION IS POOR AND INEQUITABLE

The U.S. maternity care system fails birthing people, and deep inequities are pervasive, driven by generations of intractable systemic, institutional, and interpersonal racism and other discrimination. People of color – especially Black and Indigenous birthing people, people living in rural areas, and those with lower incomes – experience notably higher rates of maternal mortality, severe maternal morbidity, and perinatal mental health concerns than their counterparts.⁶ In addition, they report higher levels of mistreatment, like being ignored or not listened to, and of having their care delayed, which can result in avoidable harm.⁷ Similarly, although data for people with disabilities and the LGBTQIA+ community are limited, what is available shows that they also endure worse quality of care experiences and outcomes.⁸

“Surviving your child’s birth or their first year of life should be the floor, not the ceiling.”

—**Monica McLemore**, Professor, University of Washington School of Nursing, birth justice leader

This crisis exacts a high cost, not only on the individuals and families directly affected, but also on our shared future as a country. Persistently substandard and inequitable maternal and infant health outcomes directly undermine our nation’s well-being. High quality, equitable maternal and newborn health are literally the foundation for a healthy population, and crucial to building the long-term health of the 83 percent of U.S. women who give birth.⁹ A growing body of research shows that what happens from pregnancy through the postpartum period and infancy can have long-term, even lifelong, health effects, both positive and negative, for both birthing person and offspring.¹⁰ Moreover, our inability to narrow equity gaps is destructive not only for those being left behind, but also for the nation as a whole, as people of color become an increasingly larger portion of the population.

The reproductive and birth justice movement, led by Black leaders and other leaders of color, is deeply engaged in transforming this reality. National organizations like Birth Center Equity, the Black Mamas Matter Alliance, the National Perinatal Task Force, and Reproductive Health Impact (formerly the National Birth Equity Collaborative), working with state and local community-led and -based organizations, have been developing, implementing, and championing strategies and programs to turn the tide. They focus on delivering culturally congruent, tailored, trustworthy, and respectful care that provides better quality, support, experience, and outcomes, and on advocating for the policies that enable them. However, despite increased media attention on this escalating crisis, decision-makers have shown insufficient political will to support concrete solutions that will pay for what works and what people need to substantively change the status quo.

VALUE-BASED PAYMENT REFORM MUST BE PART OF THE SOLUTION

For more than 15 years, health care leaders and policymakers have focused on payment reform to improve the quality and value of health care. This strategy is based on the observation that fee-for-service payments encourage the delivery of large amounts of services at the highest possible price, irrespective of the health impact. This perverse incentive is especially harmful in the maternity context because it can encourage a more expensive and often more convenient cesarean birth rather than a vaginal one, unwarranted newborn days in neonatal intensive care units, and other services that are unnecessary in a predominantly healthy population.

Shifting from volume-based fee-for-service payments to paying for the value of care reverses the current incentives and can motivate providers to improve quality and reduce costs. Value-based payment through use of alternative payment models (APMs) involves financial incentives, and sometimes penalties, tied to value.

The Health Care Payment Learning and Action Network (LAN) – a group of public and private leaders working to accelerate adoption of APMs through strategic direction, thought leadership, and ongoing support – uses a framework ranging from fully fee-for-service payments with no ties to quality to several progressive tiers of value-based payment.¹¹ Its 2022 payer survey to track adoption of APMs and payer opinion about APMs estimates that across all lines of business, 20 percent of health care payments were to providers engaged in risk-based performance models where they might be financially rewarded or penalized for their performance, 20 percent were to providers in performance models in which they stood only to gain, 20 percent involved other types of financial support (e.g., infrastructure payments, pay for reporting, or pay for performance), while 40 percent remained fully in fee for service. In that survey, 96 percent of payers agreed that APM adoption will result in better quality of care. Among equity-focused questions, 46 percent were collecting standardized race/ethnicity and language (REL) data, while 22 percent were stratifying performance measures by those subgroups.¹²

Health equity advocates have raised concerns about unintended consequences of APMs that are not proactively designed to advance equity. Compared to better-resourced providers, for example, safety net, rural, and small-practice providers may be unable to support the infrastructure for data collection and reporting and other activities required to participate in APMs. Those who care for higher-acuity patients will be disadvantaged with gainsharing and shared risk arrangements without appropriate adjustments in payment levels and performance targets for more complex patients. Higher-acuity patients could be disadvantaged by incentives for providers to decline caring for them or stint in their care. The vast majority who don't stratify performance measures by REL and other dimensions cannot understand and track inequities in care and outcomes. Without intentionally tracking inequities and implementing strategies to reduce them, they are unlikely to improve.¹³

The present administration prioritizes advancing health equity overall and maternal health equity specifically. The Centers for Medicare and Medicaid Services (CMS) issued the *CMS Framework for Health Equity 2022–2032*.¹⁴ A focus on equity is woven through the *White House Blueprint for Addressing the Maternal Health Crisis*,¹⁵ as well as the CMS Maternity Care Action Plan.¹⁶ And the CMS Innovation Center, the home of federal models and guidance for value-based payment, includes advancing health equity as a pillar of its *Innovation Center Strategy Refresh*, clarifying that equity should be built into the development, implementation, and evaluation of Innovation Center models, along with care to avoid inadvertently further harming populations that have been historically marginalized.¹⁷ Most recently, CMS announced its new Transforming Maternal Health (TMaH) Model and its intention to support up to 15 state Medicaid agencies in a three-year planning period followed by a seven-year implementation period.¹⁸

There is also a broader burgeoning commitment to developing mechanisms to integrate equity-forward design elements into APMs. In 2021, the Health Equity Advisory Team (HEAT) of the Health Care Payment Learning & Action Network put out a call to action for purchasers and payers to begin incorporating health equity-forward design elements into APMs. This recognizes that APMs present a significant opportunity to incentivize improved care delivery, create more accessible care, improve patient outcomes, and reduce inequities in care and outcomes. With this call to action, the HEAT issued *Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation*, which recommends equity-forward APM design elements focused on (1) care delivery redesign, (2) payment incentives and structures, and (3) performance measurement. A series of design elements addresses each area.¹⁹

To guide this maternity care APM project, we adapted the HEAT’s general framework to the specific circumstances of maternity care, identifying how each generic design element would apply in this context (see Table 1). The first two columns present the HEAT framework, and the final column is our adaptation. We identified two design elements that were not included in the original HEAT framework: in care delivery redesign, incorporating high-performing, underutilized maternal care models, and with respect to performance measurement, the importance of selecting high-impact consensus-based measures.

Table 1. APM Design Elements of the Health Care Payment Learning & Action Network’s Health Equity Advisory Team (HEAT), and Adaptation to Maternity Care

Alignment Categories	HEAT APM Design Elements	Maternity-Specific Application of Design Elements
Care Delivery Redesign	Partnership with CBOs and social service agencies	Partnership with perinatal and other CBOs and social service agencies
	Organizational mechanisms for partnering with patients to drive decision-making and investments	Organizational mechanisms for partnering with birthing people and the community groups that support them to drive decision-making and investments
	Provision of person-centered, culturally and linguistically appropriate care	Provision of person-centered, culturally and linguistically appropriate maternal and newborn care, including culturally congruent care
	Integrated care to address medical, behavioral health, and health-related social needs	Integrated care to address physical, mental health, and health-related social needs during pregnancy and postpartum period (ideally to 12 months). This includes early prenatal and postpartum screening, development and maintenance of co-created care plans, and proactive follow-up to meet physical, mental health, and social needs.
	Organizational capabilities to support implementation and uptake of APMs to promote health equity	Organizational capabilities to support implementation and uptake of APMs to promote quality improvement and health equity (e.g., through periodic meaningful data reports, technical assistance, and collaborative learning)
	NOT INCLUDED	Proactive provision of access to high-performing, underused maternal 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.

Continued >

Alignment Categories	HEAT APM Design Elements	Maternity-Specific Application of Design Elements
Payment & Incentives Structures	Population-based payment models with prospective cash flows	APMs with prospective cash flows that cover the entire pregnancy or pregnancy beginning with entry into care through postpartum (ideally to 12 months) and newborn periods, and offer flexibility to provide high-impact services that may not have billing codes (e.g., doula support and services of community-based organizations)
	One-time infrastructure payments for care delivery transformation	One-time or periodic (e.g., annual) infrastructure payments for care delivery transformation
	Payments designed to focus on populations historically harmed and underserved in health care systems	Maternity episode payment programs should be designed to provide the care necessary to support populations historically harmed and underserved in health care systems, and not on historical spending experience. Episode payment budgets should also reflect the expenses associated with using an expanded workforce of non-physicians (e.g., doulas and lactation counselors) Maternity care homes should be designed to provide adequate payments to care and support personnel serving historically harmed and underserved populations.
	Payment incentives to reduce health disparities in quality of care, outcomes, and patient experience	Payment incentives to advance health equity during pregnancy, birth, and in the postpartum and newborn periods
	Clinical and social risk adjustment for payment	Payment adjustment for social, physical, or mental health risk, to provide more services to birthing families with greater needs and more resources to providers caring disproportionately for such families
	Payments to community-based organizations to fund collaborative partnerships	Payments to community-based organizations providing perinatal services to fund collaborative partnerships
Performance Measurement	Collection of data related to health disparities	Complete accurate and standardized collection of data related to childbearing people’s racial and ethnic, language, sexual orientation, gender, disability status, and geographic identities
	NOT INCLUDED	Selection of consensus-based performance measures on experience of maternal and newborn care and other issues important to childbearing families, that address performance gaps and have potential for population-level impact
	Stratified and risk-adjusted performance measures	Stratified and risk-adjusted performance measures that can be used to measure, track, and reduce inequities
	Integration of state, public health, social services, and community-level data	Integration of state, public health, social services, and community-level data, which may include Maternal Vulnerability Index or similar geographic indices

ASSESSING PROGRESS OF MODELS WITH THE GREATEST POTENTIAL FOR CARE DELIVERY TRANSFORMATION ON MATERNAL HEALTH EQUITY AND OUTCOMES

The LAN's APM framework encompasses a range of payment structures with varying levels of clinical and financial risk and presumed capacity for impact. At present, maternity APMs include options like pay for performance, nonpayment, and blended payment rates for vaginal and cesarean births. We focused on episode payment programs and maternity care homes because of their potential to favorably impact quality and equity by shaping broader care delivery transformation. Episode programs largely focus on clinical care, and maternity care homes largely focus on support services. They complement one another, can be used together, and can include other payment reforms that are more limited in scope.ⁱ

Episode payment is, thus far, the only *payment* model that has the potential to focus on the entire maternal-newborn care continuum – from prenatal through birth, and the postpartum and newborn periods. Episode programs involve provider accountability, which optimally increases over time in tandem with provider performance targets and quality improvement. Payers and vendors supporting episodes can support providers with data and analytic tools they need to track and improve performance. Episode programs have the potential to pay for beneficial care not typically reimbursed, as budgets can be built to include a more expansive list of clinical and nonclinical services. As the health care system evolves with improved infrastructure, coordination, and regulatory support, episode programs can shift to design elements that may be more impactful (e.g., prospective versus retrospective payment, which may give providers the necessary resources to pay for services that are typically un- or under-reimbursed).²⁰

Maternity care homes can fall at several points along the continuum of APMs, depending on the payment mechanism used.²¹ Because four out of every five dollars paying for maternity and newborn care are allocated to the hospital phase of care, very little is left to cover all services that support health in the prenatal and postpartum periods.²² Maternity care homes have the potential to fill a major gap in the current maternity care payment system by incentivizing the provision of nonclinical prenatal and postpartum services as a complement to clinical care, in the service of improved outcomes. These may include services such as health education, social and mental health needs assessment and follow-up, and care navigation (both clinical and help securing services for which childbearing families may be eligible, such as doulas, supplemental food programs, paid leave, and workplace accommodations). Moreover, other community-based social-service-oriented personnel may be especially well-suited to supporting pregnant people who may need help with things like smoking cessation, intimate partner

i We only found one instance, in Ohio, where the same childbearing family might currently be participating in both types of programs.

violence, or housing insecurity. Potential additional personnel who might implement maternity care home activities include community doulas, social workers, and nurses.

Maternity care homes are modeled after the well-established patient-centered medical home (PCMH) in primary care. The success of the PCMH model, with both overall improvements and advancing equity, suggests similar benefits are possible when personnel and work are integrated into clinical systems, and personnel are prepared, tasked, resourced, and held accountable for supporting childbearing families.²³

Given the urgency of improving maternal health outcomes and narrowing inequities, and the health care system's transition to value-based payment model development and adoption, our goal was to assess what progress, if any, has been made where maternity care episode payment and maternity care home programs meet needs for maternal health equity and excellence. Specifically, we aimed to examine the extent of use of these models, the design features of existing programs, and whether they have helped mitigate preventable and inequitable harm and improve maternal health outcomes. We did this by interviewing birth justice movement leaders, managers of the two types of maternity programs, and other subject matter experts and thought leaders, supplemented with research and health care industry literature.

