February 2024

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

national partnership for women & families

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Executive Summary

Despite broad recognition of the escalating crisis in maternal health and its deeply inequitable impacts, policymakers, payers, and providers are not furnishing the nation's childbearing families with the services and supports they need to thrive. Substandard outcomes are largely preventable, including an estimated 84 percent of maternal deaths. Contributing to the problem is the broken fee-for-service health care payment system that involves no accountability. It rewards complications and high-cost, high-intervention services while failing to adequately support lower-cost, higher-performing care delivery models such as midwifery, birth centers, and doulas. Meanwhile, communities of color, and especially Black and Indigenous childbearing families, bear the brunt of the maternal health crisis.

Payment and delivery reform efforts that incorporate accountable care and pay for value versus volume provide an opportunity to raise quality, tackle inequities, and mitigate some of the perverse incentives in our current system. Among current payment and care delivery models, maternity care episode payment and maternity care home programs have considerable potential to improve maternal health outcomes and mitigate disparities in racial and ethnic outcomes. We undertook an assessment of these programs, some of which have been operating for more than 15 years, to understand the extent of their use, their key design features, evidence of their tangible impact on childbearing families, and lessons for accelerating transformation.

There is a growing understanding of the importance of integrating equity-forward design elements into alternative payment models (APMs), which tie payment to quality and impact. Without a proactive approach, APMs have the potential to sustain or worsen inequitable care, experiences, and outcomes. To guide and standardize our assessment of the current landscape of both types of programs, we adapted the equity-forward alternative payment model design elements of the Health Care Payment Learning & Action Network (LAN) Health Equity Advisory Team (HEAT) to the maternity care context. This framework informed structured interviews with payment reform thought leaders and subject matter experts, and with managers of both maternity care episode payment and maternity care home programs, as well as standardized profiles of the participating programs. In interviews, birth justice leaders independently underscored the importance of elements in the HEAT framework maternity adaptation.

This supplement to the main project report describes the project methodology and summarizes the landscape of maternity care episode payment and maternity care home programs that were operating or forthcoming as of May 2023, using the adapted HEAT framework. The information was obtained through interviews with managers of 17 maternity care episode payment and 4 maternity care home programs and informed by robust discussions with birth justice leaders and payment reform thought leaders. We found few programs of either type whether operating or under development, limited provider uptake of mostly voluntary programs, and limited evidence of impact on inequity and other ways to improve outcomes for birthing families. We estimate that episode maternity care programs

pay for approximately three percent of the nation's births, with considerably fewer receiving care within maternity care homes. While legacy programs largely gave little consideration to advancing equity in their initial designs, some are beginning to consider equity-related modifications. Crucially, more recent programs of state Medicaid agencies are beginning to develop maternity models that incorporate intentional elements for reducing health inequities and mitigating the maternal health crisis. And we are hopeful about the impact of the recently announced model from the Centers for Medicare and Medicaid Services, Transforming Maternal Health (TMaH).

The main project report, *Realizing the Transformational Potential of Maternity Care Payment Reform: Analysis and Recommendations* (available at nationalpartnership.org/maternity APM), provides the rationale and approach to this project and analyzes the program details presented here. That assessment of the current landscape led to many clear recommendations to help stakeholders better address the needs of childbearing families in current and future programs, as well as an appendix of performance measures that are best suited for maternity APM program impact. Continued failure to effectively leverage payment at scale for more impactful maternity care is a major missed opportunity to intervene in harmful and unacceptable maternal-newborn health trends.

Introduction: Assessing Whether Maternity Care Alternative Payment Programs are Achieving Their Potential to Transform Care Delivery and Improve Outcomes and Equity

Despite broad recognition of the escalating crisis in maternal health and its deeply inequitable impacts, policymakers, payers, and providers are not furnishing the nation's childbearing families with the services and supports they need to thrive. As discussed in the main report of this project, *Realizing the Transformational Potential of Maternity Care Payment Reform: Analysis and Recommendations*,[1] by many indicators overall maternal health is substandard and deteriorating, and inequities – especially for Black and Indigenous birthing families – are severe. At the same time, the vast majority of instances of maternal mortality and morbidity are preventable. While these trends are longstanding and persistent, widespread awareness of this situation and the unprecedented will to address it are relatively recent phenomena that have arisen since mid-2017.[2]

Our broken health care payment system fuels this crisis. It is not designed to achieve accountability; rather it rewards neonatal intensive care unit admissions, and other high-cost, high-intervention services

and fails to reliably support lower-cost, higher-performing care delivery models like midwifery, birth centers, and doulas. In the context of hospital financial considerations, the fact that maternity care is less profitable than other highly-specialized health care services and in some cases has limited volume is leading a growing number of hospital executives to shutter their maternity care units. This creates maternity care deserts, and leaves many childbearing families without adequate maternity care support and services.[3] Access to maternity services is also compromised in states that ban or severely restrict abortions, as providers migrate to more favorable states for providing women's health care while people with both intended and forced pregnancies need maternity services.[4]

Payment and delivery reform efforts to pay for value versus volume should provide an opportunity to tackle inequities and remedy some of the perverse incentives in our current system. Among current payment and care delivery models, episode payment programs and maternity care homes have considerable potential to improve maternal health outcomes and mitigate racial and ethnic disparities in outcomes. However, as detailed below, we found few such programs, limited uptake of voluntary programs, and limited evidence of impact on inequity and improved maternal-newborn health. Crucially, newer programs, largely from Medicaid agencies, are more intentionally focusing on tangible, more equitable gains for childbearing families. The limited use of payment as a lever for improvement is a major missed opportunity to strengthen our maternity care system for child-bearing families.

> *"We need to focus our providers on a population that is truly in crisis."*
>
> —***Shin-Yi Lin**, Program Manager, New Jersey Division of Medical Assistance and Health Services, APM program manager*

This technical supplement describes our methodology and summarizes the landscape of maternity care episode programs and maternity care home programs that were operating or forthcoming as of May 2023, including their specific design attributes. Appendices enumerate known maternity care episode payment and maternity care home programs and present standardized profiles of participating programs. The main project report, *Realizing the Transformational Potential of Maternity Care Payment Reform: Analysis and Recommendations*,[5] presents perspectives and priorities of birth justice leaders, interprets our results in a series of key findings, and through recommendations identifies many ways that the various stakeholders can strengthen these programs and achieve greater impact. An appendix in that report identifies performance measures that are more and less fit-for-purpose for inclusion in these APMs.

Our Aims and Process

Payers and policymakers envision alternative payment models (APMs) with incentives to impact quality and cost as vehicles for fostering better outcomes and wiser spending in health care. Two such models have the greatest potential for impacting the maternal care delivery system and maternal-newborn outcomes: maternity episode payment programs and maternity care home programs.[i] The mechanisms for impact include incorporating accountability and changing the incentives associated with the provision of maternity care services, paying for things that build health, and supporting the care team with tools, data, sufficient budgets, and other resources for delivering high-quality services.

i A maternity care home is a delivery model and not an APM per se. The type of payment that supports this determines where it falls on the APM continuum of clinical and financial risk of the widely used framework of the Health Care Payment Learning & Action Network. Within this framework, episode programs are classified as either category 3A (with shared savings only) or 3B (with shared savings as well as downside risk). See Health Care Payment Learning & Action Network (2017), Alternative Payment Model APM Framework: Refreshed for 2017, https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

As legacy programs for the two priority models have in some cases been operating for more than 15 years and childbearing families urgently need conditions for better care, experiences, and outcomes, our project aimed to take a snapshot of currently operating programs to assess whether their potential for higher-quality, more equitable care transformation is being realized. We also aimed to learn from experiences to date and identify ways to strengthen existing and upcoming programs.

DEVELOPING A FRAMEWORK FOR ASSESSMENT

To break new ground, we evaluated currently operating and upcoming programs with a central focus on their contributions to better, more equitable maternal-newborn health. We created a framework for assessment by adapting the rubric of the Health Equity Advisory Team (HEAT) of the Health Care Payment Learning and Action Network (LAN) to the specific context of maternity care. We grounded our work in the understanding and priorities of birth justice leaders. This technical supplement and the companion report are based on structured interviews with birth justice leaders, program managers of maternity care episode payment and maternity care home programs, and payment reform thought leaders.

Aligning with the wisdom of birth justice leaders

We recognize that those who bear the brunt of our underperforming health care system and unmet health-related social needs are essential for identifying and delineating effective solutions and the pathway forward. Thus, it was crucial to include in our project guidance from birth justice leaders. We interviewed a series of birth justice leaders who are involved in nationally recognized work and organizations to understand their views of the underlying causes and solutions for our poor and inequitable health outcomes, including the role of payment. Our main report describes what we learned from these exceptional leaders.[6] The priorities they identified are remarkably well-aligned with specific features in the maternity-related adaptation of the LAN HEAT framework, detailed in the following section.

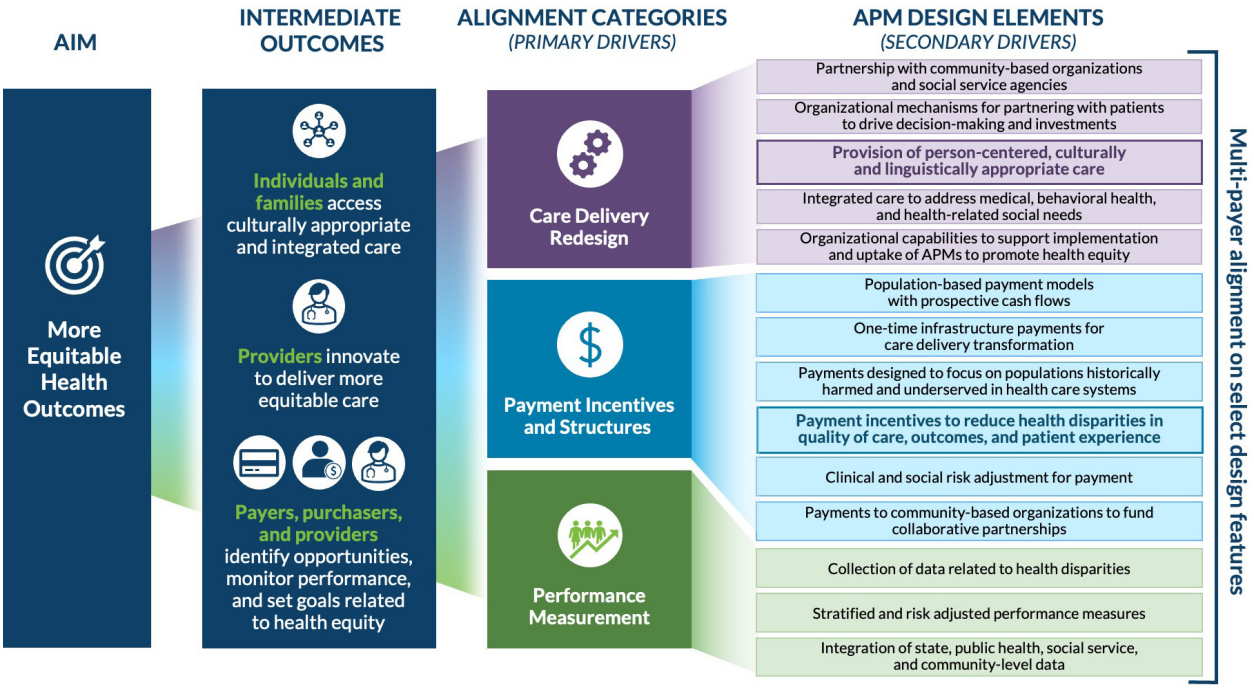
Building on the foundation of the LAN Health Equity Advisory Team's Theory of Change

As described in the main project report,[7] the current federal administration has developed a whole-of-government approach to addressing health inequities in general, and maternal health inequities specifically. Foundational statements from the Centers for Medicare and Medicaid Services (CMS), the CMS Center for Medicare and Medicaid Innovation (CMMI), and the White House include the *CMS Framework for Health Equity 2022-2032*,[8] CMMI's *Innovation Center Strategy Refresh*,[9] the *White House Blueprint for Addressing the Maternal Health Crisis*,[10] and the *CMS Maternity Care Action Plan*.[11] During the final production phase of this report, CMS announced its Transforming Maternal Health (TMaH)

Model, a program projected to operate for ten years to reduce disparities and improve outcomes and experiences for mothers and newborns enrolled in Medicaid and the Children's Health Insurance Program.[12]

CMMI worked to establish the Health Equity Advisory Team within the Health Care Payment Learning & Action Network to help guide efforts to integrate equity-forward design elements into alternative payment models. The impetus for this included concerns raised by health equity advocates and others that without such a proactive approach, APMs have the potential to sustain the inequitable status quo or worsen health care inequities. In 2021, the HEAT made a call to action for purchasers and payers to begin incorporating health equity-forward design elements into APMs and issued *Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation*. This guidance is grounded in a newly developed comprehensive theory of change framework for how APMs can advance health equity by impacting purchasers, payers, providers, individuals, and families (Figure 1). This framework identified three primary drivers (each with specific design elements), envisioned as complementary and interconnected levers: care delivery redesign, payment incentives and structures, and performance measurement.[13]

Figure 1. Health Equity Advisory Team's Theory of Change: How APMs Advance Equity



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Tailoring the HEAT framework to maternity care

The development of the HEAT's theory of change was a critical milestone in CMS's efforts to operationalize federal commitments to addressing long-standing health inequities, especially as it was created with active input from a diverse group of health equity experts and thought leaders from across the country. Our approach to assessing APMs through a health equity lens built on this comprehensive framework, by adapting it to the specifics of maternity care, as shown below in Table 1.