We believe this is the most up-to-date assessment of these two care delivery and payment models, and the fullest look at their attention to and impact on maternity care quality and equity to date. The ensuing stakeholder-specific recommendations apply lessons from this investigation to realize the potential of maternity care payment reform and do justice to the needs of childbearing families and future generations. Appendix A identifies the people interviewed for this project.

A technical supplement to this report describes the methodology for this project, summarizes results of our investigation of currently operating and upcoming programs, and presents standardized profiles of the programs studied.²⁴ We identified 17 operating episode payment programs and three under development, and were able to interview managers of 17 (85 percent) of these programs. We identified four active maternity care home programs and interviewed managers of all four.

We created semi-structured qualitative interview guides for the three groups of interviewees. To learn about the various episode payment and maternity care home programs from Medicaid agencies, health plans, and employer purchasers, we investigated basic attributes and design features of their programs, including items in the maternity-specific adaptation of the Health Equity Advisory Team framework (Table 1), as well as various opinion questions relating to maternal health and payment reform. The guide for payment reform thought leaders and subject matter experts investigated their theories of payment reform and design features that need to be used to improve maternal health and reduce maternal health inequities. The following section describes our approach to, and what we learned from, our interviews with birth justice leaders.



Centering Birth Justice in Alternative Payment Model (APM) Assessment

To ground this work in the experiences, priorities, and needs of those most affected by the maternal health crisis, we interviewed well-known birth justice leaders who work on a daily basis to improve outcomes for women and infants of color via direct care, research, and advocacy.

We understand that those who are from communities confronting persistent structural racism and other forms of discrimination, including generations of disinvestment and marginalization, are the real experts on how to solve this crisis. Yet too often their expertise is excluded from policy development and implementation. Our semi-structured guide for speaking with these leaders investigated their views regarding the most pressing inequities in the maternal health care system, and the health system and non-health-system drivers of these inequities, as well as whether and how payment reform could be part of a solution. (See Appendix A for the list of all the experts we interviewed.)

BIRTH JUSTICE LEADERS HAVE NOT BEEN ABLE TO DEEPLY FOCUS ON PAYMENT POLICY

The birth justice leaders we interviewed were no strangers to innovative payment arrangements. For example, one participated in a goal of improvements for Black birthing people that was tied to salaries of leaders across the system, and another received fixed payments from several Medicaid health plans for providing flexible services to their beneficiaries. However, the leaders we spoke with have been primarily focused on areas such as clinical transformation, combating racism and other biases, and ensuring respectful maternal care – within current health care payment structures.

“Birth justice folks have limited resources, and we pick and choose our battles. We put our energy into what we can impact. We feel that our work is not in tackling the powerful system of payment and financing.”

—**Erica Guthaus**, *Commonsense Childbirth*, birth justice leader

One respondent recognized that innovative payment models can move maternity care in a better direction, but that they have limits and are not a panacea. Several envisioned a longer-term goal of universal access to safe, beneficial, desired, and respectful services for all, but without necessarily outlining the transition to such a system and how it would be financed. While they recognized the need to change the way we pay for care, they tended to not be actively working on reforming payment policy.

Health equity or consumer/patient advocates have had limited involvement with payment reform policy development overall. In addition to their different areas of focus, government and industry do not tend to prioritize involvement of consumer advocates. Further barriers include the level of complexity of the issues and limited resources and technical assistance for engaging effectively.²⁵ This specific area is no different. For example, two of the birth justice leaders noted that payment reform is complex and esoteric and requires time, resources, and access to specialized information that the birth justice community lacks.

BIRTH JUSTICE LEADERS KNOW WHAT COMMUNITIES NEED TO ACHIEVE HEALTH EQUITY

The values and priorities that the birth justice leaders identified align closely with the maternity adaptation of the Health Equity Advisory Team’s framework for equitable APM design, as delineated in Table 1. The leverage of payment reform should be harnessed to foster the care delivery redesign and performance standards they seek.

They endorsed using payment to support equity, respectful care, and quality. They discussed the need for standardized performance measures to hold systems accountable, especially for advancing respectful and equitable care and person-reported experience measures. They also supported measures that create incentives to keep people healthy.

The birth justice leaders we interviewed were keenly focused on addressing a broad range of drivers of maternal mortality and severe maternal morbidity as necessary for advancing equity and preventing inequities from getting worse. They emphasized the importance of tackling a broader range of issues that also involve harm and need attention. These include access to clinical care – and specifically the crisis of access to maternity care in rural areas – as well as preventing unneeded cesareans, and addressing perinatal mental health and social drivers of maternal and infant health such as economic opportunity, nutrition, transportation, green space, childcare, and paid leave.

These leaders strongly advocated for prioritizing quality over cost in the maternity care system, and elevated specific elements that will make a marked difference in outcomes. They underscored the value of providing person-centered, whole-person care that centers the birthing person and newborn dyad, promoting intergenerational well-being. They identified the importance of having maternity care homes and building and supporting a diverse maternity care workforce, both in terms of cultural background and a diversity of clinical and non-clinical roles. They clarified that culturally congruent team members can offer special opportunities for trustworthy, respectful, effective care. They viewed as foundational broad access to midwives, doulas, care navigators, and other community-based perinatal health care workers that can provide relationship-based care.

Birth justice leaders call for bold, systemic action to address racism – the key driver of maternal and infant health inequities

The birth justice leaders we interviewed for this report identified systemic, institutional, and interpersonal racism as primary reasons for the inequities in maternal and infant outcomes. They called for a change in maternity care, delivery, access, and payment. One respondent argued that just as we create and implement systems for patient safety, we should create and implement systems for addressing the harm of racism and mistreatment. While there was no consensus on the role APMs could play in improving overall outcomes or equity, there was a general sense that creating new models of payment could be a step in the right direction, even if they could not eliminate all the system barriers. Further, they agreed that maintaining the status quo would continue to perpetuate the harmful effects of racial oppression.

At the same time, these leaders were keenly aware that the current maternity care payment system did not adequately support the care that birthing people need. To start with, inadequate Medicaid payments for providers undermine both quality and access. Finding providers that accept Medicaid payments can be difficult and may involve delays in receiving care. This is critical because of Medicaid's outsized role: In 2021, it covered 41 percent of the nation's births, including 66 percent of births to Indigenous mothers, 64 percent to Black mothers, 58 percent to both Hispanic and Pacific Islander mothers, 28 percent to white mothers, and 23 percent to Asian mothers.²⁶ In addition, leaders acknowledged the absence of flexible payment systems that support building relationships and meeting individual needs. This includes mechanisms for paying for the uniquely valuable services of community-based organizations that ensure their stability and sustainability, with compensation that transcends the dependence on continuous grant and fundraising cycles that plagues so many of these groups.



Analysis and Findings: Evidence on Impact of Maternity Care APMs on Better, More Equitable Maternal Health Is Unavailable, but Newer Models Show Promise

Well-designed priority model APMs – that is, maternity episode payment and maternity care home programs – could be a promising strategy to improve outcomes, reduce inequities, and lower costs. However, there is insufficient data on APMs’ impact on outcomes, quality, equity, and costs to allow us to adequately assess whether they are making a difference, both overall and for those who need it most.ⁱⁱ

ii A supplemental report details our methodology and results of our interviews with episode payment and maternity care home program managers, using the maternity adaptation of the LAN HEAT framework. Please consult this technical supplement for program details mentioned in this section. *Technical Supplement to Realizing the Transformational Potential of Maternity Care Payment Reform: Methodology and Summaries of Maternity Care Episode Payment and Maternity Care Home Programs*, <https://nationalpartnership.org/maternityAPM>

APMs must collect and track population-based outcomes – initially by race and ethnicity, and over time by other dimensions of inequity. By stratifying the data, APM managers can work with providers to develop and implement action plans to close disparities, and decision-makers, payers, advocates, and others can hold providers accountable. To be sure, maternity APMs have evolved over time, reflecting the experience of early adopters who published findings, lessons learned, and case studies on their experience.²⁷ However, considering the limited data that are available, we found that the earliest maternity APMs were more focused on reducing costs than on improving maternal and infant health or tackling the system’s deep inequities.

Key findings emerging from results and analysis of the current landscape of maternity APMs

- Most maternity care APMs were not designed to address inequities and do not stratify outcomes data, so their impact on racial and ethnic inequities cannot be known
- Because publicly available data are limited, the concrete impact of maternity care episode payment and maternity care home programs on childbearing families is not known
- Maternity care APMs generally fail to foster high-quality care delivery transformation that can lead to improved, more equitable health
 - Most maternity care APMs fail to leverage high-performing, lower-cost forms of maternal care
 - Maternity care APMs do not effectively tie payment to improved outcomes, and quality-based payments may not reach care teams
 - Most maternity care APMs exclude newborn care
 - Most maternity care APMs do not directly address the need for better quality hospital care
- Quality measures are not being used effectively to improve quality overall and reduce inequities
 - Poor measure selection undermines impact
 - APMs are not leveraging the potential of performance measurement well
 - Progress is needed on measure gap-filling, specifications, targets, and performance assessment
- Maternity care homes lack robust design elements and operational features
- Medicaid is leading in designing equity-forward maternity care episode payment and maternity care home programs with stronger designs

That said, because of the unprecedented awareness of the maternal health crisis and the deep and persistent racial inequities in recent years, we believe the tide is turning. There is a new shift in focus of maternity APMS as some operating programs and most programs under development are more intentional in focusing on substandard, inequitable outcomes and delivering tangible benefits to childbearing families. In this context, we seek to describe the current state of maternity care episode payment and maternity care home programs and identify opportunities to strengthen these maternity APM designs so that program managers can update current models or design new ones that get us closer to an equitable, accessible, and high-performing maternity care system.

MOST MATERNITY CARE APMS WERE NOT DESIGNED TO ADDRESS INEQUITIES AND DO NOT STRATIFY OUTCOMES DATA, SO THEIR IMPACT ON RACIAL AND ETHNIC INEQUITIES IS UNKNOWN

“We urgently need maternal quality measures that can be used to measure, track, and hold people accountable for inequities.”

—**Elizabeth Howell**, Chair, Penn Medicine Department of Obstetrics and Gynecology, birth justice leader

As has been the case in federal delivery and payment reform efforts generally, APMS were not initially designed to tackle racial and ethnic health inequities. Over the last few years, this has been shifting. A recent LAN report showed a significant number of payers were using value-based provider arrangements to incentivize the reduction of health disparities. As noted, 46 percent reported collecting standardized race/ethnicity and language data, and 22 percent reported measuring health disparities by stratifying along those dimensions.²⁸ However, we found that most maternity-specific APMS, particularly early models, showed little to no evidence of using equity-forward design elements, with some beginning to contemplate adding one or two.ⁱⁱⁱ Newer designs are becoming more focused on equity and overall impact. For example, the Connecticut Medicaid Maternity Bundle program defines its foremost goal as tackling racial maternal health inequities, so program plans include stratifying quality performance by race and setting disparity reduction goals.

Trailblazers like Connecticut Medicaid aside, persistent challenges around the collection of self-reported race, ethnicity, and primary language, among other dimensions of inequity, continue to be

iii A recent assessment of the CMS models implemented to date similarly found challenges with obtaining the underlying data needed to assess inequity and progress, limited focus on advancing equity, and the need for models to build equity into their design elements. <https://innovation.cms.gov/data-and-reports/2023/assessing-equity-hc-improv-wp>

the biggest barrier to leveraging payment reform for better equity. Moreover, we need better measures for identifying and tracking inequity.^{iv} Moving forward, it is crucial that *all* maternity episode payment and maternity care home programs use their leverage to rectify the maternal health crisis of care, experiences, and outcomes that are substandard overall and deeply inequitable.

BECAUSE PUBLICLY AVAILABLE DATA ARE LIMITED, THE CONCRETE IMPACT OF MATERNITY CARE EPISODE PAYMENT AND MATERNITY CARE HOME PROGRAMS ON CHILDBEARING FAMILIES IS NOT KNOWN

Despite the results of the APMs studied generally being reported as “positive,” details about how the APMs have improved outcomes for the people they serve is lacking, for a number of reasons. First, many programs we studied failed to provide specific evaluation data, which may be limited or may not reflect clear success. Moreover, APMs were designed to track process-oriented outcomes and not population-specific outcomes or patient experience. Further, while some programs track preterm birth and low birthweight, few include newborns and measure other newborn outcomes, so our knowledge about the entire maternity continuum is incomplete. Rigorous, publicly reported evaluations of maternity APMs are limited. Performance data are not yet available for the newer programs, which have stronger design elements, due to their recent implementation and the long timeframe of this particular condition.

Given the level of effort going into designing, administering, and participating in maternity APMs, and the urgency of tackling the maternal and infant health crisis, more rigorous and transparent evaluations are urgently needed. We must be able to distinguish between the operational and design elements that make a difference, and those that do not. As discussed below, a key finding of this project is that there are major opportunities to strengthen program designs and better achieve the potential of maternity care payment reform. Regulatory agencies, health plans, and program managers of both developing and ongoing programs should build in the time and resources needed to monitor population health impact, provide regular feedback to providers, and periodically recalibrate (e.g., performance measures and targets, provider reports, and technical support).

A theme that emerged strongly in our interviews is that the underwhelming results or lack of specific evidence of impact to date, and the urgent needs of childbearing families, call for subordinating the cost priority and giving laser focus to quality. By truly prioritizing persistent yet solvable quality issues, considerable cost savings will follow. These issues include preventable maternal mortality and severe maternal morbidity, the high rate of preterm birth, high rates of perinatal mental health conditions, cesarean overuse, newborn intensive care unit (NICU) overuse, and unmet social needs, and the gap

iv Appendix B identifies currently available measures that are more and less fit-for-purpose for use in these priority maternity APM programs. We should avoid including measures that reflect good clinical practices but cannot be expected to drive the priority of population-level care transformation.

between actual breastfeeding and professional guidelines for the initiation and duration of exclusive (and then any) breastfeeding. All are differentially distributed, with communities of color bearing the brunt. Both the burdens and harms to childbearing families and estimates of the cost of these conditions and outcomes strongly support a quality-first approach.²⁹ The sections that follow identify ways to make inroads in many of these areas.

“Maternity care is in such a state that quality needs to be the primary focus in all value-based maternity programs.”

—**Mary Applegate**, Medical Director, Ohio Department of Medicaid, APM program manager

“Our goal is to improve maternity care outcomes through a ‘quality first’ strategy, and we believe reduced spending will follow.”

—**David Hines**, Executive Director of Benefits, Metro Nashville Public Schools, APM program manager

“Payment models should stop focusing so much on reducing payer spending and focus on paying the right amount for good quality of care and outcomes. Focusing on quality and outcomes will reduce such things as preterm births, unneeded cesareans, and NICU admissions. Improving outcomes can result in massive savings.”

—**Harold Miller**, Founder and CEO, Center for Healthcare Quality & Payment Reform, payment reform thought leader

“We have shifted from a focus on cost to quality as the clear priority of our program. We want to tackle the tough challenges of maternal health equity and outcomes.”

—**Chloe Wilson**, Primary Care Payment Reform Analyst, Health First Colorado (Medicaid) Maternity Bundled Program, APM program manager

MATERNITY CARE APMS GENERALLY FAIL TO FOSTER HIGH-QUALITY CARE DELIVERY TRANSFORMATION THAT CAN LEAD TO IMPROVED, MORE EQUITABLE HEALTH

The most effective way for APMs to drive concrete improvements in maternal and infant health outcomes would be to embed requirements, or at least clearly set expectations, that providers engage in care delivery transformation, and that they provide care that follows best practices and evidence-based standards. Unfortunately, none of the maternity episodes studied did this, and only some maternity care home models linked care delivery transformation efforts to payment. This is a major missed opportunity to drive change and impact.

“My experience is that complexity is the biggest enemy to adoption. APM program designers should keep the programs straightforward and easy to adopt. The models can and should evolve and become more sophisticated over time.”

—**Jason Helgerson**, Founder and CEO, Helgerson Solutions Group, payment reform thought leader

“The problem isn’t that episode payment programs don’t work. The problem is that the design of most episodes is flawed.”

—**François de Brantes**, Senior Partner, High Value Incentives Advisory Group, payment reform thought leader

“While [the health care system] has partnered with us, I don’t know that they fully embraced how they can leverage the [APM] as a way to truly improve care within their organization.”

—**Anonymous**, health benefits purchaser

Most maternity care APMs fail to leverage high-performing, lower-cost forms of maternal care

“Medical systems must adopt a stance of humility and give way to maternity care homes, midwifery care, birthing centers, and doula support. They need to invest in models that work.”

—**Carmen Green**, VP of Research and Strategy, Reproductive Health Impact (formerly National Birth Equity Collaborative), birth justice leader

Ample evidence shows that specific forms of maternity care perform better and cost less than our current usual care. These include midwifery, birth centers, and community health centers.³⁰ Non-clinical doula support can improve quality, experiences, and outcomes, and analyses suggest a favorable return on investment.³¹ Additionally, community-tailored, culturally congruent support and clinical services provided by community-based perinatal health worker organizations are optimal for meeting needs of communities that have been most adversely affected by racism and other forms of discrimination.³² Moreover, the interest of birthing people in high-value midwifery care, birth center and home birth settings, and doula support far exceeds current access to and use of these care models.³³ Given their stellar track record, their cost-effectiveness, and the extraordinary value of community-based forms of these models for meeting needs of communities experiencing continuing oppression and disinvestment, they should be integrated into all maternity delivery transformation efforts. Yet maternity episodes generally fail to take advantage of these proven approaches. Similarly, community-based doulas and other birth workers are underused as care navigators and facilitators of other support services within maternity care homes.

“A guiding principle of the program we are planning is increasing access to midwifery-led care due to the strong evidence about positive impact and improved patient experiences.”

—**Beth Tinker**, Clinical Nurse Advisor/MCH Consultant, Washington State Health Care Authority,^v APM program planner

Prioritizing access to these care models during pregnancy is an important way to improve outcomes, prevent harm, achieve exemplary performance metrics, and reduce costs. For example, both midwifery-led birth center care and the extended doula support model (not limited to birth) have been

v For many reasons, this agency has paused development of its maternity care episode payment program.

associated with reduced rates of preterm birth. Midwifery care and birth doulas are associated with reduced use of cesarean birth, and midwifery care and extended model doula support are associated with very high breastfeeding rates.³⁴ Birth centers can be safe and sustainable in rural areas that may not be able to support either a hospital or a hospital maternity unit.³⁵ Community-based and -led care models providing trusted, respectful, culturally congruent care can be especially powerful.³⁶ Overall, these forms of care have often been found to reduce inequities experienced by people of color.³⁷

One analysis estimated that if 1 percent of the nation’s births moved from hospitals to birth centers, we would save \$189 million annually, and if 1 percent moved from hospitals to home births, we would save \$321 million each year.³⁸ Another analysis estimated an annual savings of \$340 million if midwives attended all low-risk births.³⁹ Yet current methods for calculating budgets and savings fail to capture these savings, making it very difficult for these provider types to participate in shared-savings arrangements that reward a reduction in health spending. This is because typically cost-efficient or lower-cost care providers have fewer opportunities for the cost reductions required to gain savings in most APMs.

The maternity care episode payment program of Metro Nashville Public Schools reported notable results for both quality – a cesarean rate that is 25 percent lower than the market average – and costs – savings of about \$3,500 per member while ensuring no member cost sharing. These results may reflect member access to the robust Vanderbilt University midwifery service and the Vanderbilt-operated birth center.

“To improve quality and spend wisely, desired care must drive payment. Too often, payment is presumed to drive care in an overly simplistic way that is unlikely to achieve the intended results.”

—Harold Miller, Founder and CEO, Center for Healthcare Quality & Payment Reform, payment reform thought leader

New APM actuarial models that reflect the quality and cost benefits to childbearing families, taxpayers, and others of averting certain outcomes, such as preterm births, cesarean births, neonatal intensive care unit (NICU) admissions, and perinatal mental health conditions are urgently needed to accelerate increased use of these valuable underutilized forms of care. For example, a simulation of “net present value of care” model where future savings of averting postpartum depression are shared with providers, offered greater financial incentives to providers for preventing this condition than shorter-term calculations.⁴⁰ Other financial models that build in payments for high-performing providers at rates equitable to other providers may also encourage the use of such forms of care. New APM financing models could lead to significant maternity care transformation that makes a concrete difference in the lives of childbearing families.

While APMs, as currently designed, may not offer the clearest path toward transforming maternity care through the increased use of midwifery, birth centers, and Federally Qualified Health Centers (FQHCs) important innovations are in the works. For example:

- Models built on prospective payment, like the Comprehensive Maternal Care program launched last year in Ohio, provide the flexibility to support financial incentives to provide the services that are most needed by pregnant people.
- The Center for Healthcare Quality & Payment Reform maternity payment model was designed to foster access to and use of birth center care, thereby increasing quality and reducing costs. In this model, care teams optimally include clinicians and other personnel and at least one birth center and one hospital. A business case analysis of the proposed APM finds that childbearing families win because quality improves, while both payers and providers win financially. Design elements for supporting this high-quality option for childbearing families include a method of calculating intrapartum costs that encourages use of birth centers when appropriate, differential payment for three levels of risk, and standby capacity payments to hospitals regardless of site of birth.⁴¹
- In Texas, a unique collaboration between the OB Hospitalist Group (OBHG) and local FQHCs will in 2024 align the financial incentives of a lower cost, higher-quality maternity care setting with hospital care providers and allow the FQHCs to share in the savings generated from providing high-quality prenatal care. Crucially, from a quality perspective, FQHC patients have ready access to a rich constellation of wraparound services in the context of a model that prioritizes respect, responsiveness, and community power building.⁴² This OBHG-FQHC partnership is expected to expand to other areas across the country. (See Innovative Maternity Episode Payment Partnership, below.) Including FQHCs in this APM has the potential to improve the quality of maternal-newborn care provided to a large population that is disproportionately people of color, with low incomes, and covered by Medicaid.^{vi}

Our health care system is deficient in not being able to provide universal access to these forms of care to the many interested and eligible birthing families. Program managers and providers should routinely incorporate these high-performing maternal care models into maternity care APMs as a pathway to a higher-performing maternity care system that provides the care and support childbearing families need, want, and deserve.

vi In 2021, FQHCs served 284,198 patients who gave birth. Among all FQHC patients, 50 percent were covered by Medicaid or CHIP, 23 percent had no medical insurance, 91 percent had incomes at or below 200 percent of the federal poverty line, and 24 percent were best served in a language other than English. FQHCs also disproportionately serve homeless people, agricultural worker families, and people living in public housing. (<https://data.hrsa.gov/tools/data-reporting/program-data/national>). Developing APMs to support pregnant FQHC clients is a way to provide quality-focused care to people having 13 percent of the nation's births and experiencing disproportionate harmful effects of historical structural racism and other forms of discrimination (<https://www.cdc.gov/nchs/data/vsrr/vsrr020.pdf>)

**Innovative Maternity Care Episode Payment Partnership:
OB Hospitalist Group and FQHCs⁴³**

OB Hospitalist Group (OBHG) is developing an innovative maternity episode model covering the full continuum of maternity care through partnerships with local Federally Qualified Health Centers (FQHCs). The largest maternal health hospitalist provider group in the country, OBHG has obstetric and midwifery clinicians in 36 states and more than 225 hospitals. (A hospitalist is a health care provider that only provides clinical care in a hospital setting.) OBHG fills a critical need for hospitals that lack 24/7 maternity care provider coverage, addresses the growing interest among physicians in improved work-life balance, and can allow both urban and rural hospitals to staff obstetric emergency departments.

In this model, FQHCs – which have an established track record of reducing inequities and improving health outcomes⁴⁴ – will provide prenatal and postpartum care to childbearing women and people, along with the typical care FQHCs provide for patients and families, including extensive wraparound support for their social, behavioral, and other health-related needs. OBHG will provide the hospital-based services, including labor and birth, consultation to support the FQHC with higher-risk pregnancy cases, and emergency maternity services, if needed. Integrated records will help FQHCs and OBHG providers communicate important clinical information and coordinate care. After birth, OBHG providers will do a warm hand-off to the FQHC for continuing postpartum care.

The collaboration will begin in Houston, with an initial year for tracking data and setting a baseline, and the following year will be a full performance period. OBHG has negotiated a shared savings arrangement with local payers where OBHG and its FQHC partners would be held accountable to a budget encompassing the total cost of prenatal, birth, and postpartum care from the first prenatal visit to 12 weeks postpartum. The budget would be based on historic costs of prenatal care at an FQHC and, if costs come in below the budget, OBHG and the FQHC would split available savings 50/50.