We added two additional design elements not included in the original HEAT framework. In the context of maternity care, a series of *high-performing maternal care and support models* are keys to achieving and accelerating impactful, equitable, care delivery redesign: midwifery care, community birth settings (birth centers and homes), doula support, and community-based perinatal support and care. When these effective services are community-based, they may offer especially respectful, trusted, and culturally congruent services for historically marginalized communities. However, whether community-based or not, these care models typically are mission-driven, minimize overuse of unneeded services and underuse of beneficial care, are enthusiastically embraced by childbearing women, and achieve exceptional results.[14] Secondly, HEAT did not underscore the importance of the *judicious selection of performance measures*. For impact, these should be game-changing measures that can make a difference for a large segment of the relevant population in an area with demonstrated improvability. And they should be robust standardized consensus-based measures that have met a high bar and are widely accepted and used. Appendix B in the companion report provides guidance on performance measures that are more and less fit for purpose for use in maternity care APMs.[15]

We share the maternity care adaptation of the HEAT APM framework both as an underpinning for this project and to help payers and purchasers consider ways to proactively build equity into their maternity APM programs, both when creating new programs or modifying existing ones. Improving maternal health is a complex challenge. We might realize the potential of maternity care payment reform to contribute to maternity care system transformation and better maternal-newborn health by implementing multiple key design elements. As shown in Figure 1, these have potential to impact multiple key stakeholder groups. We believe that lesser efforts will fail to use the significant opportunity that APMs provide to help to curb the current crisis in maternal health and health equity.

While we held all participating maternity APMs up to the maternity-specific adaptation of the 2021 LAN HEAT framework, it is not surprising that maternity care episode payment and maternity care home programs that were recently launched or are currently under development have stronger designs from the perspective of equity and overall impact. The momentous societal experiences of recent years have created an imperative for action on maternal health and health equity. Moving forward, it is crucial that all maternity APMs maximize their leverage to rectify the maternal health crisis of care, experiences, and outcomes that are substandard overall and deeply inequitable.

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 community-based organizations 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 & linguistically appropriate care	Provision of person-centered, culturally and linguistically appropriate maternal and newborn 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 the 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 the postpartum (ideally to 12 months) and newborn periods a nd offer flexibility to provide high-impact services that may not have billing codes (e.g., doula support, 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 episodes: Maternity episodes 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, lactation counselors, etc.) Maternity care homes: Maternity care homes should be designed to provide adequate payments to care and support personnel serving historically harmed & underserved individuals.
	Payment incentives to reduce health disparities in quality of care, outcomes, and patient experience	Payment incentives to advance health equity during pregnancy, at the time of birth, and in the postpartum and newborn periods
	Clinical and social risk adjustment for payment	Payment adjustment for social, physical, and/or mental health risk to provide more services to birthing families with greater needs and 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 & 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

USING THE ADAPTED HEAT FRAMEWORK TO UNDERSTAND THE CURRENT MATERNITY CARE APM LANDSCAPE

This adaptation of the HEAT framework informed our interview guide for APM program managers, the template used to summarize attributes of each program studied for this project (see Appendix C of this supplement), and – in the main report – the assessment of our results and our recommendations. Information for this project was collected through a series of semi-structured qualitative interviews with birth justice leaders and payment reform thought leaders, as well as employer purchasers, health plans, and Medicaid agencies operating or developing a maternity care episode payment or maternity care home program (see Table 2). Appendix A of the main report provides a complete list of all interviewees who participated in this project and their affiliations at the time of participation.[16]

We interviewed birth justice leaders to ensure project alignment with their understanding of the underlying drivers of maternal health and maternal health inequities and of areas for improvement and priority solutions. Interviews with payment reform thought leaders and subject matter experts helped us to position this work within the broader payment and delivery system reform enterprise and to interpret what we were learning about maternity-specific programs. The main report for this project summarizes what we learned from birth justice leaders, and discussions with thought leaders informed the findings reported.[17] Attributed and approved quotes from interviewees in both reports further share insights and concerns of interviewees.

We sought to identify as many currently operating maternity episode payment and maternity care home programs as possible and to interview managers of those programs. We expanded eligibility to include programs under development as we identified an unexpectedly small number of operating programs and as there were signs that more recent programs had stronger, including more equity-focused, designs relative to legacy pioneers. We identified health plan and purchaser-led maternity episode payment and maternity care home programs through author knowledge, industry literature, discussions with interviewees, and research. We identified 27 total maternity episode payment programs and 5 maternity care home programs led by purchasers or payers and attempted to interview managers of all programs that were either active or under development. Table 3 provides descriptive statistics of the programs identified, their status, and the proportion interviewed. A full listing of identified maternity episode payment programs can be found in Appendix A and identified maternity care home programs can be found in Appendix B.

Table 2. Vantage Points and Number of Project Interviews

Vantage Point			Organization/ Agency Count
Birth justice leaders			**5**
APM program managers	Employer purchasers	3	**19**
	Health plans	5	
	Medicaid agencies	9	
	Providers	2	
Thought leaders and subject matter experts			**6**
Total			**30**

Table 3: Identified Maternity Care Episode Payment and Maternity Care Home Programs and Percentage Interviewed

Type of Delivery System and Payment Reform	Number Identified	Percentage Active and In Development Interviewed
Maternity care episode payment programs	• Active: 17 • In development: 3 • Inactive: 5[ii] • Unknown status: 2	**85%**
Maternity care home programs	• Active: 4 • In development: 0 • Inactive: 1 • Unknown status: 1	**100%**

To systematically investigate the relevant topics, we developed semi-structured interview guides. The guide for APM program managers investigated basic attributes and design features of their programs, including items in the maternity-specific adaptation of the HEAT framework, as well as various opinion questions relating to maternal health and payment reform. The guide for birth justice leaders investigated their views of the most pressing inequities in the maternal health care system and their health system and non-health-system drivers, as well as whether payment reform could be part of

ii At the time of our initial interviews (summer 2022), the Washington State Health Care Authority was considering implementing a maternity episode. However, in the winter of 2023 Washington paused further development and implementation of its program citing cost, human resources, disturbance to an already stressed perinatal care system, and lack of compelling evidence that episodes would advance its quality goals. We have included it as "inactive," even though it was never implemented.

a solution. The guide for payment reform thought leaders and subject matter experts investigated the theories of payment reform and design features that need to be adjusted to improve maternal health and reduce maternal health inequities. We obtained permission to report any information that is not publicly available and to attribute comments and opinions. We used the results of interviews about specific APM programs to populate a standardized program template and worked with payers and purchasers to finalize these program descriptions. Program managers approved the profile describing their respective programs and compiled in Appendix C of this report. They have confirmed that the information was current as of May 2023.

Landscape of Maternity Care Episode and Maternity Care Home APMs

MATERNITY CARE EPISODE PAYMENT MODELS

Episode payment is one of the more common APMs in use for maternity care, yet as we show below, just a fraction of the nation's childbearing families receive care that was paid for through episode payment programs. The Geisinger Health System launched the first known maternity episode payment program in 2007.[18] The Pennsylvania-based health system accepted full risk for all related prenatal and birthing services, and its providers implemented over 100 discrete evidence-based care processes and protocols into the perinatal care delivery model.[19] There were no public reports of other maternity episodes until 2013 when two state Medicaid agencies, Arkansas and Tennessee, implemented similarly structured mandatory statewide maternity episode payment programs, and Horizon Blue Cross Blue Shield of New Jersey implemented its program.[20] Since then, more maternity episode APM arrangements have arisen in Medicaid, commercial, and direct employer purchaser markets. Some programs were tried and discontinued during this period, and others were developed as voluntary programs and did not attract participating providers. As of May 2023, we documented evidence of 27

maternity episode programs, 20 of which are known to be active or in development. For a full listing of these programs, see Appendix A.

This section presents a broad overview of the current landscape of maternity episode payment programs, including programs' inclusion of health equity design elements gleaned from interviewing 17 of the 20 operating or in development programs, and publicly available information from programs we were unable to interview.

> *"From my experience, episodes are one of the best vehicles for collaboration with our providers because the data/reports we share give them the ability to understand the whole spectrum of care; it provides data outside of their purview and allows for understanding of what cost and services are included in that episode. This perspective demonstrates areas of transformation, facilitates alignment with best practices and helps the provider build the foundation to move into risk-based models."*
>
> —***Julianne Pantaleone**, VP C&S Innovative Value-Based Contracting & Strategy, United Healthcare, APM program manager*

What is maternity care episode payment?

Episode payment provides one target price for a defined set of services over a defined period. Many models have target prices that vary based on the clinical acuity or claims-based risk factors of the pregnant individual. Payers hold the contracting entity responsible for outcomes by tying a portion of the payment to measured quality and cost performance. For maternity care, the target price (or budget) and quality measures most often cover pregnancy and birth-related services provided to the mother during the prenatal, birth, and postpartum phases of care. In a limited number of instances described below, the model includes the cost and quality of the newborn, or the cost of the mother's care and one or more quality measures focused on the newborn.

More childbearing families receive care through episode payment programs in Medicaid than in commercial and employer-purchaser markets

Medicaid, commercial, and employer-purchaser markets use maternity episode payment. Of the twenty active or developing maternity episodes we identified, exactly half of the models were in the commercial and employer-purchaser market, and half were in the Medicaid market. However, due to the size and scale of state Medicaid programs, individual Medicaid models covered more total births

than individual commercial carriers or employer-purchaser programs. Based on the interviews and research for this project, we estimate that approximately 3 percent of all births in the United States are paid for through a maternity episode payment APM. Table 4 below summarizes the approximate number of annual births covered under maternity episodes by market among those programs that participated in our study. The estimates include expected volume from some programs that were launched recently or are beginning to operate in 2024.[iii]

Table 4. Estimated Number of Annual Births Under Maternity Episode Payment[iv]

Market	Approximate Number of Annual Births Covered Under Episode APM
Commercial, including direct employer-purchaser	38,800
Medicaid	62,365
Total	**101,165**

OB/GYN physician practices are the primary contracting entity for nearly all maternity care episode programs, with limited leverage on maternity services in hospitals

For the most part, participants in maternity episode payment programs are employed physicians in health systems or independent OB/GYN or multispecialty physician practices. Midwives are less commonly considered "episode-initiators," though some participating hospitals and independent OB/GYN practices have midwives on staff. We found only one example where a payer had a direct APM contract with a midwifery group practice. (For more information, see the Quilted Health sidebar in the companion report.[21]) While Federally Qualified Health Centers (FQHCs) participate in the mandatory episode payment arrangements in the Ohio and Tennessee models and participated in the now-discontinued Arkansas model,[v] there are only a few examples of FQHCs participating in voluntary arrangements. (For an example of an innovative partnership between a national maternity care

iii The Connecticut Medicaid and Connecticut State Employee programs, as well as the OB Hospitalist Group's initial partnership with Federally Qualified Health Centers are scheduled to begin implementation early in 2024.

iv Data are based on qualitative interviews and research of publicly available information. Not all of the estimates were made for the same period, but were generally between 2019 and 2021. Some programs reported total births that were intended to be covered under the APM and some reported the total number of births that after reconciliation were considered "valid" episodes. We believe these data underreport the total number of births paid for using episode payment. Excluded from these data are volume estimates for the following programs known to be in operation: Aetna, BCBS Horizon, Humana, and Regence. Moreover, some newer programs are in the process of scaling up and anticipate a growth in the number of participants in the coming years.

v Arkansas phased out the Episodes-of-Care program in state fiscal years 2020 and 2021.

hospitalist group and FQHCs that is scheduled to launch early in 2024, see the OB Hospitalist sidebar in the companion report.[22])

With a few exceptions, provider participation in episode payment arrangements is voluntary after negotiation with a payer. Arkansas, Ohio, and Tennessee Medicaid require or required[vi] participation in their comprehensive episode payment programs for maternity and many other conditions for providers accepting Medicaid payments. No commercial payers or employer purchasers require providers to contract using episode payment, though one employer purchaser previously incentivized provider participation. Specifically, the Connecticut State Employee Health Plan had designated the highest-performing providers as Centers of Excellence. Employees were financially incentivized to seek care from these providers, motivating providers to obtain Center of Excellence status and gain the associated patient volume. Any provider that was deemed a Center of Excellence had to contract using episodes. Connecticut paused its program when its episode vendor exited the market in July 2022, and is redesigning this requirement for the roll-out of its new episode program starting in 2024.

While hospital maternal charges are typically included in the budget (as discussed in the following section), contracting with provider groups alone and not with hospitals limits opportunities to leverage this brief yet consequential and costly phase of care.

Maternity episode payment programs typically include physician- and hospital-provided maternal care costs, but rarely include costs for newborn care or for services not historically provided.

All maternity episodes include maternal care delivered during pregnancy, childbirth, and some portion of the postpartum period in the budget. These services typically include professional fees for prenatal care, labor and birth, and one or more postpartum visits, and facility labor and birth fees, as well as imaging services, laboratory tests, and pregnancy-related prescription drugs.

Typically, the contracting provider is responsible for the total budgeted costs of all included services, but is not responsible for paying claims billed by other providers. These budgets are established using historical data for individual providers, groups, or regional performance, which fails to acknowledge that additional resources may be needed to reduce inequities or improve quality in other ways. Connecticut Medicaid, however, intends to increase episode budgets to account for program requirements to integrate doula support and breastfeeding support.

Only two of the maternity episode programs studied included the costs and quality of the newborn or infant, and two in development are planning to do so. Current programs are: (1) Quilted Health with one commercial payer (first 30 days of newborn care) and (2) Pennsylvania Medicaid (first 60 days).

vi Arkansas phased out the Episodes-of-Care program in state fiscal years 2020 and 2021.

Programs under development are (1) the Connecticut State Employee Health Benefit Plan (first 30 days) and (2) Connecticut Medicaid (first 30 days).

Some Medicaid models have intentionally kept certain high-value maternity-related services outside the episode APM to ensure there are no inadvertent disincentives to provide important care elements. For example, New Jersey's maternity episode payment pilot does not include claims related to community doula services,[vii] contraceptive care, dental care, lactation support, or vaccinations. Colorado does not include claims related to behavioral health or drug screening. Similarly, Connecticut Medicaid plans to keep behavioral health, substance use services, long-acting reversible contraceptives, durable medical equipment (e.g., blood pressure devices, breast pumps), and some high-cost medications outside the episode. Pennsylvania excludes contraceptive care, including long-acting reversible contraception (LARC), which is costly and covered under a separate program.