In this model, OBHG and the FQHCs will have payment tied to quality metrics, which may include those listed below. Reporting-only metrics may also be included.

- Timeliness of Prenatal and Postpartum Care
- Cesarean birth (i.e., low-risk first-birth [NTSV] cesarean)
- Contraceptive Care-Postpartum
- Gestational age at birth (i.e., early preterm, late preterm, full term)

This innovative partnership aims to leverage APMS to improve the whole-person care provided at FQHCs. California and Florida sites are planned to follow. If this collaboration succeeds and spreads, organizers plan to explore including the costs and outcomes of the baby, as FQHCs have the capability to care for the entire family across the life course continuum, and adding downside risk, which would only apply to OBHG, since federal regulations limit FQHCs' ability to take financial risk.

“In my experience, bringing providers together to tackle system dysfunction, learn about pathways to better care, and design solutions – such as ways to integrate high-performing maternal care models – is more effective than attempts to force change from the outside.”

—**Harold Miller**, *Center for Healthcare Quality & Payment Reform*, payment reform thought leader

Maternity care APMS do not effectively use payment to improve outcomes, and quality-based payments may not reach care teams

APMS are well-positioned to drive progress in improving persistent maternity care challenges, yet most APMS overlook opportunities to improve quality. For example, appropriate cesarean use is widely considered an essential indicator of maternity care quality and is used as a performance measure by most programs studied. Yet no payer we spoke with requires providers in their maternity episode programs to follow the nation's two leading obstetrical societies' recommendations on safely preventing primary cesarean births, which have been in place since 2014.⁴⁵ Some payers believed tying quality measures to payment was incentive enough to change clinical care practice. However,

the available evidence from Arkansas and Tennessee, where a cesarean birth quality measure has been used over time, shows no statistically significant changes in cesarean rates in both states.⁴⁶ ^{viii}

An example of a potentially effective method for tying payment to improved outcomes is using blended payments embedded into an episode program. Blended case rates are payments where the provider receives the same amount regardless of mode of birth. The rate is typically set to accommodate a slightly lower cesarean rate relative to historical performance to foster progressive improvement in reducing the cesarean rate. The desired effect of lowering cesarean rates has been achieved when both facilities and providers receive blended payments.⁴⁷ Among the programs we spoke with, Qualcomm had incorporated blended payment for cesarean and vaginal births for both professional and hospital services. Two thought leaders interviewed for this project proposed that paying providers more for vaginal than cesarean birth could lead to fewer cesarean births without adjusting hospital payments. While blended rates for maternity care providers alone have not led to cesarean rate reduction, rebalancing to truly support vaginal birth is a potential way to avert unneeded cesareans. Optimally, data support and technical assistance are integrated to support facility-tailored quality improvement strategies among many ways to reduce cesarean rates safely. Available technical assistance resources include a comprehensive toolkit and perinatal quality collaborative support.⁴⁸ This strategy for safe, incremental, year-over-year cesarean rate reductions can be used with the balancing measure, Unexpected Complications in Term Newborn (described in Appendix B), to avert or identify any unintended adverse consequences of cesarean reduction in newborns.

viii A highly successful payment reform pilot brought cesarean rates down quickly by coupling a payment reform, blended case rate payment for cesarean and vaginal births, and technical assistance supporting facility-identified areas of improvement with a performance indicator, https://www.pbgh.org/wp-content/uploads/2020/12/TMC_Case_Study_Oct_2015.pdf

Rapid Cesarean Reduction Through Blended Case Rate Payments to Hospitals and Providers

The Pacific (now Purchaser) Business Group on Health supported a highly successful payment reform pilot in three California hospitals focused on reducing rates of Cesarean Birth, the endorsed low-risk cesarean performance measure. The payment reform was one blended case rate for professional and facility fees, regardless of the mode of birth. This was coupled with data and measurement support and technical assistance from the state perinatal quality collaborative, the California Maternal Quality Care Collaborative. The hospitals identified the strategies they wanted to use among many proven practices associated with cesarean reduction. Over several months, the program quickly reduced cesarean rates by an average of more than 20 percent. Rates of vaginal birth after cesarean increased in two of the hospitals during the pilot, though this was not a focus of the intervention. Women who both were and were not insured by the two commercial health plans that had negotiated this payment reform experienced reduced likelihood of cesarean birth.⁴⁹

The logic behind using APMs to drive higher-value care is to align financial incentives with desired outcomes. Theoretically, the prospect of realizing shared savings because of improved outcomes motivates care teams to improve the quality of care. However, it is generally unclear whether any shared savings in episode programs are shared with the individuals providing care. Overall, the APM program managers did not encourage the savings to reach care team members, and many were unable to report whether the contracting entity passed any savings on to care team members. No maternity episode program with shared savings, except Pennsylvania Medicaid, required contracting entities to share savings with the people actually providing the care. This could mean that health systems, multispecialty physician groups, medical groups, or independent practitioner associations contracted with payers under these arrangements are not distributing any realized savings through compensation models or other means to those with the direct ability to improve outcomes.

Failure to share savings with members of the care team effectively eliminates the financial incentive for individual members to work together toward shared aims and reliably provide desired high-value care. For example, if quality incentives or shared savings payments reached care providers across the continuum of maternity care, providers in two or three phases of care could be motivated to support improvements in such performance measures as Cesarean Birth, Exclusive Breast Milk Feeding,

and Contraceptive Care-Postpartum.^{ix} When the contracting entity retains the financial incentive, performance on the measures may not improve, and fewer shared savings would flow from the payer. This is a priority design element for fostering care transformation, quality improvement, and better outcomes, including the potential for advancing equity through equity-forward performance measures and other design elements. The Pennsylvania Medicaid requirement of directing no more than 20 percent of shared savings to the contracting entity for administrative costs and at least 80 percent to care team members may be a solid guideline for achieving improvements.⁵⁰

The design of maternity care episodes and maternity care home payment models could be improved to facilitate practice transformation and better, more equitable care and outcomes by including incentives that encourage and support the care team.

“Our goal is to incrementally improve on performance measures, in tandem with rapid-cycle data feedback and quality improvement.”

—Jason Helgerson, Helgerson Solutions, APM thought leader

While no maternity care episode program included in our project set care transformation expectations, one of the maternity care home models did. Ohio’s Comprehensive Maternal Care maternity care home program is tying incentive payments directly to maternity care provider activities that aim to strengthen population health. Participating providers are expected to take responsibility for providing coordinated team-based care and population health activities such as identifying birthing people in need of medical, behavioral, and community support services, and connecting them to needed services. Annual incentive bonuses are provided for such activities. We were unable to interview people from the Geisinger Health System or identify recent references to their maternity care episode program. Earlier information states that their “Proven Care” program used many detailed standardized care pathways to provide exemplary care.⁵¹

Lastly, commercial programs do not have a captive market, must offer voluntary programs, and are reluctant to discourage participation through stringent care practice requirements. However, they may be especially motivated to attract participation by offering flexible contracts that are tailored to specific markets or contracted providers. For example, one program manager noted that while valuable services such as lactation and doula support were not required, they could be included in program services if the contracted provider wanted to offer these and had them in place.

ix See Appendix B for details of these and other performance measures that are fit-for-purpose for inclusion in maternity care episode payment and maternity care home programs.

“We’re open to being as agile as possible to customize value-based care programs in response to the various markets in which we operate.”

—**Julianne Pantaleone**, VP C&S, Innovative Value-Based Contracting and Strategy,
UnitedHealthcare, APM program manager

Most maternity care APMs exclude newborn care

“We must give priority to both the mother and the infant and invest in families and multigenerational well-being. We need to see them as one unit.”

—**Elizabeth Howell**, Chair, Penn Medicine Department of Obstetrics and Gynecology,
birth justice leader

One fundamental limitation of most maternity care APMs is that they disconnect the birthing person and infant and rarely include newborn care and costs, which are interconnected with maternity care. The many reasons to create programs that encompass newborn care and costs include:

- Care, experiences, and outcomes of mothers are strongly related to newborn outcomes; the well-being of the “couplet” or “mother-baby dyad” is an optimal focus
- These programs are an opportunity to improve quality and accountability for both mothers and newborns, including in the latter case, reduced preterm and low-birthweight births, increased breastfeeding, reduced unnecessary NICU admissions, and fewer babies whose maternal caregivers have perinatal mental health conditions, which all reduce costs significantly
- Such opportunities for better newborn health, with extensive long-term effects, impact population health⁵²
- About 37 percent of all payments across the entire episode from pregnancy through postpartum and newborn care cover newborn services (primarily, facility and professional fees)⁵³
- Programs inclusive of both are administratively more efficient than separate programs

Despite the clear value of including newborn outcomes and incentivizing appropriate and equitable use of crucial and costly NICUs, the cost and quality of newborn care were only included in three of the episode payment programs studied. Slightly more included newborn-specific quality measures, such as preterm birth, without including newborn care.

This exclusion is particularly troubling given rising cost and quality concerns due to increasing admission into NICUs of lower-risk infants – which now account for more than half of these admissions.⁵⁴ Highly-profitable NICU admissions are in hospitals’ financial interests and are driven by the increasing availability of neonatologists and NICU beds within the fee-for-service payment system. There is also variation in the care delivered to similar newborns across NICUs suggesting a lack of standardization in NICU care,⁵⁵ which may contribute to the inequities that adversely impact newborns of color within and across NICU units.⁵⁶ Needless separation of mothers and babies is a major quality concern, as it interferes with breastfeeding, attachment, and other highly orchestrated physiologic processes after birth.⁵⁷

Interviewees cited two primary reasons for not including the newborn in their models. First, some payers and purchasers described data-related challenges with associating newborn claims with the birthing parent. This made capturing the costs of newborn care within an episode in a timely manner unfeasible. In some instances, states or managed care organizations address this by allowing hospitals to bill newborn charges with the birth before the baby has a policy. One payer noted that gestational age was needed to adequately risk-adjust costs and that this is not available through claims. These challenges were more often reported by, but not limited to, Medicaid payers, as babies may be covered under different plans from parents. Newer programs or programs in development were more likely to have resolved some of the data-related challenges suggesting that solutions exist and should be routinely implemented.^x

Second, maternity care providers were reportedly hesitant to take responsibility for newborn outcomes and costs. Concerns included how to incorporate the role and costs of pediatric care and the expense of potential NICU services. Because many of the programs studied did not mandate provider participation, payers reported the need to compromise certain optimal aspects of the model to attract providers, such as excluding newborn costs and care. However, this approach detaches the prenatal and childbirth care teams from accountability for the welfare of the baby.

x Bertoia and colleagues report an approach to identifying pregnancies, gestational age, and linked infants through claims diagnosis and procedure codes, <https://onlinelibrary.wiley.com/doi/full/10.1002/pds.5483>. Leonard and colleagues found high validity of gestational age codes when compared with best gestational age estimates on birth certificates, https://journals.lww.com/epidem/abstract/2023/01000/validation_of_icd_10_cm_diagnosis_codes_for.9.aspx. Heins and colleagues documented state Medicaid capacity for linking Medicaid claims with birth certificates and other data sources, [Linking Medicaid Claims, Birth Certificates, and Other Sources to Advance Maternal and Infant Health Final Report \(hhs.gov\)](#)

“A major misunderstanding in episode program design is the failure to recognize that risks of including the baby can be managed with tight financial guardrails, for example, through stop-loss for outlier costs and selected exclusions such as babies with congenital anomalies.”

—**François de Brantes**, Senior Partner, High Value Incentives Advisory Group,^{xi} payment reform thought leader

Despite these concerns, a few payers and purchasers have designed programs that include the newborn in a maternity APM to meaningfully influence the outcomes and costs of newborn care (see Pennsylvania Medicaid case study, below), and others report the desire to do so. To allay concerns about taking some financial risk beyond a provider’s control, payers are using mechanisms like per-episode stop-loss, risk caps, and exclusion of high-cost newborn conditions or multiple gestations. Other payers have simultaneously engaged hospitals in separate neonatal episodes to focus on the cost and quality of newborn care, which risks siloed and uncoordinated care across the two episodes. Combining the birthing person and newborn in a single-episode program enables the larger care team to work together toward shared aims and support the well-being and deep interconnection of mother and baby.

In all cases, the maternity care home programs studied focus on mothers alone, with the exception that some programs included performance indicators with strong implications for the newborn such as preterm birth and low birthweight.

Most maternity care APMs do not directly address the need for better quality hospital care

Optimally, maternity care APMs should support improving hospital quality and safety, enhancing maternal and newborn outcomes, and spending wisely. They would foster a choice among birth settings, including birth center and home birth for those at lower risk. They would combat overuse of unneeded tests, treatments, interventions, and NICU admissions. They would foster respectful care, and do all of this equitably.

Hospital maternal-newborn care is technology-intensive, regardless of need or preference.⁵⁸ The hospital phase of care is the optimal time to address high rates of cesarean birth (stalled at nearly one birth in three for many years) and the low national rate of vaginal birth after cesarean, which in 2021 was a mere 14.2 percent, with broad variation for both indicators.⁵⁹ Increasingly, lower-risk newborns are

xi François de Brantes was with Signify Health when he was interviewed for this project.

being admitted into the growing number of highly profitable NICUs and receiving care from a growing number of neonatologists.⁶⁰ Many hospitals are falling short on best practices and policies for infant feeding.⁶¹ Of great concern is the cost – and opportunity cost, given unmet prenatal and postpartum needs – of hospital maternity care: About four in five dollars paid for all maternal and newborn care is allocated to the brief hospital stay.⁶²

The great variation in hospital maternity quality, outcomes, and costs points to many opportunities for improvement and better maternal-newborn health. A stark example is the above-noted tenfold variation across facilities in a measure for low-risk women that should have a narrow range and lower rate.⁶³ Hospitals vary in rates of maternity complications and quality of maternity care, with people in Black-serving hospitals especially vulnerable to receiving poor quality care.⁶⁴ Within hospitals, inequities by race and ethnicity are well-documented.⁶⁵ Within and between hospitals, racial and ethnic inequities extend to NICU care.⁶⁶ Racial and ethnic inequities in hospital care are reflected in reports of Black, Indigenous, and people of color receiving various kinds of mistreatment, including coercion, not being listened to, and dangerous delays in having concerns addressed.⁶⁷ The cost of intrapartum care also varies widely by hospital.⁶⁸

The steady, unabating closure of rural hospital maternity units is a crucial aspect of the maternal health crisis.⁶⁹ More than one-third of all U.S. counties have been designated as maternity care deserts due to the lack of hospital maternity units, birth centers, and obstetric or nurse-midwife providers.⁷⁰ Especially hard-hit are Southern states, with least access concentrated in highly rural, highly racially diverse areas with high rates of maternal mortality and severe morbidity and, in many instances, without Medicaid expansion.⁷¹ Recent closures have disproportionately affected areas with majority Black populations.⁷² The volume-based payment model, including associated staff shortages and inadequate payment rates, is at the root of the closure of these essential community resources.⁷³

It is important to also note a new trend of designated obstetric emergency departments (OB-EDs) staffed by maternity care providers. This largely undescribed model has potentially great implications for quality and cost that will come into view with future studies.⁷⁴

Many hospital-specific factors driving substandard, inequitable, and largely preventable maternal and newborn outcomes are clear, yet the great majority of maternity care APMs do not directly address hospital care. Most maternity episode programs focus on the professional costs of caring for the birthing person, and do not provide incentives for hospitals to improve their maternal-newborn services. Similarly, the maternity care home model provides additional support for birthing families during the prenatal and postpartum periods, but lacks leverage to support hospital care improvements.

The Center for Healthcare Quality & Payment Reform has developed a detailed design for a maternity care episode payment program inclusive of the hospital phase of maternity care. The approach segments payments to address the specific attributes of the phases and special components of care.

We provide a brief overview here and encourage episode planners and implementers to consult the fuller report.

Center for Healthcare Quality & Payment Reform Maternity Care Payment Model Proposals

The Center for Healthcare Quality & Payment Reform (CHQPR) recommends maternity APM design elements to fund a care team – including clinicians, at least one hospital, and ideally at least one birth center – with several types of payment:

- Separate payments for the three phases of care, each adjusted for need:
 - Monthly bundled payments for all pregnancy-related services needed prior to childbirth;
 - A bundled/warrantied payment for labor and birth services, calculated to compensate safe and achievable rates of vaginal births in birth centers, vaginal hospital births, and cesarean hospital births;
 - Monthly bundled payments for all postpartum care services for up to six months;
- A standby capacity payment for each pregnant woman, regardless of birth setting, for hospitals in the community to support the minimum capacity needed to offer labor and birth services round-the-clock as needed;
- Outlier payments for infrequent unavoidable high-cost events and people with very high needs.

Among the many other details tailored to this episode of care, no payments would be made during a month or phase if the team failed to provide all evidence-based care or if a “never-event” occurred, and payments would be reduced if certain outcomes were not achieved.⁷⁵

Although standby capacity payments, referenced in the preceding sidebar, have not been used in maternity care to date, they have the potential to mitigate several crucial hospital maternity care payment issues. These payments complement payment for services that are actually delivered. They recognize the value of having a service that *may* be needed ready and waiting. In maternity care, they are relevant to:

- Rural hospital maternity units that are invaluable to communities, though annual volume may be modest

- CHQPR defines standby capacity payment for rural maternity units as “a monthly payment for each insured woman of childbearing age living in the community”⁷⁶
- Hospital maternity units that are available and of value to all who plan birth center or home births and used in situations when a higher level of care is needed
 - CHQPR recommends that hospitals in care teams (composed of clinicians and other personnel, and at least one birth center and one hospital) would be paid a standard predefined standby capacity payment for everyone receiving childbirth care services, regardless of the place of birth. Payments would support the cost of staff and facility readiness, should hospital services be needed.⁷⁷
- Neonatal intensive care units (NICUs), which are crucial for a small proportion of births⁷⁸
 - CHQPR writes, “A hospital that provides essential standby services should receive a Standby Capacity Payment from each health insurance plan (Medicare, Medicaid, Medicare Advantage, and commercial insurance) based on the number of members of that plan who live in the community served by the hospital (regardless of whether the member receives a hospital service). The amounts of the payments should be designed to ensure that the hospital receives adequate revenues to support the minimum standby costs of essential services ... regardless of how many patients actually need services during any given month or year.”⁷⁹ Applying this general guideline to NICU care would reflect the proportion of births covered by the various types of insurance.

Standby payments are intended to be fair to hospitals and support their sustainability, while ensuring the availability and use of the maternity services people need and want. They may help address the dilemma of steady closure of rural hospital maternity units relying on payment systems based on a volume of births that is simply not available. They may help hospital-based maternity care providers embrace their role providing back-up services for planned community births. And they may help address the concerning trend of healthier and healthier babies being admitted to neonatal intensive care units due to supplier-induced demand from a surfeit of NICUs and neonatologists. The concept can potentially be extended to other circumstances, such as the need for 24/7 anesthesia services to handle emergencies and enable planned vaginal birth after cesarean.

QUALITY MEASURES ARE NOT BEING USED EFFECTIVELY TO IMPROVE QUALITY OVERALL AND REDUCE INEQUITIES

APMs are intended to foster provider accountability by tying payment to performance measures, either by meeting a benchmark or improving upon past performance. In this way, performance is tracked over time, and this is expected to encourage or incentivize members of the health care team to work together to improve in focal areas. Programs typically tie six or fewer measures to payment while also collecting and reporting on quality measures for monitoring purposes only, with the possibility of shifting monitoring measures to payment in the future. Unfortunately, reality has not lived up to potential.

Poor measure selection undermines impact

The process and criteria for maternity care APM measure selection matters. Some legacy programs reported relying on participating providers to identify metrics and targets, resulting in low-bar performance expectations instead of a commitment to continuous improvement in high-priority areas. Some program managers suggested that a high proportion of providers eligible for shared savings indicates high quality. This, however, depends on what the measure is and where targets are set. The fact that many providers are reluctant to enter into shared risk arrangements with financial penalties for poorer performance suggests that improvement is a lower priority than other factors.

To actually improve outcomes and equity for birthing people and their families, garner provider support by limiting provider burden of collecting and reporting, and enhance potential for improvement, measures used for accountability (e.g., for payment or reporting) should be well-tested, carefully evaluated consensus measures with the potential for population-level impact. Appendix B identifies measures that best meet these criteria and are recommended for maternity care APM measure sets and those that are less likely to foster the broad improvement that childbearing families need.

Cesarean Birth is a nationally endorsed measure recommended for use in maternity care APMs (Appendix B). About two-thirds of the participating programs used the Cesarean Birth measure or another cesarean indicator such as total cesarean rate. These indicators have the potential to meaningfully impact a broader segment of the childbearing population (including longitudinal impact on mode of birth in future births).⁸⁰ About half of the programs reported a measure of depression, a high-prevalence condition of great consequence in this population. Other than those, a small number or no programs at all used the other broader impact consensus measures or measure concepts identified in Appendix B. Many maternity APM programs we studied miss the mark by including in their accountability measures some that might help selected individuals but do not apply to a large segment of the childbearing or newborn population, would not impact childbearing families at scale, and would not meaningfully mitigate the maternal and newborn health crisis. For example, HIV screening and chlamydia screening are essential clinical practices that should be implemented with fidelity to clinical guidelines, along with many other recommended elements of care. However, including HIV Screening and Chlamydia Screening for Women among a very limited list of program performance measures intended to improve outcomes squanders the opportunity to prioritize measures that can improve maternal and newborn health for more people.

“We urgently need a measure of respectful maternity care to use in payment models. We need to hold hospitals and others accountable for people’s experience of care. This is especially important for Black mamas.”

—**Carmen Green**, Vice President for Research and Strategy, Reproductive Health Impact, formerly National Birth Equity Collaborative, birth justice leader

APMs are not leveraging the potential of performance measurement well

Selecting appropriate measures to use in an APM is just the beginning. Other concerns relate to how to link measurement and payment for better maternal and infant health:

- Are targets being set to support the status quo or to drive improvement and stretch goals?
- Are the set points adjusted to account for a trajectory of learning and improvement over time, and how often?
- What kinds of data, technical assistance, and other support for quality improvement and successful performance on program measures do program sponsors provide to participating providers?
- Are payment adjustments limited to receiving extra payments with stronger performance (gainsharing, upside risk) or do they also include the more impactful potential for reduced payments based on poorer performance (downside risk)?
- Are the needed infrastructure supports, payment adjustments, and other mechanisms to avoid penalizing providers with higher acuity patients in place?
- Do individual members of the care team have a financial stake in any gains or losses associated with performance?

We used these questions to guide our analysis of the APMs we reviewed, and they helped explain the lack of robust evidence of improved maternal and newborn care, experiences, and outcomes over time.

- APM performance targets enable many provider entities to collect gainsharing revenue. But the programs are largely voluntary, and to foster provider participation, they are not migrating quickly to include downside risk, which is more likely to drive change than gainsharing alone,⁸¹ and must include appropriate infrastructure, payment, duration of on-ramp, and other supports for providers who care for higher acuity patients, have smaller rural practices, and other limits on risk-taking beyond their control.⁸²
- Many programs reported providing detailed reports to show participating providers their data in relation to the performance of others and program standards. Specific support for quality improvement activities was less common.

- The programs periodically assess and modify the measures collected and in some cases the set points. However, in general, there is no strong expectation of steady continued improvement and movement toward exceptional performance.
- Only one episode payer required any earned savings to be distributed to members of the care team, while limiting the amount of savings that the contracting entity could use for administrative costs. Other payers were unable to report how provider entities were handling this. The maternity care home programs ranged from strong design elements to support and reward providers to none at all.

“It’s hard to drive improvement with upside ‘risk’ alone.”

—**Josh Wojcik**, Connecticut Office of the State Comptroller, APM program manager

Leaders from one program under development identified their intention to shine the light on themselves through global outcome measures to assess whether the overall program is working, along with more standard measures for accountability of participating providers. As global measures would roll up the performance of program providers, the greater numbers could also enable a clearer understanding of how racial, ethnic, and other subgroups are faring and whether progress is being made on program equity goals.

Progress is needed on measure gap-filling, specifications, targets, and performance assessment

It is important to note several maternity-specific measurement challenges. First, providers must collect and track disaggregated data by race and ethnicity and other dimensions of disparities and tie payment to advancing equity as a bedrock of maternity APMS.⁸³ A data infrastructure indicator has been proposed to address this: the percentage of participants for whom, e.g., race/ethnicity and language data are provided.⁸⁴

A limitation to more effective use of measurement as a mechanism for advancing quality improvement and equity is how few nationally endorsed maternal and newborn measures exist. At present, there are only six unique nationally endorsed maternity-specific measures, and many crucial gaps.^{xii} A strategy for attenuating this limitation to some degree is considering impactful measures from other consensus-

xii In 2023, responsibility for national endorsement and maintenance of performance measures shifted from the National Quality Forum (NQF) to Battelle’s Partnership for Quality Measurement, the “consensus-based entity” referenced in statute. Appendix B in the final report from NQF’s Perinatal and Women’s Health Standing Committee identifies just six unique nationally endorsed maternity-specific measures, with three having both “paper” and “electronic” versions: <https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=98168>

based measure programs, such as the Inpatient Quality Indicators (IQI) program of the Agency for Healthcare Research and Quality (AHRQ) and the Healthcare Effectiveness and Data Information Set (HEDIS) program of the National Committee for Quality Assurance (NCQA). Another possibility is to adapt strong, suitable more general consensus measures in these programs to the relevant maternity population and time frame. In Appendix B, we identify consensus-based maternity measures, and gap-filling consensus measures that might be adapted for this population and episode, distinguishing those with the potential to make a meaningful difference to a notable proportion of birthing families from those that do not.