Care delivery redesign: How maternity episode programs encourage care delivery transformation

Maternity care episode payment models offer the opportunity to align payment with high-value, evidence-based care, and foster delivery system transformation, thereby improving the overall quality of care provided to women and birthing people. Furthermore, members of the LAN HEAT and more recent program developers find that specific design expectations incorporated into APM contracts for care delivery are an important way to advance health equity. This section describes the care delivery redesign elements of maternity episodes, including equity-forward elements that were identified by the LAN HEAT and adapted for this report.

> *"We focus on three priority areas for improving maternal health: access to midwifery care, better perinatal mental health, and fewer unneeded cesareans."*
>
> —***Melissa Real**, Director, Americas Benefits, Qualcomm, APM employer purchaser*

- **Is there a requirement to partner with community-based organizations?**
  Although none of the episode payment programs studied had contractual requirements for providers to partner with community-based organizations, a couple make individual community-based personnel available. Pennsylvania requires multi-disciplinary care teams that include the availability of at least one doula, community health worker, social worker, or peer recovery specialist with responsibility for coordinating support for meeting mental health and social needs.

vii As of January 1, 2021 community doula services are a covered benefit under New Jersey Medicaid.

The developing Connecticut HUSKY Maternity Bundle program is working out how to make doulas and lactation support available to childbearing families.

"Engaging in community-based care and partnering with experts with their ears to the ground creates pathways for providing exemplary, impactful relationships and services."

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

- **Are there mechanisms for partnering with birthing people and the community groups that support them to guide program planning, implementation, and evaluation?**
  Several programs convened advisory groups composed of various possible stakeholders. Some included community advocates and doulas. Providers and representatives from state agencies were also mentioned. These groups serve as sounding boards during both program development and implementation. We were unable to evaluate how influential these groups were, including the relative sway of community versus professional members.
- **Are measures taken to foster access to culturally and linguistically appropriate care?**
  Many programs lacked the ability to collect basic information about the childbearing women receiving care, such as their self-identified race, ethnicity, and preferred language or whether they had limited English proficiency. In some cases, the data in hand were considered to be incomplete and of poor quality. It is thus not surprising that the programs gave little emphasis to culturally and linguistically appropriate care. A number expressed an interest in providing access to community-based perinatal health workers, but these arrangements were largely aspirational.
- **Is there a requirement to screen for physical, mental, and social health needs and follow up to address unmet needs, at a minimum, shortly after initiation of prenatal care and optimally, again during the postpartum period?**
  There were no screening and follow-up requirements in the maternity episode payments studied, but some included screening in their quality incentive rubric, especially with respect to postpartum depression. No program reported routine co-creation and updating of care plans with the pregnant or postpartum person.
- **Is there specific support for care delivery transformation, such as in-depth data reports, technical assistance, and clinical guidance?**
  While we did not directly view any provider data reports or data portals, many program managers spoke highly of the support they offered to participating providers. Reporting ranged from portals with the opportunity for providers to view their data on demand to less frequent but in-depth reports of performance. Some program managers offered regular meetings with providers. Some programs interfaced with their state perinatal quality collaboratives. While no participating

programs had specific expectations for adherence to clinical pathways, some provided educational materials to inform providers of evidence-based clinical pathways.

> *"Providers will have access to our reporting portal and be able to view their data at any time. The operations team will meet regularly with providers to go through metrics and opportunities to succeed in the episode."*
>
> —***Josh Wojcik**, State of Connecticut Health Plan Episodes of Care Program, APM program manager*

- **Is there proactive provision of access to high-performing care models?**
  Only two payers integrated or expressly incented high-performing care models like midwifery, birth centers, and doulas into their APM design, though some indicated a wish to explore providing greater access to such care models in the future. Connecticut Medicaid requires the integration of doula and breastfeeding support, and PA Medicaid requires the maternity care team to have a doula, community health worker, social worker, or peer recovery specialist. Payers or purchasers contracted directly with midwives or birth centers in a small number of cases; however, it is unclear whether this reflects an express intention to ensure access to high-performing care models.

> *"Traditionally, value-based programs benchmark providers to their historical performance. This works great for providers with the opportunity to improve but isn't as effective at rewarding already high-performing providers, who should be benchmarked to their peers."*
>
> —***Emily Chen**, Chief Growth Officer, Quilted Health, provider participating in an APM program*

Payment incentives and structures: how maternity episode programs use financial incentives to drive performance

Many episode arrangements are designed to give providers the flexibility to maintain or reduce costs while optimally improving quality. Ideally, providers under episodes would provide whole-person care consistent with each person's needs, preferences, culture, and identity resulting in more equitable, higher quality, and lower-cost care. However, the payment mechanisms and design details of most maternity episode payment programs encourage providers to focus on providing more cost-efficient care than in previous years rather than determining the level of investment needed to provide high-

quality, more equitable care. This section describes the payment mechanisms of maternity episode payment programs, including equity-forward programs.

> *"To correctly set payment levels, we need to know the true costs, for example, of caring for different types of patients, maintaining a basic level of labor and birth services, or maintaining a NICU. Right now, we understand spending, but not actual costs."*
>
> —***Harold Miller**, Center for Healthcare Quality and Payment Reform, payment reform thought leader*

- **Are maternity episodes promoting health equity by using prospective payment?** Only two payers are using or planning to use prospective payment in their episode design. Prospective payment gives providers up-front resources, which can cover capital costs to build infrastructure capacity needed to succeed with APMs and valuable services not otherwise paid, which would otherwise fall on birthing people in the form of potentially unaffordable out-of-pocket costs. Connecticut Medicaid offers a hybrid payment approach wherein a smaller prospective payment is made to assist providers with needed capital for practice transformation activities to achieve the State's goals, while a retrospective reconciliation covers direct maternity care costs. Metro Nashville Påublic Schools also has a hybrid model with a portion paid up front. All other maternity care providers participating in the studied episode payment models are paid fee-for-service with a retrospective reconciliation to the budget after the episode or performance period. Some programs are considering prospective payments in the future.

> *"Value-based payment works best when providers can focus on delivering excellent care and are given actionable data to understand their performance in real time. For the most optimal, equitable outcomes, we seek to provide the best care to everyone who walks in the door, versus adhering to standards that may vary from payer to payer."*
>
> —***Emily Chen**, Chief Growth Officer, Quilted Health, provider participating in an episode program*

- **Is there a one-time or periodic infrastructure payment for care delivery transformation?** There were no infrastructure payments to providers in the maternity episodes interviewed for this report.
- **Are maternity episodes using shared-savings or shared-risk models?** Central to the logic of alternative payment models is that having a financial stake in desired outcomes increases the likelihood of achieving those outcomes. Fewer than half of the studied

maternity episode payment models offered two-sided risk models (i.e., shared savings and shared risk). Some commercial payers offered providers a choice of shared savings with a glide path to shared risk once providers gained more comfort with taking on financial risk. Currently operating statewide mandatory Medicaid models in Ohio and Tennessee were shared risk models from the beginning, whereas other Medicaid program managers expressed an intention to progress to shared risk after some years in shared savings-only arrangements. While we were unable to obtain data on the proportion of payer episode contracts in shared risk models, we believe it is relatively small, as many payers reported the desire to attract providers to participate in their APM before imposing shared risk requirements, citing provider reluctance to take on risk for maternity care.

An important qualification is that just one program, Pennsylvania Medicaid, required that shared savings reach the care team: the contracting provider is permitted to retain up to 20 percent of shared savings for administrative costs, and at least 80 percent must go to the care team. Other programs had no such requirement and were unable to say whether the contracting entity distributed any shared savings, or imposed any shared risk, on those actually providing care.

- **Were payments provided to advance quality, especially for those who have been most adversely affected?**
  In general, dedicated payments for improving quality and equity were not part of episode program designs. Connecticut's Medicaid hybrid payment design is an example of prospectively provided payments for care transformation, with separate retrospective payments for typical fee-for-service maternity care services. Retrospective reconciliation, which is widely used, is strictly limited to reimbursement of standard fee-for-service payments.
- **Is payment adjusted for physical, mental, and social risk?**
  Most budgets were risk-adjusted using claims-based data, sometimes limiting the ability to adjust for mental health and social risks. Connecticut Medicaid is the only payer with plans to implement a social risk adjustment, the Area Deprivation Index (ADI), when it goes live in 2024.
- **Are there payments to community-based organizations providing perinatal services to fund collaborative partnerships as a means to improve health equity?**
  No commercial payer was funding community-based organizations to foster collaborative relationships with providers, and most state Medicaid regulations prohibit payments to community-based organizations, though the tide is shifting and some states are innovating by requiring managed care organizations or accountable care organizations to form collaborations with community-based organizations.[23]

Performance measurement: How maternity episode programs encourage quality improvement, including more equitable care

APMs are designed to improve the overall quality of care delivered by holding providers accountable for performance on quality, experiences, and outcomes of the health system. All maternity episode programs attempt to address quality and outcomes by including process and/or outcome measures in the episode design. We asked participating programs which measures they collect, and we report these in the program profiles. The main report identifies many opportunities for ways to leverage performance measures for greater impact, including the selection of measures, and Appendix B in that report identifies maternity-specific measures with the potential for greatest impact.[24]

This section describes the performance measurement elements of maternity episode payment programs, including equity-forward programs.

> *"Given that we will only include a finite number of measures for accountability, why would we include any without notable variation, improvability, and implications for population health?"*
>
> —***Beth Tinker**, Clinical Nurse Advisor/MCH Consultant, Washington State Health Care Authority, APM program planner*[viii]

- **Do payers collect disaggregated data by race and ethnicity? Are performance measures stratified and risk-adjusted?**
  Collecting and reporting data based on race and ethnicity is relatively rare within maternity episode payment programs. However, there is some movement in the Medicaid market toward collecting and reporting disaggregated quality performance data. Only two of the active maternity episode payment programs, New Jersey Medicaid and Pennsylvania Medicaid, require the reporting of quality data by race and ethnicity. The Pennsylvania program uses a specific "health-equity" score that awards points to providers for achieving the 75th percentile or greater on four or more Healthcare Effectiveness Data and Information Set (HEDIS) measures when stratified by Black patients in the program. This intentional design decision by Pennsylvania incentivizes providers to implement strategies to improve maternal and infant health outcomes for a segment of the population that experiences deeply inequitable birth outcomes. No maternity episodes risk-adjust performance measures, and only a few expressed interest in adding that feature to their programs in the coming years.

viii For many reasons previously mentioned, this agency has paused maternity care episode payment development work.

- **What measures were most often used?**

  Episode payment program measures are often maternal-centric process measures, such as screenings for certain conditions that, if left untreated, could harm the birthing person or infant. Examples include screening for gestational diabetes, group B streptococcus, depression, or chlamydia. Other process measures intended to reflect the quality of care provided include vaccine administration and timeliness of prenatal and postpartum visits. Outcomes measures typically included mode of birth measures, such as the nationally endorsed Cesarean Birth measure, the primary cesarean rate, or the overall cesarean rate.

  The three maternity episode payment models that include the infant in the design, track process and outcome measures. Two of the three programs that include the infant in the payment model use various measures of low-birthweight and preterm birth. One program measures unexpected complications in term newborns, and another measures the percentage of children who receive expected well-child visits with their pediatric care provider in the first 60 days of life.

  With one exception, the participating episode payment programs do not measure experience of care, such as whether women and birthing people feel treated with dignity and respect or are satisfied with their maternity care. However, some payers reported receiving feedback from members in other ways on their overall maternity experience. Only one purchaser reported surveying members to determine what was most important to women when receiving maternity care, and then surveying patients regarding their satisfaction with maternity care. Connecticut Medicaid reported a desire to include patient experience, particularly people's experience of bias or discrimination, but noted that tools to do so are limited at this point. The current portfolio of nationally endorsed maternity care measures does not include any person-reported measures of the experience of maternity care, and no measures in this portfolio are stratified by race and ethnicity or other dimensions of inequity.[25]

- **How is quality tied to payment?**

  All maternity episode payment programs studied use quality measures to assess the performance of participating providers, though there is no standard approach to how this is done. All programs tie performance on quality measures to payment, meaning quality performance can change the level of the shared savings payment, the liability for shared risk, or could lead to an add-on bonus payment. Some programs require providers to achieve a marketwide (i.e., state or regional) performance benchmark, while others require providers to improve upon their performance from a previous time period. Most programs also had reporting-only quality measures that the payer or purchaser uses to track and monitor quality improvement and might tie to payment in the future. While some program managers expressed a desire to be able to measure, track, and improve inequities by race and ethnicity, this is largely aspirational.

> *"If you publicize results of validated performance measurement, the people we serve can make more informed care choices and you can generate interest in understanding how the highest performers got there."*
>
> —***Mary Fliss**, Deputy, Clinical Strategy and Operations, Washington State Health Care Authority,*[ix] *APM program planner*

- **Are state, public health, social services, and community-level data integrated?** No maternity episodes utilize integrated state, public health, social service, or community-level data.

Quality and cost-effectiveness of maternity episode programs

Among clinical episodes, the time frame for maternity episodes is particularly long, requiring from nine to as many as 17 months to complete. This makes it difficult to understand the true impact of a maternity episode program for at least 2 years after initiation or modification and may be a disincentive for some payers to develop a maternity APM that covers a full year postpartum. More than half of the interviewees had no results to share because the maternity episode payment program was still in development, had begun too recently, or had not enrolled enough participants to report meaningful results.

Sometimes, payers were not specific about their results and reported general findings. While these general findings were positive (e.g., many providers obtained shared savings, indicating achieving some quality targets), it was difficult to assess whether the episode had improved quality and/or cost.

Two of the largest and some of the earliest maternity episode programs have published results: the Arkansas Health Care Payment Improvement Initiative and the Tennessee Health Care Innovation Initiative. Ohio's maternal episode, which was part of the larger Ohio Department of Medicaid Episodes-of-Care program of episodes for 43 separate conditions, did not separately report maternity results. Arkansas and Tennessee results did not show large improvements in cost or quality. Neither program achieved statistically significant differences in cesarean birth rates over time, and both remain among the states with the highest total cesarean rates in the country.[26] Specific cost outcomes reported in Tennessee showed spending at 9 percent below the projected level between 2014 and 2018. Arkansas did not report specific maternity cost outcomes. Quality outcomes, which were almost exclusively focused on screening for certain conditions (e.g., HIV and chlamydia screening), were weak. Birth outcomes and patient satisfaction were not evaluated. This lack of strong evidence for

ix For many reasons previously mentioned, this agency has paused maternity care episode payment development work. Mary Fliss currently serves as Deputy Program Director, One Washington.

improved quality outcomes was one of several reasons why Washington Medicaid recently paused its efforts at creating a maternity episode payment program.[27]

The legacy episode payment programs were established to consider both cost and quality, with cost often predominating, and they did not focus on equity. More recent programs are focusing more intensely on quality and are incorporating equity-forward design elements. At this point in time, no programs could report the effectiveness of episode payment on maternal health equity, as most models with equity-forward design elements are either still in development or too new to evaluate impact.

MATERNITY CARE HOME PAYMENT MODELS

The maternity care home[x] refers to an enhanced model of prenatal and postpartum care that emphasizes patient-centeredness, care coordination and services to address the mental health, and social needs that women and birthing people may have during the perinatal period. High-quality provision of these functions is important to meeting the physical, mental health, and social needs of women and birthing people. This enhanced model offers responsive accessible support for achieving positive maternal-newborn outcomes, through support that is generally out of reach within the prevailing maternity prenatal and postpartum care model, with brief visits focused primarily on physical health and clinical matters.

> *"Social needs are major factors in maternal-newborn outcomes. We need to give more attention to screening and helping people with their unmet social needs."*
>
> —***Elizabeth Howell**, Penn Medicine Department of Obstetrics and Gynecology, birth justice leader*

Maternity care homes are an adaptation of the patient-centered medical home (PCMH), a well-established care model with a similar focus in primary care. The National Committee for Quality Assurance (NCQA) has created a widely used recognition program for a standardized approach to PCMH. Studies have shown that this standardized approach to PCMH improves clinical outcomes, is cost-effective, and eliminates or reduces disparities by race and income.[28] The available evidence for maternity care homes is more limited because the model is not widespread and has not been implemented in a standardized way making it difficult to truly assess the impact of this model on pregnancy and birth outcomes. For example, maternity care homes were one of three enhanced prenatal care interventions tested in five-year multi-site demonstration (see Strong Start for Mothers and Newborns Initiative), but the model was not standardized, leading to widespread variation in implementation.

x Other names for this model include pregnancy medical home, maternity medical home, and obstetric medical home.

Like PCMH, the maternity care home is typically supported through financial incentives to providers for meeting program requirements, including performing risk screening or achieving optimal birth outcomes. These financial incentives may not always meet the definition of an APM, where payers tie at least some portion of funding to quality. We did not rule out any maternity care home models in this study because we find value in reporting on the current landscape of these programs and describing their financing and clinical models with the overall goal of better understanding of their current design and optimal directions for the future.

In total, we interviewed managers or reviewed publicly available data from three maternity care home programs that are currently active or had been implemented by a major payer. We also interviewed managers from one provider-led maternity care home model that received funding from a non-payer source. A full listing of programs included in our analysis is in Table 5. While there may be other examples of maternity care home models currently in operation, whether small pilots or individual examples, we were unable to confirm the existence of additional large payer-led models.

> *"Clinicians want to provide high-quality care for the patient, but they don't have the tools to do so. The use of payer information engines and supportive activities as part of value-based payment can make a big difference in outcomes."*
>
> —***Mary Applegate**, Medical Director, Ohio Department of Medicaid, APM program manager*

Table 5. Maternity Care Home Programs Identified[xi]

Maternity Care Home Programs	Status
CMMI's Strong Start for Mothers and Newborns Initiative[xii]	Inactive
North Carolina Medicaid	Active
NYC Health + Hospitals	Active
Ohio Medicaid	Active
Texas Children's Health Plan	Unknown
Wisconsin Medicaid	Active

xi Texas Children's Health Plan had a maternity care home payment model but declined to be interviewed for this report. We do not know whether this program continues to be active.

xii The Strong Start for Mothers and Newborns Initiative included 17 different awardees, though we categorize it here as one because they were all under one program.

This section describes the current landscape of the four active maternity care home payment models, the mechanics of the payment, and quality and cost outcomes to date.

Strong Start for Mothers and Newborns Initiative

Strong Start, one of the earliest programs of the CMS Innovation Center, was a four-year program that operated between 2013 and 2017. Its goal was to evaluate the ability of several prenatal care models to reduce preterm births and low birthweight infants and improve outcomes for newborns and pregnant people, while reducing costs to Medicaid. The Innovation Center funded and tested three enhanced prenatal care interventions among pregnant individuals who were enrolled in Medicaid or CHIP and at risk of preterm birth. One of the three models tested was maternity care homes, which offered care coordination, support and nonclinical referrals, and sometimes other enhanced services at 112 sites across the country.[29]

Participating maternity care home sites received funding to support their participation in the model, which might cover costs of up-front or ongoing infrastructure development, integration into electronic health records, staff training, developing community resource directories, data collection and other activities.[30] However, the model was not standardized and varied widely. Care managers – often nurses, social workers, or perinatal community health workers – frequently reported that this work was not well-integrated into systems of care and that they lacked access to electronic health records and had little contact with clinical staff. Uptake of ancillary services was low. Across all maternity care home sites, Medicaid beneficiaries averaged 4.6 visits with care managers.[31]

While maternity care home sites attempted to compensate for fragmented clinical care with brief visits, limited attention to mental and social needs, and other shortcomings, the project impact analysis found neither improved outcomes nor reduced postpartum utilization, but increased costs relative to similar Medicaid participants.[32] Due to the success of a rigorous "patient-centered medical home" model with proven elements in primary care,[33] Strong Start results suggest that a more standardized approach with robust design features may be needed to effectively address similar needs in the maternity care context.

What is maternity care home payment?

Unlike maternity care episode payment programs, there is no consistent definition of maternity care home alternative payment models. This variation in payment arrangements for maternity care homes makes the evaluation of maternity care home APM effectiveness difficult to discern as each model rewards or incentivizes different activities. The multiple models of maternity care home payments we found were:

- Prospectively paid per member per month (PMPM) payments to providers to complete required activities (Ohio Medicaid)
- Payments to care management vendors or health plans to coordinate care with providers (North Carolina Medicaid)
- One-time per activity payment to complete required actions, meet certain quality outcomes or meet program requirements (Wisconsin Medicaid)
- Grant based payments to providers to operate a maternity care home model (NYC Health + Hospitals)

All payers offering maternity care home payments were developed by or on behalf of Medicaid, either the national demonstration led by CMMI or state Medicaid agencies in North Carolina, Ohio and Wisconsin. The NYC Health + Hospitals program predominantly serves Medicaid beneficiaries and people without insurance but is supported by revenue that the city proactively provides, versus revenue from payers. By the very nature of the maternity care home model, payments were made to support services complementary to clinical care during pregnancy and the postpartum period, but not within the hospital phase of care. Across the various maternity care home examples, many types of maternity care providers, including OB/GYN practices (independent and health-system affiliated practices), FQHCs, and midwifery clinics, implemented maternity care home payments.

Care delivery redesign: How maternity care homes encourage care delivery transformation

Maternity care homes offer the opportunity to incentivize providers to adopt a model that is largely focused on identifying mothers and birthing people most in need and providing them with additional support. There was no standardized approach to how this model is implemented, though some payers detailed specific program requirements. This section describes the care delivery redesign elements of maternity care homes, including those that are health equity forward.

"It is crucial that women with complex health circumstances feel enveloped, supported, and nurtured."

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

- **Is there a requirement to partner with community-based organizations?**
  Through its Comprehensive Maternal Care Model, Ohio is the only payer that requires partnership with community-based organizations. Ohio is requiring providers to have a documented community engagement plan that regularly engages local stakeholders in collaborating to improve maternal and infant outcomes and strengthens the relationship between community-based organizations and the health care system.[34] The intention is to try to ensure that the birthing woman or person has an ongoing source of support, such as a doula, in the community.
- **Are there mechanisms for partnering with birthing people and the community groups that support them to guide program planning, implementation, and evaluation?**
  The Ohio Medicaid maternity care home used formative research with childbearing families to shape program planning and communication with stakeholders about program aims and design. There is also an expectation that participating providers will at least annually assess patient experience and incorporate this feedback into their practices. The other three maternity care home programs did not report mechanisms for engaging clients in program design and administration.
- **Are measures taken to foster access to culturally and linguistically appropriate care?**
  The Ohio Medicaid program requires the provider to facilitate cultural connectedness for each pregnant person, such as a community doula. The other three maternity care homes did not report fostering culturally congruent support.
- **Is there a requirement to screen for physical, mental, and social health needs and follow up to address unmet needs, at a minimum, shortly after initiation of prenatal care and, optimally, again during the postpartum period?**
  Every maternity care home program interviewed performed some sort of screening to identify at least physical risk, and often mental health risk. However, not all payers made this a program requirement. For example, North Carolina did not require providers to perform screening, but did incentivize them with a payment for each standardized prenatal risk screen completed.
- **Are there any specific care delivery transformation requirements, including to address physical, mental, and social needs during pregnancy and the postpartum period?**
  Yes. Maternity care home programs we interviewed had specific criteria to meet, either imposed by a payer or in the case of NYC Health + Hospitals, developed on its own. For example, all

programs we included performed some care coordination, but the specifics of each model varied slightly. In North Carolina, care coordination is provided by local health departments in conjunction with OB providers. Ohio's Comprehensive Maternal Care Model requires participating providers to manage population health, including by referring women in need of medical, mental health, or community support to the appropriate service, offering team-based care, and engaging the local community on shared goals for improving maternal and infant health.

While no payer-initiated models require screening and follow-up for social risk factors, two programs were specifically targeted at individuals who may have social risk factors. For example, 75 percent of the patient population served by NYC Health + Hospitals, a safety-net provider serving New York City residents, are covered by Medicaid or uninsured. Wisconsin's Obstetric Medical Home program targets pregnant women and individuals with the potential for social risk factors, including those who were under 18 years of age, Black, and/or homeless.

- **Is access to high-performing care models proactively provided?**
  Some participating providers in maternity care home payment models are high-performing providers, like FQHCs or midwifery practices. Yet none of the payer-operated maternity care home programs specifically incentivized using midwives, birth centers, or doulas.

Payment incentives and structures: How maternity care homes use financial incentives to drive performance

Under the fee-for-service model, maternity care providers could be incentivized to provide more clinical services or costlier services to generate or sustain revenue needs. Maternity care home payment models, for the most part, try to incentivize providers to deliver traditionally unreimbursed care (e.g., care coordination) or high-value care (e.g., breastfeeding or doula support) that could lead to better birth outcomes. This section describes the payment incentives available to maternity care homes, including those that are health equity forward.

- **Are maternity care homes promoting health equity by using prospective payment?**
  Ohio Medicaid is the only payer-led maternity home offering a per member per month prospective payment to providers engaged in the model to support population health activities. NYC Health + Hospitals receives a prospectively paid investment from New York City to support its maternity care home activities.

We contract with a Medicaid MCO that gives us a fixed payment per beneficiary. This frees us up to provide what our clients need, whether a four-hour visit, help with meeting social needs, or something else.

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

- **Is there a one-time or periodic infrastructure payment for care delivery transformation?**
  No interviewed maternity care home program manager reported providing infrastructure payments to the program care team. Maternity care home applicants to the now-inactive Center for Medicare and Medicaid Innovation's Strong Start program had the opportunity to request infrastructure support in their proposals, for example, for integration into workflows, integration in electronic health records, training of personnel, and development of community resource directories.[35]
- **Do maternity care home personnel have a financial stake in payment levels?**
  The Ohio Comprehensive Maternal Care program offers the strongest payment incentives aimed at advancing birth equity. In addition to per member per month payments, providers are eligible for annual incentive payments for such activities as participating in the state's Perinatal Quality Improvement Collaborative, implementing patient safety practices bundles; integrating and supporting community partners, and integrating information from patient feedback processes.

  In the Wisconsin maternity care home program, providers are eligible for a $1,000 payment when a baby is born at term and with normal birthweight. The North Carolina maternity care home program uses modest payment incentives in the form of small pay for performance bonuses: eligible providers receive $50 for completing a standardized risk screening tool at the initial visit and $150 for completing a postpartum visit within 56 days of the birth. The NYC Health + Hospitals program managers did not report similar incentives.
- **Are payments adjusted to support the greater needs of people from most adversely affected communities?**
  The Ohio Medicaid program provides two levels of payment based on risk. The NYC Health + Hospitals program assigns clients to three levels of risk, with each successive tier eligible for an additional set of services. Only pregnant people at higher risk are eligible for the additional set of services offered by the North Carolina and Wisconsin programs.
- **Is payment adjusted for physical, mental health, and social risk?**
  Ohio varies per member per month (PMPM) payments according to two tiers of physical, mental, and social risk: standard and enhanced. Ohio includes pregnant people with serious and persistent mental illness (SPMI) and/or living in lower opportunity areas into higher risk categories.

No other maternity care home programs received payments adjusted for risk factors, though, as noted, Wisconsin and NYC Health + Hospitals specifically target their medical home only to individuals meeting high-risk criteria.

- **Are there payments to community-based organizations providing perinatal services to fund collaborative partnerships to improve health equity?**
  No payer funds community-based organizations to foster collaborative relationships with the maternity care home care team as part of an APM. The Centers for Medicare and Medicaid Services are working to make it easier for states to direct money in this direction through state plan amendments or section 1115 waivers.[36]

Performance measurement: How maternity care homes encourage quality improvement, including more equitable care

APMs are designed to improve the overall quality of care delivered by using payment to hold providers accountable for meeting targets for a series of metrics. Not all maternity care home programs studied have done so, however. This section describes the performance measurement elements of maternity care home models, including those that are health equity forward.