Additionally, there are gaps in equity-sensitive maternity and other measures that can be used in APMs.⁸⁵ None of the nationally endorsed maternal-newborn performance measures is stratified by race and ethnicity or other demographic dimensions widely associated with inequity. Measure developers must specify these measures to be able to track performance by race and ethnicity and other dimensions of inequity, so that APMs and other programs can use the data to drive quality improvement that centers equity. Fortunately, this is beginning to happen with two recommended measures listed in Appendix B: NCQA, the developer, will stratify both Prenatal Depression Screening and Follow-up and Postpartum Depression Screening and Follow-up by race and ethnicity, beginning in measurement year 2024. Efforts are underway to develop person-reported measures of the experience of care, including experiences of respect and discrimination and other types of mistreatment.⁸⁶ These measure gaps are a tremendous impediment to accountability for advancing equity in maternity care APMs.

Another limitation is that managers of voluntary programs reported the need to temper their expectations of provider performance to encourage provider participation in their programs.

A final measurement challenge is the long timeframe of the cycle of maternity care. Depending on the setting of the start and end dates, this episode or period of maternity care home service covers a year or more. Evaluations that, for example, consider all births in a given calendar year involve a data collection period that extends well before and after that year. As a result, opportunities for program managers to assess impact and periodically recalibrate (e.g., selection of performance measures, their set points, and mechanisms for quality improvement) occur at intervals of many months. For this reason, an interviewee considered including a 12-month postpartum period, which would be desirable from the perspective of attention to maternal well-being and alignment with the Medicaid postpartum extension to 12 months that most states have adopted, but rejected this to be able to assess and recalibrate more frequently. From a provider perspective, low-burden data systems with rapid-cycle feedback about one's performance can be especially effective in facilitating quality improvement,⁸⁷ and more frequent provider feedback than the cycle of program evaluation and recalibration is possible. Some programs operate data portals that providers can access at any time to view currently available data about their performance. Most reported providing in-depth periodic performance reports.

For all of these reasons, current use of performance measures in maternity APMs, which is central to accountability and impact, falls far short of the potential.

MATERNITY CARE HOMES LACK ROBUST DESIGN ELEMENTS AND OPERATIONAL FEATURES

Without question, the track record to date of maternity care homes, including the experience of 17 maternity care home awardees within the Strong Start for Mothers and Newborns Initiative, has been disappointing (see a summary of Strong Start and details of the legacy North Carolina and Wisconsin programs in the supplemental report⁸⁸). New York City Health & Hospitals began its program in 2019 and did not share any results with us. While it provides a rich array of services, it is not using payment to leverage improvement. To date, Ohio is the only state that has started an advanced population-based maternity care home model that allows maternity care providers to offer the care needed and preferred by childbearing people, with incentives to integrate care across systems and settings (see Ohio Medicaid's Comprehensive Maternal Care [CMC] Program, below). Ohio's robust maternity care home began last year, and we look forward to the availability of outcome data.

Despite its disappointing impact to date, the model warrants strategic refinement because of its potential for addressing birthing people's whole person health, mitigating adverse social drivers of health, and providing tailored support, whether a person faces challenges with smoking cessation, intimate partner violence, food insecurity, or something else. Evidence is clear that unmet social and mental health needs have a major impact on maternal-newborn outcomes,⁸⁹ but the current structure of prenatal and postpartum care cannot readily incorporate addressing these needs and supporting care navigation. Just about one dollar in five among all payments made on behalf of childbearing women and newborns across the full episode is currently available to cover all of prenatal and postpartum care.⁹⁰ Due to this limited allocation, office visits with maternity care providers are brief and focused on many clinical matters. Per member per month or other maternity care home payments have the potential to support other personnel who can provide complementary services beyond the scope of 15-or-so-minute clinical visits. Community-based perinatal health workers, nurses, or social workers may be especially well-suited to facilitate these services. Cultural concordance between personnel and childbearing families would likely add value.

“Social needs are major drivers of outcomes of pregnant and postpartum people and their babies, but we’re not adequately addressing them in prenatal care”

—Aza Nedhari, Executive Director and Co-Founder, Mamatoto Village, birth justice leader

While efforts to create “homegrown” models of maternity homes may allow them to be tailored to the specific needs and landscape of diverse settings, the lack of standardized elements has limited the development of a replicable, evidence-based, successful model. The track record of the Patient-Centered Medical Home (PCMH) program suggests that progressive refinement of, and fidelity to, an evidence-based model through a formal designation program can improve overall care and outcomes and advance equity.⁹¹ Developing a total package of design elements and operational features shown to produce results is indicated to ensure that this kind of APM improves outcomes for birthing people and their families, especially those bearing the brunt of inequities. Developing a maternity care home recognition program (similar to the PCMH program) would help ensure consistent, longitudinal fidelity to an effective model and steady improvement of the model over time. Elements that show promise include:

- Routinely screening for physical, mental, and social needs and developing and implementing a care plan to address them, at minimum early in pregnancy and in the postpartum period⁹²
- Creating closed-loop, preferably compensated referral systems with culturally centered, community-based health promotion and social services entities, including developing resource directories and cultivating trusting relationships with them.
- Identifying optimal personnel for carrying out this work, providing adequate training and support, and holding them accountable.
- Effectively integrating this function and staff into clinical workflows and electronic health records
- Using strategically chosen performance metrics that are disaggregated by race, ethnicity, and other demographic factors, both to align with clinical metrics and to address core maternity care home functions
- Employing payment models that are able to support both the provision of these services and the infrastructure needed to manage the program and track results, which could include population-based payment models common to PCMHs

“Given brief time-limited clinic visits, it is essential to have ways to provide a rich array of wraparound services.”

—**Machelle Allen**, VP, Chief Medical Officer, NYC Health & Hospitals, maternity care home program manager

Ohio Medicaid’s Comprehensive Maternal Care (CMC) Program

Ohio Medicaid’s Comprehensive Maternal Care (CMC) program began operation in 2023 as a population-based maternity care home APM. This APM is part of the state’s larger, multi-component Maternal and Infant Support Program (MISP),⁹³ designed to reduce and eliminate racial disparities in maternal and infant outcomes, and to reduce infant mortality.

The CMC is a population-based payment model that provides a per-member, per-month (PMPM) payment to participating Medicaid maternity care providers of prenatal and postpartum care to deliver a set of enhanced services to all pregnant individuals, with additional funds allocated for those at higher risk. Quality incentive payments will also be distributed annually based on participation in a perinatal quality collaborative, the implementation of safety practices or bundles, integration and support of community partners, the integration of information from patient feedback processes, and performance on quality measures.

To participate in this maternity APM, providers must include patient identification, risk stratification, patient engagement, population health management, team-based care, relationship and care continuity, and improved patient experience. Each childbearing person must have an ongoing relationship with a stable source of community-based support.

For more information on the developing program see the profile in Appendix D of the supplemental report.⁹⁴

MEDICAID IS LEADING IN DESIGNING AND IMPLEMENTING EQUITY-FORWARD MATERNITY CARE EPISODE PAYMENT AND MATERNITY CARE HOME PROGRAMS WITH STRONGER DESIGNS

Medicaid plays a large role in financing maternity care in the United States, through a careful balance of federal requirements, guidelines, and provisions and state-tailored details of program eligibility, coverage, financing, and accountability. Medicaid pays for about 41 percent of the nation’s births and covers a disproportionate number of births of Black, Hispanic, and American Indian and Alaska Native families.⁹⁵ Some states have especially high proportions of Medicaid births, particularly in the South. Increasingly stringent abortion restrictions in many states could mean that those states have

an even greater share of Medicaid-covered births than before the overturning of *Roe v. Wade*.⁹⁶ This gives Medicaid an imperative to lead the way in designing and implementing impactful equity-forward maternity APMs. With the newer programs, Medicaid agencies are indeed leading this charge. The Pennsylvania HealthChoices Maternity Bundle overview, below, illustrates the direction for 2.0 maternity APM models.

Pennsylvania HealthChoices Maternity Bundle

Pennsylvania's HealthChoices maternity episode program began operation in January 2021. The program requires Medicaid managed care organizations (MCOs) to offer contracted maternity care providers a comprehensive maternity episode payment program inclusive of the newborn. It includes design elements intended to address racial disparities in care, improve overall outcomes, and integrate care across the prenatal, childbirth, postpartum, and infant continuum. For example, the model requires a maternity care team to consist of typical maternity care providers, hospitals, specialized maternity care providers, and at least one doula, community health worker, or social worker. At least 80 percent of any shared savings earned must be shared directly with the maternity care team, ensuring that contracting providers can only keep a portion of the earnings at the contracting entity level for administrative costs.

The model requires MCOs to assign a health equity score to participating providers based on their performance on quality measures for Black birthing people. The quality measures providers are held accountable for cover screening and follow-up for physical health needs, behavioral health needs, and social needs. For more information about Pennsylvania's Maternity Bundle, which includes multiple design elements from the LAN HEAT framework, see the program profile in the supplemental report.⁹⁷

Important design features in this path breaking program that are not typically included in the legacy maternity episode programs include: access to and use of data disaggregated by race and ethnicity from most plans, attention to equity, inclusion of the newborn, inclusion of community support personnel, requiring that at least 80 percent of shared savings go to the care team, screening and follow-up for behavioral health and social needs, and collaboration with the state's perinatal quality collaborative.⁹⁸

“I do not believe that our Medicaid program spends too much on maternity care. The primary goal of our episode payment program is to improve quality and reduce disparities. We want to tie payment to priority outcomes.”

—**Greg Woods**, *New Jersey Division of Medical Assistance and Health Services,*
APM program manager

As previously mentioned, the federal government has created supportive frameworks for Medicaid to advance overall health equity through CMS’s *Strategic Plan*,⁹⁹ and CMMI’s *Innovation Center Strategy Refresh*,¹⁰⁰ and specifically to advance maternal health equity through the *White House Blueprint for Addressing the Maternal Health Crisis*¹⁰¹ and the *CMS Maternity Care Action Plan*.¹⁰² Furthermore, the American Rescue Plan Act permits state Medicaid agencies to extend Medicaid coverage from 60 days to 12 months postpartum, expanding states’ ability to set expectations for, and incentivize, improved postpartum outcomes. Most states have implemented, or are planning to implement, this option.¹⁰³ The current administration is also working to increase access to priority elements of care identified in the HEAT adaptation and birth justice leader interviews. For example, the administration has prioritized maternal mental health and mental health in general, and CMS is working to increase access to community-based personnel and help with meeting social needs.

CMS recently announced its newest model, Transforming Maternal Health (TMaH). TMaH will support up to 15 state Medicaid agencies with up to \$17 million each and in-kind resources for a three-year planning period followed by a seven-year implementation period. The competition for selection and opportunity to strengthen systems and put infrastructure in place encourage state-level stretch goals. The comprehensive approach aims to advance equity and improve maternal-newborn outcomes.¹⁰⁴ Participating states will be able to apply valuable lessons from experiences of pioneering legacy programs, including recommendations in the following section of this report.

Medicaid is uniquely positioned to bring maternity APMs to scale in a way that commercial payers cannot. The average volume expected to flow through Medicaid APMs among our interviewees, (including when the developing programs that we studied are operational) is 61 percent greater than expected in the commercial or employer-purchaser programs.¹⁰⁵ State Medicaid programs have the power to mandate provider participation in APMs in direct-pay states such as Colorado and Connecticut, whereas commercial payers typically lack the leverage to do so. For example, the Connecticut HUSKY Maternity Bundle will be mandatory for any provider who has billed 30 or more births in the past 12 months. Tennessee mandates participation in its episode program by providers contracted with state Medicaid managed care organizations (MCOs). Ohio Medicaid’s Perinatal Episode of Care program mandates participation of providers contracted with the state Medicaid

program or its MCOs. Pennsylvania mandates participation of its physical health MCOs. TMaH will catalyze uptake, engage a growing number of providers, and reach many more childbearing families.