- **Do the programs have access to standardized collection of data disaggregated by race and ethnicity and other dimensions of inequity?**
  Of the four maternity care home programs, both Ohio's Comprehensive Maternity Care program and NYC Health + Hospitals have access to race and ethnicity data.
- **What measures were most often used, and how?**
  Ohio has the most robust measurement program among the four studies. It includes a series of measures tied to payment in the initial 2023 program year (e.g., HIV, hepatitis B, tobacco cessation screening, and postpartum visit), several reported during year one and scheduled to be tied to payment after that (e.g., early prenatal visit, some breastfeeding in the first 90 days, low-risk cesarean, perinatal depression screening, WIC enrollment during pregnancy), and several for reporting only (e.g., preterm birth, low birthweight birth, dental visit).

  Providers participating in the North Carolina maternity care home program were expected to commit to performance targets such as maintaining or reducing elective births during pregnancy weeks 37 and 38, and reduce primary and low-risk cesarean rates. However, oversight on these targets is unclear. The Wisconsin program, as noted above, pays providers $1,000 for term normal birthweight births, but did not otherwise report performance metrics. The NYC Health + Hospitals program provides services but does not use performance measures as incentives for quality improvement.

- **Are performance measures stratified or risk-adjusted?**
  Ohio is stratifying performance measures and is exploring whether to use results to impact payment. Wisconsin is exploring ways to disaggregate its performance data. The NYC Health + Hospitals program is beginning to look at severe maternal morbidity by race. The North Carolina program does not collect stratified performance measures.
- **Are state, public health, social services and community-level data integrated?**
  Wisconsin Division of Public Health shares data with Wisconsin Medicaid to assist in administratively linking the birthing parent and baby and to determine birth outcome data. We did not identify any other examples of data integration.

Quality of Maternity Care Homes

The Ohio Comprehensive Maternal Care program is aptly named, with many components that might impact participants. As 2023 was the initial year of operation, performance data are unavailable. The NYC Health + Hospitals program provides a rich array of services but did not provide data on its impact on quality, experience, and outcomes. The North Carolina and Wisconsin programs did not provide evidence of impact. Notably, there is no standardization across these programs in care delivery redesign, payment structures and incentives, and performance measurement, accountability, and evaluation. This lack of standardization was also found in the design of the maternity care homes that participated in the five-year Strong Start analysis.[37]

Conclusion

Maternity care episode payment and maternity care home programs have the potential to improve maternity care equity and overall quality through better payment design and continuous evaluation and refinement. Such improvement is urgent within the nation's underperforming and deeply inequitable maternity care system. Childbearing families, our overall population health, and Black and Indigenous communities above all, pay a steep price for this flawed system.

Comprehensive equity-forward program designs are needed to support delivery system transformation and help provide all childbearing families with what they need to thrive. The adapted framework of the LAN's Health Equity Advisory Team targets care delivery redesign, payment, and performance measurement, in ways that can impact individuals and families, providers, payers, and purchasers. However, the two models examined here largely have not realized the potential to help turn the tide on maternal health outcomes and inequities.

Low participation is a major challenge. We estimate that merely three percent of childbearing women receive maternity care within episode payment programs, with participation in maternity care homes even lower. This is a function of few payers and other entities offering primarily voluntary programs,

with limited provider uptake. A second major concern is the limited impact of these programs to date, based on shared and publicly available information, even on a small scale. We await initial results from newer 2.0 programs, particularly those recently developed and under development in the Medicaid market, which have stronger design elements, with intentional pro-active attention to equity and to mitigating the maternal health crisis. These include Ohio's maternity care home program; Medicaid episode programs in Pennsylvania, New Jersey, and Connecticut; and Connecticut's companion maternity care episode program for state employees.

The path breaking legacy programs and newer programs of both types of models suggest clear direction for future success. Our companion report, *Realizing the Potential of Maternity Care Payment Reform: Analysis and Recommendations*,[38] presents a series of major project findings, recommendations based on the results described in this supplement, and recommended higher-impact performance measures.

Fee-for-service practice can foster a sense of complacency. By contrast, working together toward shared aims and performance targets and being financially accountable for exemplary professional practice and improvement over time is a needed culture shift within our maternity care system. Participation in APMs has grown substantially in many areas of health care due to policy signals and models promulgated by the CMS Innovation Center. We believe that a clear central policy signal is needed to foster strong equity-first designs, accelerate uptake, and achieve scale and impact. The 10-year Transforming Maternal Health (TMaH) Model, just announced by CMS, has great potential to be such a signal, beginning with a three-year pre-implementation period for strengthening state policies, programs, and infrastructure. Initial big-picture plans suggest that TMaH will be closely aligned with the maternity adaptation of the HEAT framework.[39]

Through strategic design recalibration of existing maternity care APMs and creation of new high-impact programs, payment reform can complement other initiatives and help create a maternity care system that reliably provides access to safe, effective, equitable care and positive experiences for all.

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.

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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. Status of Known Maternity Care Episode Payment Programs

Purchaser or Payer	Status	Interviewed
Aetna	Active	N
AmeriHealth Caritas Bundles for Babies	Active	Y
AmeriHealth Caritas Perinatal Quality Enhancement Program in Louisiana	Active	Y
Anthem	Active	Y
Arkansas Medicaid	Inactive	N
Blue Cross Blue Shield of North Carolina	Active	Y
Cigna	Active	Y
Colorado Medicaid	Active	Y
Community Health Choice	Inactive	N
Connecticut Medicaid	In development	Y
Connecticut State Employees	In development[xiii]	Y
GE	Unknown	N
Geisinger Health System	Unknown	N
Horizon Blue Cross Blue Shield of New Jersey	Active	N
Humana	Active	N
Metropolitan Nashville Public Schools	Active	Y
New Jersey Medicaid	Active	Y
New York Medicaid	Inactive	N
OB Hospitalist Group/FQHC partnership*	In development	Y
Ohio Medicaid	Active	Y
Pennsylvania Medicaid	Active	Y
Providence	Inactive	N
Regence Blue Shield Washington*	Active	N
Tennessee Medicaid	Active	Y
QualComm	Active	Y
UnitedHealthcare	Active	Y
Washington State Health Care Authority	Inactive[xiv]	Y

* We interviewed providers versus payers participating in these programs (OB Hospitalist Group versus Medicaid payers of maternity services for Federally Qualified Health Center clients, and Quilted Health versus Regence). Because the profiles present the payer perspective, we do not provide profiles for these initiatives. However, sidebars about both initiatives in the main report, Realizing the Transformational Potential of Maternity Care Payment Reform, identify innovations and other learnings. See https://nationalpartnership.org/maternityAPM.

xiii The State of Connecticut Health Plan Episodes of Care Program was operational from October 2020 until its episode vendor, Signify, exited the market July 2022. The program was paused and expects to restart with a new vendor in January 2024 with some design modifications.

xiv Washington Medicaid paused the development of their maternity episode in the winter of 2023.

Appendix B. Status of Known Maternity Care Home Payment Programs

Purchaser or Payer	Status	Interviewed
CMMI's Strong Start for Mothers and Newborns Initiative	Inactive	N
North Carolina Medicaid	Active	Y
NYC Health + Hospitals	Active	Y
Ohio Medicaid	Active	Y
Texas Children's Health Plan	Unknown	N
Wisconsin Medicaid	Active	Y

Appendix C. Maternity Care Episode Payment and Maternity Care Home APM Profiles

About these Profiles:

The following profiles of maternity episode payment and maternity care home APMs summarize in a standardized way essential details and design elements of currently operating and upcoming programs, including details of care delivery redesign, payment, and performance measurement. The profiles also highlight model performance and plans for modifying the model in the future. These details can help payers, providers, purchasers, and other interested stakeholders understand the current landscape of maternity care APMs.

The profiles identify where the program is positioned along the LAN framework of various degrees of leveraging payment for impact. This ranges from 1 – fee for service/no payment link to quality and value to 4c – integrated finance and delivery systems. Episode programs are classified relatively far along this continuum, either as 3a or 3b, APMs with shared savings alone, or with both shared savings and shared risk. However, the strength of specific design elements, and the relative degree of focus on quality, equity, and cost must also be considered to determine how impactful, and in which ways, the programs can actually be. Various types of payments can support maternity care homes and determine their placement within this framework.

The profiles specifically highlight any equity-forward care delivery, payment incentive and structure, and performance measurement elements. These equity-forward design features were derived from the APM design elements identified by the LAN Health Equity Advisory Team's Theory of Change: How APMs Advance Health Equity,[40] reproduced as Figure 1, and adapted to the context of maternity care in Table 1, as discussed earlier in this report.

If an APM model was fully or partially meeting an equity-forward design element, the box next to the feature is checked followed by a brief description of the activity; otherwise, the profile lists the equity-forward element with an unchecked box and no description. Descriptions of model parameters deemed to not impact equity are listed as "other elements."

These profiles were created based on qualitative interviews of payers and purchasers conducted between April 2022 and August 2022, and updated in May and June 2023. They include current and forthcoming APM programs.[xv] While this study includes some provider interviews, the focus

xv We interviewed the Washington State Health Care Authority as it was planning a Medicaid episode program. Developers subsequently suspended that work, and we do not include a profile. We also do not include profiles based on provider perspectives of interviews with Quilted Health and the planning lead for the upcoming collaboration between the OB Hospitalist Group and federally qualified health centers. These programs are, however, featured in sidebars in the companion report.

of these profiles is from the payer and purchaser perspective. In the few cases where providers were interviewed but the payer operating the APM was not, we did not create a profile using these standardized templates. Rather we used the information to inform our analysis and, in some cases, highlighted the provider perspective in the main body of this and the companion report.[41]

Representatives from the organizations profiled reviewed and approved the content of the profiles. Design parameters and technical details may have changed since the writing of these profiles along with any reported outcomes. To the extent possible, contact information has been supplied for interested readers to follow up or learn more about the programs. A complete list of known maternity episodes inclusive of forthcoming programs, current programs that we were unable to interview, and discontinued programs is provided in Appendix A, and the list of maternity care homes included in this analysis is in Appendix B.

TABLE OF PROFILES

	Commercial	Medicaid	Page
Episode Payment Programs			
AmeriHealth Caritas Bundles for Babies		✓	47
AmeriHealth Caritas Perinatal Quality Enhancement Program in Louisiana		✓	49
Anthem Blue Cross Blue Shield	✓		51
Blue Cross Blue Shield of North Carolina	✓		53
Cigna	✓		55
Colorado Medicaid		✓	63
Connecticut Medicaid		✓	57
Connecticut State Employees	✓		60
Metro Nashville Public Schools	✓		66
New Jersey Medicaid		✓	68
Ohio Medicaid (Maternity Episode)		✓	71
Pennsylvania HealthChoices (Medicaid)		✓	73
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Maternity Care Home Programs			
North Carolina Pregnancy Medical Home (PMH)		✓	83
NYC Health + Hospitals Maternal Medical Home		*	85
Ohio Medicaid Comprehensive Maternal Care		✓	87
Wisconsin Obstetric Medical Home Initiative		✓	91

* New York City is the payer. Most childbearing people across the seven participating hospital clinics are Medicaid clients. Others, including those without insurance, are eligible to participate.

EPISODE PAYMENT PROGRAMS

AmeriHealth Caritas Bundles for Babies

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	July 1, 2020	
Program participants	Independent OB/GYN maternity care practice in Louisiana	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	Administrative and clinical exclusions as defined in the Prometheus methodology, including but not limited to multiple births and certain high-cost comorbidities.
Episode time period	270 days before birth to 60 days postpartum	
Services included/ excluded	Pregnancy-related services such as physician services, inpatient and outpatient hospital services, emergency department services, labs, imaging, and prescription drugs are included.	
Estimated volume	50+ episodes	
Care delivery redesign elements	**Equity-forward elements** ☒ required prenatal and postpartum screening for physical, mental and social health needs, and follow-up ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☐ other	
	Other care delivery redesign elements: AmeriHealth Caritas does not require contracted providers to use a specific care delivery model.	
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ inclusion of newborns in the model ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: Episode target price is risk-adjusted for clinical, demographic, and other factors defined in the Prometheus methodology. ☐ other	
	Other payment incentive and structure design elements: AmeriHealth Caritas offers OB/GYN groups a shared savings payment model for maternity services. AmeriHealth Caritas creates a risk-adjusted target price based on network average episode case rate and the provider's historical experience. If a provider's episode performance is below the target price, they earn a portion of the shared savings. The provider's quality performance governs the percentage of shared savings earned.	

Profile continued ›

Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements Provider performance is governed by a composite quality score. The quality score is determined by meeting benchmarks for program measures. The program includes four quality measures and aligns with the State Medicaid Agency priorities. The program also includes a reporting measure for social determinants of health screening and assessment. • Timeliness of Prenatal Care • Postpartum Care • Chlamydia Screening in Pregnant Women • Syphilis Screening in the 3rd Trimester of Pregnancy • Social needs screening (reporting only) AmeriHealth Caritas shares performance by group, provider, and member on these measures, as well as on potentially avoidable complications, with participating clinicians.
Model performance	Participating providers have exceeded quality and efficiency benchmarks since the program's inception. AmeriHealth Caritas has expanded the model based on the positive outcomes.
Future of the model	**Equity-forward anticipated changes:** AmeriHealth Caritas intends to share performance reports stratified by race and ethnicity at a future date.
	Other anticipated changes: The plan has implemented and is developing maternity episode-based payment programs in other Medicaid markets.
For more information	Providers can contact their AmeriHealth representative

AmeriHealth Caritas
Perinatal Quality Enhancement Program in Louisiana

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	April 1, 2022	
Program participants	All OB/GYN maternity care providers in Louisiana with the minimum number of attributed deliveries during the quarterly measurement period.	
Provider participation	Voluntary with automatic enrollment of qualifying providers	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	Administrative and clinical exclusions as defined in the Prometheus methodology, including but not limited to multiple births and certain high-cost comorbidities.
Episode time period	270 days before birth to 60 days postpartum	
Services included/ excluded	Pregnancy-related services such as physician services, inpatient and outpatient hospital services, emergency department services, labs, imaging and prescription drugs are included.	
Estimated volume	Nearly 2,700 deliveries	
Care delivery redesign elements	**Equity-forward elements** ☐ required prenatal and postpartum screening for physical, mental, and social health needs, and follow-up ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☐ other	
	Other care delivery redesign elements: AmeriHealth Caritas does not require contracted providers to use a specific care delivery model, but shares practice transformation and care redesign best practices with network providers	
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ inclusion of newborns in the model ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: Episode "expected" price is risk-adjusted for clinical, demographic, and other factors defined in the Prometheus methodology. ☐ other	
	Other payment incentive and structure design elements OB/GYN providers are eligible for shared savings based on the difference between risk-adjusted Prometheus-defined expected episode costs and actual costs.	