In addition, Medicaid agencies have the leverage to implement specific innovative program elements that commercial payers typically do not. For example, the Pennsylvania maternity episode program requires participating providers to share the vast majority of any shared savings with the care team, which sets clear expectations and provides support for care teams to achieve care practice and outcome goals. Whereas many programs to date have stalled with modest, less impactful design elements, TMaH states should be able to begin with or quickly advance to more optimal program features.

To continue to lead in developing and implementing well-designed APMs and realizing their potential for care transformation and culture change, Medicaid agencies need dedicated resources, beginning with a core internal development team. Such a team needs to carry out extensive stakeholder engagement to understand the recommendations of the birth justice community and the maternal-newborn care needs and desires of childbearing families, and to engage providers and hospitals. The available TMaH budgets and planning period will support effective program administration. The new programs can also benefit from many adjacent state Medicaid initiatives, such as payment for doula services, maternal coverage to 12 months postpartum, and pathways for meeting social needs and providing access to services of community-based organizations.

Medicaid APMs also need infrastructure investments for collecting and reporting data on race and ethnicity and other dimensions of inequity and a dashboard of impactful measures that can identify lagging and inequitable performance, leading to performance targets and strategies for reaching them.¹⁰⁶ As a start, New Jersey's FamilyCare Perinatal Episode pilot stratifies quality measures by race/ethnicity and requires providers to develop a health equity plan tied to payment and reporting to address any racial disparities in quality measure data. State or MCO program managers also need resources to provide technical assistance to participating providers and to develop reports that present participating providers with feedback on their performance and progress over time. An essential goal throughout is to adequately resource and support the providers who care for people with disproportionately great physical and mental health and social needs, as well as those in smaller practices and rural areas, to participate and succeed in this care transformation journey. Finally, by allocating the resources to conduct rigorous evaluations, Medicaid programs can help provide transparency and a clearer understanding of how APMs can improve maternal and infant health outcomes and advance equity for all payers. TMaH will enable state Medicaid agencies and participating entities and providers to develop and refine strategic approaches to these matters.

In the context of unprecedented awareness of the maternal health crisis and will to address it, the comprehensive TMaH program will provide states with funds to design, develop the needed

infrastructure, plan, and stand up a new generation of impactful, equity-forward maternity APMs. The initial TMaH Model description aligns with many elements of the maternity-specific HEAT adaptation espoused here, including centering equity, providing access to high-performing care models, and identifying and meeting social needs. We believe TMaH has the potential to catalyze transition of the culture of maternity practice from fee-for-service support of the status quo to commitments to shared learning, accountability, and steady progressive improvement.

“Provider practices that lack the tools and capacity to participate in value-based payment systems will have difficulty succeeding in these models.”

—**Aza Nedhari**, Executive Director and Co-Founder, Mamatoto Village, birth justice leader



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), CHIP¹⁰⁷ 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.^{xiii}
 - 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^{xiv} 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.

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

xiv 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.¹⁰⁸ (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.^{xv}
 - 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.

xv 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,¹⁰⁹ including the use of stand-by payments.¹¹⁰
 - 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.¹¹¹
 - 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.¹¹²
- **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.¹¹³
 - 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.



Conclusion

“People need to be able to imagine a different future. This was all made, and it can be remade. We need courageous thinking to fix institutions.”

—Monica McLemore, Professor, University of Washington School of Nursing, birth justice leader

The U.S. cannot thrive if childbearing families continue to experience substandard care and high rates of preventable harm. Despite our wealth, technological advances, and high expenditure on maternity services, crucial childbearing outcomes are worsening. Racism, misogyny and other structural inequities are key drivers. At the same time, our health care system’s underlying financial structure all too often rewards the wrong things. Together, we must ensure that health care pays for what works and what birthing families need and want.

Among the many types of payment reform, well-designed maternity care episode payment and maternity care home programs have great potential to advance equitable care delivery transformation.

To understand the current landscape of these two types of programs, we carried out structured interviews with program managers, as well as with birth justice leaders and payment reform thought leaders. Our most troubling finding was the limited evidence of impact of the programs on addressing the needs of birthing families – especially those most affected by the maternal health crisis. The most recent programs are more intentional about measuring and reducing inequities and improving maternal health. However, evidence of their impact is unavailable at this time. We also found that the extremely limited offering and uptake of these models is impeding the scale needed for meaningful population-level impact. Only an estimated 3 percent of births each year are within a maternity care episode payment program, and maternity care homes reach even fewer childbearing families.

The potential of maternity care alternative payment models is not being realized. There are many plausible reasons why existing programs provided little compelling evidence of positive impact on childbearing families, and why maternity care has been slow to transition to APMs, despite the potential. Payers and other entities offering these programs are not materially strengthening designs and targets over time. Sponsors of voluntary programs risk provider defection with more stringent expectations. Until the December 2023 announcement of the new CMS Transforming Maternal Health (TMaH) Model, federal and most state policymakers had not provided program developers and implementers with incentives or requirements to make the considerable effort to develop and operate such programs. Providers may be unwilling to eschew more comfortable and familiar fee-for-service practice routines for the uncertainty and accountability of working in a value-based payment environment, a challenge especially when their participation is voluntary. A value-based culture shift in maternity care practice is needed to reliably provide the high-quality equitable care that birthing families need and that will help us thrive as a nation. While some state Medicaid programs are beginning to set APM policies to guide maternity care in this direction, the new federal policy TMaH leadership is needed to address these barriers at scale.

“Change doesn’t happen overnight. Over time, by generating and applying learnings, episode models can realize the potential to change the culture of care. We seek to grow and deepen provider relationships and to try new innovative things through rapid-cycle data and continuous improvement.”

—**Jason Helgerson**, Founder and CEO, Helgerson Solutions Group, payment reform thought leader

“Purchasers and providers can’t go into this process thinking they have all the answers. It’s an evolving process of learning together.”

—**David Hines**, Executive Director of Benefits, Metro Nashville Public Schools,
APM program manager

“This is a long-term process that requires continuous collaboration, assessment, creativity, and refinement.”

—**Mignon Norman**, Manager of Provider Contracting, Blue Cross Blue Shield of North Carolina,
APM program manager

Analysis of pioneering legacy programs and the newer 2.0 programs with greater focus on tangible, more equitable improvements for childbearing families points to many ways to strengthen new and existing programs. The many detailed recommendations herein for key stakeholder groups and appendix of higher-impact performance measures are predicated on the following overarching principles:

- 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 admission, 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.

Maternity care episode payment and maternity care home programs are an essential part of the solution to substandard, inequitable, and preventable maternal and newborn adverse outcomes and should be leveraged for this end. The relevant stakeholders can and should take many clear steps to expand reach, strengthen designs, increase effectiveness, and contribute to the well-being of childbearing families.

Project Limitations

An important limitation of this project is that we may not have been able to identify all eligible programs. We were also unable to secure interviews with personnel from a small portion of identified programs. We also focused on payers and purchasers and did not systematically obtain provider perspectives. We did not assess the markets in which the programs are operating, which can impact payment model design, uptake, and outcomes. Lastly, some beneficial care elements that might have been included in these APMs were available through adjacent programs in the respective health systems or states, and we lacked visibility into adjacent programs and care coordination processes.

A companion report, *Technical Supplement to Realizing the Transformational Potential of Maternity Care Payment Reform*, provides details of the project methodology, summarizes design features of participating programs, and presents program profiles. This is available at www.nationalpartnership.org/maternityAPM.

About the Authors

Carol Sakala, PhD, MSPH, is a nationally recognized thought leader in maternal health and maternity care, including expertise in maternity care system transformation and high-performing maternal care models. She is Senior Director for Maternal Health at the National Partnership for Women & Families, which is a founding member of the Health Care Payment Learning & Action Network (LAN) and the Health Care Transformation Task Force (HCTTF). Dr. Sakala was a member of the LAN Clinical Episode Payment Workgroup that developed guidance on maternity episode payment, and of the Strategy Team that led the LAN's Maternity Multi-stakeholder Action Collaborative, and she has supported the HCTTF Maternal Health Hub. Her considerable involvement with maternity care performance measurement includes serving for many years as co-chair of the National Quality Forum's Perinatal and Women's Health Standing Committee and on numerous other measurement-related advisory bodies. She is the lead author of recent major reports on several high-performing care models – midwifery care, community birth settings, and doula support – and works to delineate health care's role in meeting the social, mental health, and physical health needs of childbearing families.

Megan Burns, MPP, is an independent health policy consultant focused on value-based payment, strategic planning, facilitation, policy development, and implementation. Megan has more than 15 years of experience in health policy and hospital administration. As a consultant, Ms. Burns has worked with dozens of organizations, including state Medicaid agencies, state regulatory agencies, employer purchaser coalitions, commercial and Medicaid health plans, provider organizations, and other health policy-engaged stakeholders. She has facilitated many public bodies focused on health care improvement and has performed both research and applied work on maternity payment reform, including having designed and developed content for the Health Care Payment Learning & Action Network (LAN) Maternity Multi-stakeholder Action Collaborative (MAC) and designed a maternity episode payment model for an Oregon Medicaid Coordinated Care Organization.

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We are extremely grateful for the time and trust of the individuals who participated in this study, particularly birth justice leaders, APM program managers, payment reform experts, and maternity care providers. Their generosity of time, thoughtfulness during the interviews, and timely communication afterward made this project possible. Insights revealed in their approved quotes enrich both this main and the supplemental report. We salute the pioneering spirit, dedication, and hard work of those who have designed and operate these APMs and laid the groundwork for considering what more impactful 2.0 versions of these APMs might look like. Appendix A provides the names and affiliations of all interviewees.

This project also benefited from the support of colleagues on the Health Justice Team at the National Partnership for Women & Families. Sinsi Hernández-Cancio, VP for Health Justice, has been a sounding board throughout and her extensive content editing led to a much-improved product. Stephanie Green, our Coalition and Partnerships Manager, coordinated dozens of project interviews. Sarah Coombs, Director for Health System Transformation, provided guidance on early project conceptualization. James Campbell, former Justice Policy Analyst, synthesized guidance from interviews with birth justice leaders. Erin Mackay, Health Justice Managing Director, facilitated production, communications, and dissemination phases of this work. Our Social Impact and Congressional Relations colleagues reviewed our recommendations. Communications colleague Mettabel Law prepared the website landing page and materials.

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Appendix A. Project Interviewees and their Affiliations

Birth Justice Leaders

Commonsense Childbirth

- Erica Guthaus

Mamatoto Village

- Aza Nedhari

Reproductive Health Impact (formerly National Birth Equity Collaborative)

- Carmen Green

University of Pennsylvania Department of OB/GYN

- Elizabeth Howell

University of Washington School of Nursing

- Monica McLemore

Episode Payment and Maternity Care Home APM Program Leaders

AmeriHealth Caritas

- Jim Jones

Anthem

- Meredith Day
- Andrew Price

Blue Cross Blue Shield of North Carolina

- Tabatha Dixon
- Mignon Norman
- Shaunteria Scott

Cigna

- Joe Bailey

Colorado Department of Health Care Policy & Financing

- Trevor Abeyta
- Chloe Wilson
- Ke Zhang

Connecticut Department of Social Services

- Bradley Richards
- Fatmata Williams

Connecticut Office of the Comptroller

- Josh Wojcik

Metro Nashville Public Schools

- David Hines

NC Medicaid Division of Health Benefits

- Kelly Crosbie
- Elizabeth Kasper

New Jersey Division of Medical Assistance and Health Services

- Nadia Glenn
- Shin-Yi Lin
- Pamela Orton
- Jonathan Tew
- Greg Woods

NYC Health & Hospitals

- Mabelle Allen
- Matthew Siegler
- Wendy Wilcox

Wisconsin Department of Health Services

- Makalah Wagner

Ohio Department of Medicaid

- Mary Applegate
- Mylynda Drake

Pennsylvania Department of Human Services

- Sally Kozak
- Maranatha Perez
- Michele Robison
- Laurie Rock
- Pauline Saunders

Qualcomm

- Melissa Real

Quilted Health

- Melissa Mendez
- Emily Chen

TennCare Medicaid

- Jessica (Schwartz) Hill
- Johnny Lai

UnitedHealthCare

- Julianne Pantaleone

Washington State Health Care Authority

- J. D. Fisher
- Mary Fliss
- Beth Tinker

**Thought Leaders and Subject
Matter Experts**

Center for Healthcare Quality & Payment Reform

- Harold Miller

Helgerson Solutions Group

- Jason Helgerson

Office of Management and Budget

- Meril Pothen

Purchaser Business Group on Health

- Blair Dudley

Signify Health

- François de Brantes
- Kim Holland
- Sage Nakagawa

Wildflower Health

- Leah Sparks

Appendix B. Performance Measures Better Suited and Not Recommended for APM Accountability

Consensus-Based Measures Recommended for Inclusion in Maternity Care Alternative Payment Programs

Measure Name	Consensus-Based Entity Endorsement?	Steward	Level Measured	Phase of Care	Inclusion in Measure Programs and/or Core Sets	Rationale / Notes
Cesarean Birth	CBE 0471 CBE e0471 (uses medical records) LRCD-CH (uses state vital records)	The Joint Commission PC-02, ePC-02 CDC/NCHS	Facility	Labor and birth	The Joint Commission Perinatal Care Core Set, Large Hospital Accreditation Program, and Advanced Certification in Perinatal Care Inpatient Quality Reporting (required) Core Set of Rural-Relevant Measures Core Quality Measures Collaborative Ob-Gyn Core Set (and disparities-sensitive designation) The Leapfrog Group Medicaid Child Core Set (required)	Variation in this “low-risk” measure is tenfold or more across hospitals. Dozens of maternal and child outcomes are worse with cesarean versus vaginal birth. Overuse and improvability are great. Leading obstetric professional societies find that steep rise in cesarean rate was not associated with improvements in maternal or infant health. Despite professional recommendations, cesarean rate has been high and essentially level for more than a decade. Payers pay about 50 percent more when births are cesarean versus vaginal. About 85 percent of births after cesarean are repeat cesareans.
Contraceptive Care-Postpartum	CBE 2902	U.S. Office of Population Affairs	Clinician/group Health plan Population	Labor and birth Postpartum	Core Quality Measures Collaborative Ob-Gyn Core Set (and designated disparities sensitive) Medicaid Child Core Set (required) Medicaid Adult Core Set CMS Measure ID 166	Many pregnancies are unplanned. Unplanned pregnancies involve greater risk than planned ones. Professional consensus supports healthy pregnancy intervals. Abortion restrictions may compel individuals to carry unwanted pregnancies to term. Measures provision of a most or moderately effective method of contraception within three days of birth and within 60 days of birth.

Continued >

Measure Name	Consensus-Based Entity Endorsement?	Steward	Level Measured	Phase of Care	Inclusion in Measure Programs and/or Core Sets	Rationale / Notes
Exclusive Breast Milk Feeding	CBE 0480 CBE e0480	The Joint Commission PC-05	Facility	Labor and birth	The Joint Commission Perinatal Care Core Set and Advanced Certification in Perinatal Care CMS Measure ID 251	This is an essential early step for establishing breastfeeding toward meeting six-month and 12+-month consensus professional goals Breastfeeding has numerous preventive benefits for both lactating parent and child. The recommended threshold of 70 percent allows for informed choice, contraindications, challenges. There are inequities by race and ethnicity.
Maternity Care: Postpartum Follow-up and Care Coordination	No	CMS Quality ID #336	Clinician/group	Postpartum	Merit-based Incentive Payment System (MIPS) Core Quality Measures Collaborative Ob-Gyn Core Set (and designated disparities sensitive)	There is broad consensus about the need to improve postpartum support. Women experience many new-onset morbidities after birth. Many women report that postpartum visits did not cover many core topics.
Patient Activation Measure (PAM)	CBE 2483	Insignia Health (Phreesia)	Clinician/group	Prenatal	CMS Measure ID 1212	Level of activation (1-4) and ability to manage one’s health, are positively related to many positive effects. There are evidence-based ways to increase activation levels over six or more months. Intended for use in all clinical areas; measure a change score between prenatal intake visit and third trimester with aim of increasing activation level before birth and parenting. In this context, the 10-item version is more suitable than the 13-item version for people with chronic conditions and, per developer, can use “your maternity care provider” versus “your doctor.”
Postpartum Depression Screening and Follow-up	No	National Committee for Quality Assurance PDS-E	Health plan	Postpartum	Healthcare Effectiveness Data and Information Set (HEDIS) Core Quality Measures Collaborative Ob-Gyn Core Set (and designated disparities sensitive)	Postpartum depression is common and often untreated. These reflect racial/ethnic inequities. Reports rates of screening and of positive screens with follow-up within 30 days. NCQA will stratify PDS-E by race and ethnicity, beginning in measurement year 2024. A parallel measure for anxiety is also a priority, and this could be adapted.

Continued >

Measure Name	Consensus-Based Entity Endorsement?	Steward	Level Measured	Phase of Care	Inclusion in Measure Programs and/or Core Sets	Rationale / Notes
Prenatal Depression Screening and Follow-up	No	National Committee for Quality Assurance PND	Health plan	Prenatal	Healthcare Effectiveness Data and Information Set (HEDIS)	Prenatal depression is common and often untreated. These reflect racial/ethnic inequities. Reports rates of screening and of positive screens with follow-up within 30 days. NCQA will stratify PND by race and ethnicity, beginning in measurement year 2024. A parallel measure for anxiety is also a priority, and this could be adapted.
Unexpected Complications in Term Newborn	CBE 0716	The Joint Commission PC-06	Facility Integrated delivery system Population (regional, state)	Labor and birth	The Joint Commission Perinatal Care Core Set, Large Hospital Accreditation Program, and Advanced Certification in Perinatal Care Core Quality Measures Collaborative Ob-Gyn Core Set (and designated disparities sensitive)	This “balancing measure” is used with Cesarean Birth to deter or detect possible harm to infants from excessive or too rapid cesarean reduction. Results can help health teams safely and confidently reduce cesarean rates.
Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated	No	Agency for Healthcare Research and Quality IQI 22	Facility	Labor and birth	Inpatient Quality Indicator 22	More than 85 percent of people with a history of cesarean have repeat cesareans. Repeated uterine scarring is associated with placental problems and other serious risks to pregnant people and fetuses/newborns in future pregnancies. There are racial and ethnic inequities in access to VBAC. Consider limiting to facilities with 24/7 anesthesia coverage, many of which have low VBAC rates.

Consensus-Based Entity references endorsement by the National Quality Forum before 2023 and moving forward by the Partnership for Quality Measurement led by Battelle.

At present, none of the above measures are specified for stratification by race and ethnicity or other dimensions of inequity. The National Committee for Quality Assurance will stratify the two depression measures by race and ethnicity, beginning in measurement year 2024. APM designs should include collection of data on self-identified race, ethnicity and other demographic dimensions of inequity and should foster expeditious measurement, tracking, and programs and incentives for advancing equity.

Options for Person-Reported Experience of Maternal Care Measures Until Broad Consensus-Based Measures are Available

Measure Name	Consensus-Based Entity Endorsement?	Steward	Level Measured	Phase of Care	Inclusion in Measure Programs and / or Core Sets	Rationale / Notes
Birth Satisfaction Scale - Revised Indicator (BSS-RI)	No	Caroline J. Hollins-Martin and Colin R. Martin	Facility	Labor and birth	Longer Birth Satisfaction Scale-Revised (BSS-R) is in ICHOM Pregnancy and Childbirth Core Set	Validated: 6 items/2 domains -Stress and emotional response to labor and birth 4 -Quality of care 2 https://doi.org/10.1186/s12884-017-1459-5
Person-Centered Maternity Care Scale-US Person-Centered Prenatal Care Scale-US	No	Person-Centered Equity Lab (University of California, San Francisco)	Facility Clinician	Labor and Birth Prenatal	No	PCMC is validated among Black birthing people: 35 items/3 scales -Dignity and respect 14 -Communication & autonomy 10 -Responsive & supportive care 11 PCPC has 34 items, same 3 scales, with 14, 10, 10 items. Option to use 1, 2, or 3 scales. Developers are creating a parallel postpartum care scale. https://doi.org/10.1016/j.whi.2022.01.006
[Respectful Maternity Care Measurement Registry]	No	Birth Place Lab (University of British Columbia)	Varied	Varied	No	210 validated items across 17 domains of respectful care. Option to select domains and items of interest and construct customized tool. https://www.birthplacelab.org/rmc-registry/
Shared Decision-Making Processes	CBE 2962	Massachusetts General Hospital	Clinician/ group	Prenatal Labor and Birth Postpartum	No	Newly endorsed person-reported experience measure: brief four-item questionnaire. Flexibly assesses shared decision-making process for a user-specified test or treatment within a specific condition. In maternity care, e.g., has been used to assess planning a vaginal birth after cesarean versus a repeat cesarean. https://mghdecisionsciences.org/wp-content/uploads/2018/07/user-guide-sdmp_4-nqf-measure-2962.pdf

Consensus-Based Entity references endorsement by the National Quality Forum before 2023 and moving forward by the Partnership for Quality Measurement led by Battelle.

Person-reported measures of the experience of maternity care, and especially of respect and mistreatment, are urgently needed given widespread reports of not being listened to, delays in care, substandard care, and other forms of disrespect and mistreatment. While various efforts to develop such experience of care measures are underway, no consensus person-reported broader experience of maternity care is currently available. This table identifies some research-based indicators that APM managers can use to integrate this measure concept in the interim, including a generic consensus shared decision-making measure that can be used for a specific maternity decision. It is urgent to use these tools to identify, track, and address inequities.

Options for Social Needs Screening and Referral Until Strong Consensus-Based Maternity-Specific Measures are Available

Measure Name	Consensus-Based Entity Endorsement?	Steward	Level Measured	Phase of Care	Inclusion in Measure Programs and / or Core Sets	Rationale / Notes
Social Needs Screening and Intervention	No	National Committee for Quality Assurance SNS-E	Health Plan	Not specified for maternity care	Healthcare Effectiveness Data and Information Set (HEDIS)	<p>Social needs have a strong impact on maternal and infant health outcomes.</p> <p>Identifies members screened for food, housing and transportation needs, as well as help provided to those with positive screens.</p> <p>Could be used with a maternity care denominator.</p> <p>https://www.ncqa.org/wp-content/uploads/2022/07/HEDIS-MY-2023-Measure-Description.pdf</p>

Routine screening and support for meeting identified needs has the potential to improve maternity outcomes. SNS-E includes screening and helping. Two related measures have received consensus-based endorsement and are being added to the federal Inpatient Quality Reporting program and as optional reporting measures to meet The Joint Commission’s accreditation reporting requirements: Driver of Health Screening Rate (CMS Measure ID 1664) and Driver of Health Screen Positive Rate CMS Measure ID 1662). Although these do not measure whether the person received help for identified social needs, they cover screening for five domains: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. They could be used with a maternity care denominator.

For operational guidance on social needs screening in maternity care, see <https://nationalpartnership.org/wp-content/uploads/rtb-op-guidance-address-social-drivers-maternal-infant-health.pdf>

Measures Not Recommended for Inclusion in Maternity Care Alternative Payment Programs

The measures listed below represent important clinical practices that should be used reliably in accordance with clinical guidelines and important clinical outcomes. However, they should not be prioritized for inclusion in a finite set of measures selected for an alternative payment model, in lieu of an above-mentioned measure that is likely to have greater population-level impact.

Measure	Rationale for not prioritizing for maternity care alternative payment programs
Chlamydia Screening in Women	No expected impact at population level; APM measures should focus on core practices and outcomes specific to the episode
Elective Delivery (PC-01)	No expected impact at population level; quality improvement efforts have led to low rates of elective birth in gestational weeks 37-38 for about a decade, with limited variation and limited improvability
HIV Screening	No expected impact at population level; APM measures should focus on core practices and outcomes specific to the episode
Incidence of Episiotomy	No expected impact at population level; according to the Leapfrog Group, their member hospitals had an average episiotomy rate of 4.6 percent in 2022. This is below their 5 percent standard, with limited variation and limited improvability.
Maternal Morbidity Structural Measure	No expected impact at population level; provides no information about the quality of care provided at the facility or other effects of participation in a perinatal quality collaborative and at least one QI project; binary Y/N scoring provides limited scope for improvability
Percentage of Low Birthweight Births	This endorsed measure is specified for the population level (e.g., community, county, city, region, state). It is not risk-adjusted and is not used with facilities or clinicians/groups.
Postpartum Care	No expected impact at population level; the fact of a postpartum visit is a low bar; due to reliance on bundled billing codes, this measure underestimates receiving a postpartum visit; it is not aligned with current professional guidelines.
Severe Obstetric Complications	The incidence of intrapartum severe maternal morbidity and maternal mortality at the facility level is extremely low, limiting the ability to observe, measure, interpret, compare variation, and improve.
Timeliness of Prenatal Care	The fact of early entry into care is clinically important, but a low bar; this is unlikely to be a game-changing measure for childbearing families participating in an APM.

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