Profile continued ›

Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☒ stratified and risk-adjusted performance measures: AmeriHealth Caritas shares performance data by group, stratified by race and ethnicity with participating clinicians. ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements Providers are eligible for a quality performance incentive tied to the following measures: • Timeliness of Prenatal Care • Postpartum Care • Chlamydia Screening in Women During Pregnancy • Gonorrhea Screening in Women During Pregnancy • Syphilis Screening in Women During Pregnancy • HIV Screening in Women During Pregnancy In addition to the quality measure performance incentive, AmeriHealth Caritas has a separate funding pool that incentives providers for improvement on its "Health Equity measure" which compares the performance of OB/GYN providers to others OB/GYN providers in the network on their performance on the following two measures for the Black/African American population: • Timeliness of Prenatal Care • Postpartum Care All providers who rank above the 50th percentile of performance for the health equity measure will receive funds from this separate pool.
Model performance	Performance data was not available at the time of this writing.
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes: AmeriHealth Caritas is exploring ways to include non-traditional providers such as midwives and birth centers. The plan has implemented and is developing maternity episode-based payment programs in other Medicaid markets.
For more information	Providers can contact their AmeriHealth Caritas representative.

Anthem Blue Cross Blue Shield Maternity Episode

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	January 2020	
Program participants	As of May 2023, Anthem had episodes of care contracts with approximately 90 OB/GYN and multispecialty provider groups across 14 markets.	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	Excluded from the episode include members with gaps in coverage, members with third-party liability, birthing people <13 and >55 years of age and members with certain clinical conditions.
Episode time period	270 days prior to delivery to 60 days postpartum	
Services included / excluded	Includes all professional and facility fees for prenatal care, delivery, postpartum care, ultrasounds, and other related care.	
Estimated volume	The anticipated annual volume is approximately 25,000 births.	
Care delivery redesign elements	**Equity-forward elements** ☐ required prenatal and postpartum screening for physical, mental, and social health needs, and follow-up ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☐ other	
	Other care delivery redesign elements: Anthem does not contractually require its providers to use a specific care model.	
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ inclusion of newborn in the model ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk ☐ other	
	Other payment incentive and structure design elements: Anthem offers OB/GYN and multispecialty groups a shared savings payment model for maternity services, with the anticipation of moving to shared risk. Anthem creates a non-risk-adjusted per-episode budget based on a provider group's historical performance on maternity services, taking into account any shifts in volume and case mix. If a provider comes below their aggregate episode budget, they will receive shared savings so long as they meet a quality gate, described below.	

Profile continued ›

Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements: In order to be eligible to receive shared savings, providers need to meet or exceed their quality thresholds that are set based on provider historical performance on both measures: • Timeliness of prenatal care, HEDIS • Overall cesarean rate Anthem anticipates that the performance threshold for meeting these two measures will be enhanced over time.
Model performance	Not yet available
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes: In 2024 Anthem will be adding risk adjustment to account for demographic and clinical factors that affect the expected cost of a specific episode. It will also be adding a new quality measure focused on primary cesareans and a reporting-only measure focused on VBAC. Finally, in 2024 Anthem will update its shared savings methodology to more closely correlate quality performance with the amount of shared savings a provider can receive.
For more information	Providers can contact their Anthem representative

Blue Cross Blue Shield of North Carolina

Maternity APM type	Episode-based payment. HCP-LAN Category 3A-3B	
Date started	July 1, 2021	
Program participants	Commercial and Federal Employee Health Benefits Program (FEHBP) maternity care providers in North Carolina, including independent OB/GYN practices and health systems.	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	Administrative and clinical exclusions as defined in the Prometheus methodology, including but not limited to multiple births and certain high-cost comorbidities.
Episode time period	300 days before birth to 60 days postpartum	
Services included/ excluded	Pregnancy-related services such as physician services, inpatient and outpatient hospital services, emergency department services, labs, hospital readmissions, and imaging are included.	
Estimated volume	Blue Cross NC had approximately 4,100 completed episodes in the first year of its program.	
Care delivery redesign elements	**Equity-forward elements** ☐ required prenatal and postpartum screening for physical, mental, and social health needs, and follow-up ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☐ other	
	Other care delivery redesign elements: Blue Cross NC does not require contracted providers to use a specific care delivery model.	
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ inclusion of newborns in the model ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk ☐ other	
	Other payment incentive and structure design elements: Blue Cross NC offers OB/GYN and multispecialty groups a shared savings payment model for maternity services, with the anticipation of moving to shared risk by year three. Blue Cross NC creates a non-risk adjusted per episode budget based on a provider group's two-year historical performance on maternity services. If a provider comes below their aggregate episode budget, they will receive shared savings based on their quality performance, described below.	

Profile continued ›

Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements Providers must improve their quality performance over prior experience to earn points which determine what percentage of shared savings the provider is eligible for. The greater the rate of improvement, the more points can be earned. The following five measures are each weighted equally in the quality scoring rubric: • Timeliness of prenatal care • Postpartum visit • Total cesarean birth rate • ED visits • Readmission rate The plan tracks other claims-based indicators such as rates of high blood pressure and preterm birth.
Model performance	In the first year of the program, all participants reached or exceeded goals in the following quality measures: timeliness of prenatal care, postpartum visits, and ED visits, and all except one reached or exceeded their goals in cesarean rates and readmissions.
Future of the model	**Equity-forward anticipated changes:** Blue Cross NC would like to begin collecting data by race/ethnicity in the future. Future models may include the newborn and prospective payment
	Other anticipated changes
For more information	https://www.bluecrossnc.com/provider-news/update-maternity-health-episode-based-payments-program

Cigna's Episode of Care Program

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	January 1, 2017	
Program participants	Cigna commercial products and 44 participating provider organizations nationwide.	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	• High- and low-cost outliers • Pregnant people without continuous coverage during the episode time period
Episode time period	280 days before birth to 60 days after birth	
Services included / excluded	All services related to the pregnancy using the Prometheus Payment Model	
Estimated volume	In 2022, there were approximately 8,800 completed episodes.	
Care delivery redesign elements	**Equity-forward elements** ☐ required prenatal and postpartum screening for physical, mental, and social needs, and follow-up ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☐ other	
	Other care delivery redesign elements: Cigna employs "clinical enablement" registered nurses who help practices identify improvement opportunities but does not require or specify a care delivery model to participate in the APM.	
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for social, physical and/or mental risk ☐ other	
	Other payment incentive and structure design elements: Contracting providers are paid on a FFS basis with retrospective reconciliation to an episode budget. Episode budgets are based on prior cost performance of the contracting entity and all providers within a given market and then risk adjusted using a claims-based software program. If the contracting provider meets or come below its episode budget and meets all quality improvement targets, the contracting provider is eligible for shared savings.	

Profile continued ›

Performance measurement	**Equity forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements Cigna has identified three quality measures that are tied to a provider entity's ability to share in savings. Each provider entity must meet or exceed the target set for them in each of the following three measures. • Type 1 Potentially Avoidable Complication rate • Primary Cesarean Delivery Rate, Uncomplicated (IQI 33) • Screening for gestational diabetes Cigna also has three quality measures that are for reporting and monitoring only: • Depression screening (tracking only) • Pregnant Women that had HBsAg Testing (NQF 0608) (tracking only) • Medical Assistance with Smoking and Tobacco Use Cessation (NQF 0027) (tracking only)
Model performance	A subset of providers share in savings annually
Future of the model	**Equity forward anticipated changes:** Cigna is in early discussions about updating its model and is beginning to consider equity-forward elements.
	Other anticipated changes
For more information	Providers can contact their Cigna representative

Connecticut HUSKY (Medicaid) Maternity Bundle

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	Anticipated launch January 1, 2024	
Program participants	HUSKY (CT's Medicaid Program) and maternity care providers including obstetricians, licensed midwives, and family medicine maternity service providers	
Provider participation	Mandatory	
Patient population	Included	☒ **birthing person** ☐ **newborn** (plan to include after year 1)
	Excluded	• Limited clinical conditions are being considered • Administrative exclusions such as non-continuous enrollment are being considered
Episode time period	40 weeks before birth to 3 months postpartum	
Services included / excluded	The episode will cover most services across all phases of maternal health. Certain care that is covered will be excluded from the episode such as newborn care, mental health, substance use services, LARCs, some high-cost medications, and care not related to maternity.	
Estimated volume	HUSKY covers approximately 36% of births in Connecticut.	
Care delivery redesign elements	**Equity-forward elements** ☐ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☐ partnership with community-based organizations ☒ access to high-performing care models at a minimum, optimally proactive provision of access: CT will be launching a doula integration initiative with prenatal through postpartum support as a new benefit to HUSKY members, provide support for doulas/doula organizations to facilitate partnerships with providers, and build capacity. Exploring how to diversify the doula workforce. Episode budgets will be adjusted to allow providers to hire doulas. Ensures midwife-physician payment parity. ☒ other: CT will establish general guidelines for doula support and breastfeeding support through various communication vehicles, including care collaboratives. Includes a broad spectrum of types of lactation personnel.	
	Other care delivery redesign elements	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☒ prospective payment: CT anticipates hybrid model paying providers prospectively at regular intervals during the prenatal phase and then retrospectively reconciling the budget at the conclusion of an episode. It will use a blended case rate for professional fees for vaginal and cesarean births. ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships: N/A, Medicaid regulations do not permit direct payments to community-based organizations. ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: episode budgets are anticipated to be risk adjusted using a claims-based software grouper at the conclusion of the episode as well as using the Area Deprivation Index (ADI) for social risk adjustment ☒ other: CT anticipates increasing episode budgets to account for program requirements to integrate doula support and breastfeeding support to achieve the "number one goal" of addressing racial disparities **Other payment incentive and structure design elements:** CT is developing provider specific episode budgets that are anticipated to be a predetermined ratio of (1) single blended statewide average costs of cesarean and vaginal births and (2) provider specific historical costs. CT is planning for providers to be eligible for shared savings upon the conclusion of an episode based on cost and quality performance.
Performance measurement	**Equity-forward elements** ☒ collection of disaggregated data: by race and ethnicity ☒ stratified and risk-adjusted performance measures: CT intends to stratify performance measures based on race and ethnicity and set targets with the goal of closing gaps ☐ integration of state, public health, social services, and community-level data **Other performance measurement elements:** CT will implement a quality scorecard that measures provider performance and offers incentives for achieving certain quality targets, improving, or reporting. The pay-for-performance measures are: • Maternal adverse events • Total cesarean birth rate • Low birth weight • Timing of prenatal care initiation • Postpartum care The pay-for-reporting measures are: • Doula utilization • Breastfeeding • Behavioral health risk assessments • Preterm birth/preterm labor • Postpartum contraception usage These measures, many of which align with the CT State Employee Health Plan episode-based payment program and/or Medicaid Core Set, are anticipated to be reported by race and ethnicity.

Profile continued ›

Model performance	Not yet available
Future of the model	**Equity-forward anticipated changes** • CT anticipates adding a social determinant of health measure into the risk adjustment and is using the Area Deprivation Index to adjust for social needs. • CT is actively searching for an outpatient-based patient experience survey to include in the program to determine individual experience of bias or discrimination and satisfaction with prenatal care. • CT plans to include the newborn after year one.
	Other anticipated changes • CT has indicated an interest in including the newborn in the episode in the future after providers gain more experience and comfort, and CT ensures it can link the newborn to the birthing individual. • After more experience with the program, e.g., gradually beginning in year 3, CT is anticipating phasing in shared risk over time.
For more information	https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Details-of-Connecticut-Maternity-Bundle

State Of Connecticut Health Plan Episodes of Care Program: Maternity Episode

Maternity APM type	Episode-based payment. HCP-LAN Category 3A and Category 3B	
Date started	October 1, 2020-July 2022[xvi]	
Program participants	Connecticut's employee and retiree health plans, the Connecticut Partnership Plan[xvii] and contracted independent and employed OB/GYN groups	
Provider participation	Mandatory for providers participating in the state's Center of Excellence[xviii] program and voluntary for all other providers.	
Patient population	Included	☒ **birthing person** ☒ **newborn**
	Excluded	Business exclusions generally include enrollment gap and birthing people with third trimester claims only. Clinical exclusions generally include multiple births, stillbirth, some age restrictions, newborns with congenital anomalies
Episode time period	280 days before birth to 60 days postpartum for the birthing person and 30 days post birth for the newborn	
Services included / excluded	• For the birthing person: all pregnancy, birthing and postpartum related services including wellness visits, prescriptions, labs, imaging, DME, fetal monitoring, hospital stay, birthing procedure physician fees, etc. • For the newborn: physician services, hospital facility fees, screenings, medications and NICU	
Estimated volume	Approximately 500 per year	

Profile continued ›

xvi CT Health Plan's episode vendor, Signify, exited the market in July 2022. The episode program was put on hold and will be restarted with a new episode vendor in 2024 with some design modifications. This profile details the Signify episode with information on updates included in the "future of the model" section.

xvii The Connecticut Partnership Plan offers non-state employers the opportunity to purchase benefits through the state employee health plan.

xviii CT incentivizes its employees to utilize Providers of Distinction and Centers of Excellence to increase beneficiary use of providers that have been found through extensive performance reviews to be exemplary performers.

Care delivery redesign elements	**Equity-forward elements** ☐ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☐ partnership with community-based organizations ☐ access to high-performing care models at a minimum, optimally proactive provision of access ☐ other
	Other care delivery redesign elements: CT does not contractually require its providers to use a specific care model but its episode-of-care vendor offers providers maternity pathways and educational materials and resources (e.g., links to risk assessments and screenings, and patient education material).
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk: episode budgets are risk adjusted based on claims-based assessment of risk. ☐ other
	Other payment incentive and structure design elements CT offers independent and employed OB/GYN provider groups the opportunity to contract on an episode-of-care basis for a comprehensive maternal/newborn bundle. The providers contracted under this APM can choose a shared savings or a shared risk model, both of which are retrospectively reconciled to a target budget. CT incentivizes providers to choose the shared risk arrangement by making the shared savings arrangement more modest in available savings opportunities. If a provider's cost performance would allow for shared savings, the provider must have met a quality benchmark and/or improved quality a predetermined amount based on its own baseline. If the provider does not meet the quality requirements, 5% of the available savings are held in a withhold pool that will be available in the following year. If the provider does not meet quality targets for three consecutive years, the amount held back is returned to the CT state employee and retiree health benefit plan. CT state employee health benefit members receive $250 if they choose to have their pregnancy care with a Provider of Distinction and $500 if they choose a Center of Excellence.

Profile continued ›

<table>
<tr><td rowspan="2">Performance measurement</td><td>Equity-forward elements
☐ collection of disaggregated data
☐ stratified and risk-adjusted performance measures
☐ integration of state, public health, social services, and community-level data</td></tr>
<tr><td>Other performance measurement elements: CT weights six different quality measures to make one score used in the financial model. The measures and weights are:
<table><tr><th>Measure</th><th>Weight</th></tr><tr><td>Low-risk cesarean birth rate</td><td>30%</td></tr><tr><td>LBW/premature babies in Level 1 nursery</td><td>10%</td></tr><tr><td>Rate of LBW/premature babies</td><td>20%</td></tr><tr><td>Maternity adverse actionable events[xix]</td><td>15%</td></tr><tr><td>Vaccination and screenings</td><td>15%</td></tr><tr><td>Postpartum depression screening and visits</td><td>10%</td></tr></table></td></tr>
<tr><td>Model performance</td><td>Not yet available</td></tr>
<tr><td rowspan="2">Future of the model</td><td>Equity-forward anticipated changes: In the future, CT will identify specific targets for improvement based on the Comptroller's recent health equity study and anticipates stratifying selected quality measures by race and ethnicity, monitoring performance, and identifying targets for improvement.</td></tr>
<tr><td>Other anticipated changes: As of May 2023, CT Health Plan is working to re-establish maternity episodes with a new vendor and seeks to align its quality measures with the HUSKY (CT Medicaid) Maternity Bundle. It plans to include the following measures:
• Readmission rate
• Complication Rate
• Prenatal Timeliness Visit Rate
• Cesarean Section Rate</td></tr>
<tr><td>For more information</td><td>https://carecompass.ct.gov/</td></tr>
</table>

xix Adverse actionable events are a term defined by Connecticut's Episode of Care vendor and represent adverse outcomes that may have been potentially preventable, such as a patient safety failure.

Health First Colorado Maternity Bundled Payment Program

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	November 1, 2020	
Program participants	Health First Colorado (CO's Medicaid Program) and maternity care providers including FQHCs, independent obstetric provider groups, and the employed obstetric care providers of one rural hospital	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person:** so long as the maternity care provider provided at least one prenatal visit ☐ **newborn**
	Excluded	• Birthing persons cannot have third-party coverage or be dually eligible for Medicare and Medicaid Services. • Cost outliers above the 95th percentile, below the 5th percentile and members who die during the episode are excluded.[xx]
Episode time period	280 days before birth to 60 days after birth[xxi]	
Services included/ excluded	CO identified codes to create a comprehensive episode definition consisting of most services provided to a birthing person during the prenatal, labor and birth, and postpartum care phases. Behavioral health services, drug screening, and testing are excluded to not create a disincentive to accessing those services.	
Estimated volume	Approximately 6,700 deliveries in the first two years, which represents about 10% of all births in CO in Year 1 and 25% in Year 2.	
Care delivery redesign elements	**Equity-forward elements** ☐ required prenatal and postpartum screening for physical, mental, and social health needs, and follow-up ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☐ other	
	Other care delivery redesign elements: CO does not specify a care delivery model for its participants.	

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xx For a full list of exclusions see: https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20Maternity%20-%20Maternity%20Event%20Definition_Updated%20Feb%202022.xlsx

xxi The episode will extend beyond 60 days postpartum until the birthing person is discharged from any inpatient admission that may extend beyond 60 days postpartum.

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ inclusion of newborns in the model ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: CO recognized that individuals with SUD and MH conditions will have higher medical spending during a maternity episode than those without. Maternity care providers of pregnant people with SUD and/or MH have enhanced budgets based on historical cost performance of caring for these individuals. This reduces any disincentive to restrict access or care to individuals with SUD or MH conditions. ☐ other
	Other payment incentive and structure design elements: Model participants are paid on a FFS basis with retrospective reconciliation. Each model participant has an "acceptable" and "commendable" threshold set based on the most recent two years of their own cost performance. The thresholds are not risk adjusted. If the maternity care provider's spending is less than the commendable threshold, they will receive 50% shared savings. If the provider exceeds the acceptable threshold, they will not be financially penalized.
Performance measurement	**Equity-forward elements** ☒ collection of disaggregated data: race and ethnicity ☒ stratified and risk-adjusted performance measures: CO stratifies performance measurement based on race and ethnicity. If a provider has a statistically significant difference in cost and number of services provided between racial groups, the provider will not be eligible for an incentive payment. ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements CO has identified four quality measures that will be tied to payment in the second year of participation for providers and one measure that is for reporting only. Those measures are: • Postpartum Depression Screening and Follow-up (tied to payment) • Contraceptive Care – Postpartum (tied to payment) • Unexpected Newborn Complications in Term Infants (tied to payment) • Severe Maternal Morbidity (tied to payment) • Percentage of Low-birth-weight Babies (tracking only) During the first year of providers' participation, CO will collect data to set quality measure performance baselines for the providers' second year of participation when the quality performance ties to payment.
Model performance	Not yet available

Profile continued ›

Future of the model	**Equity-forward anticipated changes** To ensure that the future design of the model is informed by people with lived experience, CO convened and is engaging its Maternity Advisory Committee. CO will consider addressing health equity, patient experience, and midwifery care in the next iteration of the program.
	Other anticipated changes
For more information	https://hcpf.colorado.gov/bundled-payments

Metro Nashville Public Schools MyMaternityHealth Program

Maternity APM type	Episode-based payment. HCP-LAN Category 4A	
Date started	January 2020	
Program participants	Metro Nashville Public Schools (MNPS) covered employees, Vanderbilt University Medical Center, and Vanderbilt Wilson County Hospital	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☒ **newborn** (for normal newborn care only)
	Excluded	Cases when prenatal care was not provided in the first trimester
Episode time period	First prenatal visit to 3 months postpartum	
Services included / excluded	All maternity care related medical services, including physician, hospital, labs, imaging, related inpatient admissions, ER visits and observation stays. Also included are educational lactation and newborn classes, concierge services with a patient navigator (across all episodes, not specific to maternity), and access to a birth center.	
Estimated volume	~250 births per year	
Care delivery redesign elements	**Equity-forward elements** ☐ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☐ partnership with community-based organizations ☒ access to high-performing care models at a minimum, optimally proactive provision of access: MNPS employees have access to the Vanderbilt-operated birth center ☐ other	
	Other care delivery redesign elements: MNPS does not require a care delivery model as part of this arrangement, but Vanderbilt offers high-touch concierge services to support birthing people and other episode participants.	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☒ prospective payment: MNPS makes a partial payment to Vanderbilt at the time of the first ultrasound and the balance is paid at the conclusion of the episode. ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: Payment is adjusted into three tiers based on medical claims-based diagnoses and comorbidities only ☒ other: MNPS offers an employee incentive to choose Vanderbilt for maternity care by eliminating patient cost-sharing for its employees
	Other payment incentive and structure design elements
Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements
Model performance	The latest quality and cost performance for MNPS from 2020 show: • cesarean birth rate decreased by 25% compared to market average • $364,000 total savings ($3,500 / member) • $260,000 total member out of pocket savings ($1,700 per employee) • Program Net Promoter Score (NPS) of 89
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes: MNPS and Vanderbilt have bi-weekly meetings to review and evaluate their prenatal episodes and other episodes-of-care which lead to frequent refinements of program elements.
For more information	David Hines, Executive Director Employee Benefits (David.Hines@mnps.org)

New Jersey FamilyCare Perinatal Episode Pilot

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	Three-year pilot started April 1, 2022	
Program participants	Maternity care providers participating in NJ FamilyCare (NJ's Medicaid managed care population). First year participants include hospital affiliated and independent obstetric provider groups. Midwives are eligible to participate as are FQHCs, which must do so in partnership with other providers.	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person:** so long as the maternity care provider attended 15 eligible births during the performance period. ☐ **newborn:** (newborn services are not included in the episode budget, but some quality measures apply to newborns)
	Excluded	• Birthing persons cannot have third-party coverage or be dually eligible for Medicare and Medicaid Services. • Birthing persons with higher-risk conditions, such as AIDS diagnosis are also excluded
Episode time period	9 months before birth to 60 days after birth	
Services included/ excluded	Pregnancy-related services such as physician services, inpatient and outpatient hospital services, emergency department services, labs, imaging, and prescription drugs are included in the episode budget. Claims associated with a specific set of services NJ considers to be high-value pregnancy-related care are excluded, including community doula services, contraception, dental care, lactation support and vaccinations to avoid a disincentive to providing those services.	
Estimated volume	Between 5,000 and 10,000 births are expected in the first performance year, which represents approximately 20% of births among NJ's FamilyCare population.	
Care delivery redesign elements	**Equity-forward elements** ☒ required prenatal and postpartum screening for physical, mental. and social health needs, and follow-up: The episode-of-care pilot does not require screening and follow-up, however, as of May 2020, NJ requires all pregnant patients with Medicaid health coverage or without insurance to be screened using a standardized risk assessment on clinical and psychosocial risk factors, with links to needed state and local resources to facilitate healthy pregnancies and birth outcomes. ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☒ other: participating providers are required to create a health equity plan to address any racial disparities in quality measures tied to payment and reporting	
	Other care delivery redesign elements: participating providers are required to participate in a multidisciplinary review of clinical outcomes, at a minimum, after every primary cesarean birth with the aim of avoiding unneeded cesareans.	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☒ inclusion of newborns in the model: Newborn costs are not included in the episode budget, but providers are held accountable to a quality performance measure related to the initial neonatal visit (described further below). ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: each episode is adjusted for clinical risk factors and age ☐ other
	Other payment incentive and structure design elements Each pilot participant has a risk-adjusted budget target based on their own historical performance. If a provider's episode budget is below the target, they are then eligible for shared savings, so long as the provider meets the "acceptable" level for all five quality measures tied to payment. There are two additional incentives for participating providers, each funded with a separate $1 million bonus pool. 1. High Performer Bonus: a provider is eligible for a portion of this pool when their episode costs are below statewide median, performance on at least 2 quality measures is at the state-defined "excellent" level and performance on the remaining quality measures is at least at the state-defined "acceptable" level. 2. SUD Participation Incentive: providers are eligible for this pool if they are in the top 20% of providers who have the highest volume of pregnant and postpartum people with substance use disorder.

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Performance measurement	**Equity-forward elements** ☒ collection of disaggregated data: race/ethnicity ☒ stratified and risk-adjusted performance measures: NJ will be reporting quality measures attached to payment and reporting-only measures by race/ethnicity. ☐ integration of state, public health, social services, and community-level data **Other performance measurement elements** NJ has identified five quality measures tied to payment and the minimum required performance levels. Each measure will be reported by race/ethnicity. Those measures are: • Prenatal depression screening • Gestational diabetes screening • Vaginal birth for low-risk births • Postpartum clinical visit within 3 weeks of discharge • Neonatal visit within 5 days of discharge. Measures NJ identified for reporting only, which will be stratified by race/ethnicity, include: • Mental health treatment (% of episodes where patient has a mental health diagnosis and patient received treatment for mental health in the prenatal period) • SUD treatment (% of episodes where patient has a SUD diagnosis and patient received treatment for SUD in the prenatal period) • Vaginal birth rate • Vaginal births without episiotomy • Term newborn free of unexpected complications • Absence of maternal complications • Absence of post-birth acute event • Postpartum visit within 60 days Providers will receive detailed data about their performance.
Model performance	Not yet available
Future of the model	**Equity-forward anticipated changes** **Other anticipated changes:** At the time of this writing, NJ is within its first performance period and plans to evaluate the program routinely to determine whether any changes need to be made for performance years 2 and 3. NJ intends to investigate how to bring FQHCs into the program, how to better involve community-based organizations, how to promote comprehensive quality improvement with our episode model, and when to add shared risk. NJ intends to require providers to develop performance improvement plans based on performance data.
For more information	https://www.nj.gov/humanservices/dmahs/info/perinatalepisode.html

Ohio Medicaid Perinatal Episode of Care

Maternity APM type	Episode-based payment. HCP-LAN Category 3B	
Date started	First year of accountability was 2016	
Program participants	Ohio Medicaid and maternity care providers, including OBs, FPs, CNMs.	
Provider participation	Mandatory for Medicaid providers contracted with Ohio Medicaid or Medicaid's managed care organizations.	
Patient population	Included	☒ **birthing person** ☐ **newborn:** The newborn is not included in the perinatal episode, but OH has a separate newborn episode of care launched in 2017.
	Excluded	• Business: members under 12 and over 49, multiple payers, third party liability, etc. • Clinical: certain clinical conditions, like HIV, ESRD, Parkinson's disease, or high numbers of co-morbidities, death, left against medical advice • High-cost outliers: greater than 3 standard deviations above the average risk-adjusted mean (after business and clinical exclusions)
Episode time period	280 days before birth to 60 days postpartum, beginning at discharge from hospital	
Services included / excluded	All inpatient, outpatient, professional and pharmacy claims tied to maternity care and complications. Some exclusions apply for high-cost medications.	
Estimated volume		
Care delivery redesign elements	**Equity-forward elements** ☐ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☐ partnership with community-based organizations ☒ access to high-performing care models at a minimum, optimally proactive provision of access: nurse midwives can be the principal accountable provider in Ohio's episode model ☐ other	
	Other care delivery redesign elements: OH does not contractually obligate its providers to any care redesign elements.	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: Episode performance is risk-adjusted uniformly across all providers by the state using cost-based comorbidities. ☐ other
	Other payment incentive and structure design elements: EOC participants are paid on a FFS basis with retrospective reconciliation and may have assessed positive or negative incentives based on quality and cost. OH sets "acceptable" and "commendable" cost thresholds based on historical statewide data. The "acceptable" threshold is calculated so that maternity care providers with the highest risk-adjusted average annual cost (generally the top 25% in costs) are subject to risk-sharing payments, regardless of quality performance. To be eligible to receive gain-sharing payments, the maternity care providers must have risk-adjusted average annual costs below the commendable threshold and pass all quality metrics tied to payment.
Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements OH ties the following measures to payment: • Screening for HIV • Total cesarean rate • Percent of episodes with a postpartum visit within 60 days OH tracks the following measures for monitoring only: • Screening for Group B Streptococcus • Screening for gestational diabetes • Screening for chlamydia • Screening for hepatitis B • Number of ultrasounds
Model performance	The state releases a consolidated report on performance of its entire episode of care program and does not detail perinatal episode performance specifically.
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes: OH Comprehensive Maternal Care maternity care home model launched on January 1, 2023 to advance maternal health equity in ways the episode of care program cannot. How the two APMs will operate simultaneously is currently under review.
For more information	https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/episode-based-payments/episode-based-payments

Pennsylvania HealthChoices Maternity Bundle

Maternity APM type	Episode-based payment. HCP-LAN Category 3A	
Date started	January 1, 2021[xxii]	
Program participants	PA Physical HealthChoices (Medicaid) managed care organizations and their contracted maternity care providers.	
Provider participation	The APM is mandatory for Pennsylvania's physical managed care organizations to implement, but voluntary for providers contracted with MCOs.	
Patient population	Included	☒ **birthing person:** so long as the maternity care provider uses a maternity care team and has at least twenty (20) births attributed to the maternity care team during the performance period. ☒ **newborn:** newborn is included for the first 60 days post birth
	Excluded	Multiple gestation pregnancies
Episode time period	The time period starts at the first prenatal visit and continues to 60 days postpartum.	
Services included/ excluded	All services provided during the prenatal, labor and delivery, care coordination services, and up to sixty (60) days postpartum for the mother and newborn. Contraceptive care is excluded from the bundle.	
Estimated volume	Estimated annual volume is 25% of all Medicaid-covered births	

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xxii Physical health managed care plans in PA's Medicaid program were required to begin the implementation of the maternity bundle January 1, 2021 with the expectation that contracts between the managed care plans and network providers would be in place by the end of 2021.

Care delivery redesign elements	**Equity-forward elements** ☒ required prenatal and postpartum screening for physical, mental, and social health needs, and follow-up: providers can receive points toward their overall quality score that includes screening for social determinants of health ☐ partnership with community-based organizations ☐ proactive provision of access to high-performing care models ☒ other: providers participating in this bundle must have a multidisciplinary care team that includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide prenatal care to pregnant women; at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to assist in vaginal delivery of babies; at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide newborn services; access to at least one (1) physician who is qualified to treat women with high-risk pregnancies, to treat complications experienced during pregnancy or childbirth, and to perform cesarean sections; access to at least one (1) hospital that has the capability to perform cesarean sections and treat common complications of labor and delivery; access to at least one (1) physician practice, hospital, clinical laboratory, or other entity that has the ability to perform laboratory tests or imaging studies needed as part of prenatal care, labor and delivery, and postpartum care; and at least one doula, community health worker, social worker, or peer recovery specialist who is responsible for coordinating the care of the pregnant woman to address other needs, including mental health, substance use disorder, and social needs.
	Other care delivery redesign elements
Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☒ inclusion of newborns in the model: costs and quality related to the newborn are included for the first 60 days post birth ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk ☒ other: Providers are required to attest that if eligible to receive shared savings, that at least 80% of shared savings will be distributed directly to the care team and no more than 20% of shared savings will be used for administrative purposes. This provision ensures that any savings earned by large participating health systems or entities is distributed to the maternity care providers and maternity care team.
	Other payment incentive and structure design elements: MCOs are required to develop a shared savings arrangement for this maternity bundle. While some specific details are left for the MCO to negotiate with its network providers, MCOs are required to develop target budgets based on: (a) the trimester in which the pregnant woman engaged in care; (b) historical spending with factors taken into consideration that reflect patient acuity; and may include (c) blended regional prices of vaginal and cesarean births, with the proportion of cesarean births set by PA Medicaid based on regional averages. If provider costs are below the target budget, they will be eligible to share in a proportion of savings based on their quality score, described below. MCOs are also required to implement a stop-loss mechanism such that costs that exceed 300% of the target price will be excluded from the episode.

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Performance measurement	**Equity-forward elements** ☒ collection of disaggregated data: race/ethnicity ☒ stratified and risk-adjusted performance measures: MCOs are required to assign a health equity score to participating providers based on their performance on quality measures for the Black/African American population. ☐ integration of state, public health, social services, and community-level data **Other performance measurement elements** PA has developed a quality scoring system based on the performance of 9 measures. The number of points earned is based on the performance on each quality measure relative to NCQA percentiles. The more total points earned the greater the percentage of shared savings the provider may receive. Those measures are: 1. Screening for social needs 2. Initiation of alcohol and other drug abuse or dependence treatment 3. Timeliness of Prenatal Care 4. Postpartum Care 5. Prenatal depression screening and follow-up 6. Postpartum depression screening and follow-up 7. Prenatal immunization status 8. Well child visits for visits falling within episode time frame 9. Health equity score, which awards quality points to providers who perform at the 75th percentile or higher on a subset of the above measures for the Black/African American population. PA is also requiring its managed care organizations to report the following measures at the aggregate level for their Maternity Care Bundle population and non-Maternity Care Bundle population. The MCOs track these quality measures for the Maternity Care Bundle population at the Practice level and will report them to the Department, as requested. • Severe maternal morbidity rate by race and ethnicity (+AIM) • Obstetrical needs assessment form (ONAF) screening: number of completed forms turned in • Postpartum care follow-up , including maternal medical home visit and telehealth services in the numerator • Prenatal care screening (AHRQ) • NTSV cesarean birth rate • Birth weight and length of stay of the neonate
Model performance	Not yet available
Future of the model	**Equity-forward anticipated changes** **Other anticipated changes:** PA is in discussion on how it would like to revise its zone specific Consumer Guides with maternity performance results to help members choose among health plans. The performance measures will be updated for the 2024 contract period.
For more information	The Physical HealthChoices Agreement is located at the following link: 2023 HealthChoices Agreement including Exhibits and Non-financial Appendices (pa.gov) Information on the Maternity Care Bundle is Exhibit B(7) Maternity Care Bundled Payment (page 258).

Qualcomm and Scripps Health Maternity Bundle

Maternity APM type	Maternity episode within an inclusive population-based contract	
Date started	January 1, 2021[xxiii]	
Program participants	Qualcomm employees and Scripps Health provider network	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	Post-birth complications, newborn complications/NICU, multiple gestations (beyond twins), and high-cost or complex medical complications, e.g., cancer.
Episode time period	27 weeks before birth to 6 months postpartum	
Services included / excluded	All services related to prenatal care, labs, ultrasounds, childbirth charges, anesthesia and hospital fees for single or twin baby delivery. Excluded services include post-birth complications, readmissions, NICU or newborn complications.	
Estimated volume	~150 births per year	
Care delivery redesign elements	**Equity-forward elements** ☐ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☐ partnership with community-based organizations ☒ access to high-performing care models at a minimum, optimally proactive provision of access: Midwives are part of the Scripps Health provider network. Qualcomm employees can select varying levels of midwifery services at designated locations. In addition to offering a comprehensive maternity bundle, Qualcomm also pays for lactation and doula services as a covered benefit. ☐ other	
	Other care delivery redesign elements: Qualcomm does not contractually obligate Scripps Health to any care redesign elements.	

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xxiii From 2018-2020 QualComm and Scripps Health were engaged in a case rate model of payment for maternity services.

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk ☐ other
	Other payment incentive and structure design elements: Qualcomm has a risk-based population-based direct contract with Scripps Health. Within that contract is a specific maternity price where Scripps Health receives a negotiated rate of payment split between the time of birth and at the conclusion of the bundle time window. The negotiated fee paid was calculated using a blended rate of historical vaginal and cesarean birth rates for both professionals and hospitals. Costs above the negotiated price or savings achieved are accrued at the health system level. Quality performance is measured as part of the overall population-based contract.
Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements Qualcomm has incorporated several maternity measures into its overall risk-based population arrangement with Scripps Health. • NTSV cesarean birth rate • Depression screening • Access • Membership feedback It also tracks performance on the following measures for monitoring purposes: • Low birth weight • Preterm birth • Unexpected newborn complications • Midwife utilization for delivery
Model performance	Qualcomm is still working to achieve its goal of 24% NTSV rate. It has achieved its goal of prenatal and postpartum depression screening. Cost savings have generally been positive when compared to employees who did not qualify for the bundle or employees who did not choose the Scripps Health medical network.
Future of the model	**Equity-forward anticipated changes:** Qualcomm is working with Scripps Health to increase use of midwives and on a possible future partnership with a birth center.
	Other anticipated changes
For more information	Contact Melissa Real, Director Americas Benefits at Qualcomm mreal@qualcomm.com

TennCare Perinatal Episode of Care

Maternity APM type	Episode-based payment. HCP-LAN Category 3B	
Date started	First year of accountability was 2015	
Program participants	TennCare (TN's Medicaid Program) and maternity care providers, including OBs, FPs, CNMs.	
Provider participation	Mandatory for Medicaid providers contracted with TennCare's managed care organizations	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	• Business: third-party liability, dual eligibility, FQHCs/RHCs, etc. • Clinical: certain conditions including 3+ gestations, COVID-19, active cancer management) • Patient: death, left against medical advice • High-cost outliers greater than 3 standard deviations above the average risk-adjusted episode • Episodes in which the quarterback is a maternal fetal medicine specialist
Episode time period	280 days before birth to 60 days postpartum, beginning at discharge from hospital; two quality metrics capture postpartum care up to 84 days after discharge from hospital	
Services included / excluded	All pregnancy-related care including prenatal visits, lab tests, ED visits, medications, ultrasound imaging, professional and facility components of baby birth and postpartum care. Medication assisted treatment for substance use is excluded.	
Estimated volume	Over 18,000 valid and completed episodes were completed in 2021	
Care delivery redesign elements	**Equity-forward elements** ☒ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum: Mental health screening is a tracking-only quality measure for 2023. ☐ partnership with community-based organizations ☒ access to high-performing care models at a minimum, optimally proactive provision of access: midwives can be the "quarterback" or responsible provider in TN's episode model ☐ other	
	Other care delivery redesign elements	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental, and social risk: Episode performance is risk-adjusted by each managed care organization, using cost-based comorbidities. ☐ other
	Other payment incentive and structure design elements: Model participants are paid on a FFS basis with retrospective reconciliation and may have shared savings ("gain-sharing payments") or shared risk ("risk-sharing payments") payments. TN sets "acceptable" and "commendable" cost thresholds based on historical statewide data. The "acceptable" threshold is calculated so that maternity care providers with the highest risk-adjusted average annual cost (generally the top 10% in costs) are subject to risk-sharing payments, regardless of quality performance. To be eligible to receive gain-sharing payments, the maternity care providers must have risk-adjusted average annual costs below the commendable threshold and pass all quality metrics that are tried to gain-sharing.
Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements TN has tied the following quality measures to payment in 2023: • Screening for HIV • Screening for Group B Streptococcus • Primary cesarean birth TN tracks the following quality measures for monitoring only in 2023: • Screening for gestational diabetes • TDAP vaccination • Cesarean • Percent of valid episodes with diagnosis of diabetes where the patient receives services from an MFM provider • Screening for Hep C • Routine Postpartum Care (one visit) • Routine Postpartum Care (two visits) • Mental health screening.

Profile continued ›

Model performance	The latest quality and cost performance for TN from 2021 show: • Participating providers performing HIV screening at an average rate of 87% (90% threshold to pass) • Participating providers performing Group B Streptococcus screening at an average of 92% (90% threshold to pass) • Participating providers performing an average of 30% Cesarean delivery rate (38% threshold to pass)
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes
For more information	https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html

UnitedHealthcare Maternity Episode of Care[xxiv]

Maternity APM type	Episode-based payment. HCP-LAN Category 3A and Category 3B	
Date started	2019 - Medicaid only	
Program participants	Professional OB/GYN groups contracted with UnitedHealthcare for Medicaid populations in 16 states.[xxv]	
Provider participation	Voluntary participation[xxvi]	
Patient population	Included	☒ **birthing person** ☐ **newborn:** The newborn is not included in the maternity episode in this profile, but United Healthcare has launched a NICU/newborn episode of care model in one state.
	Excluded	Birthing people with comorbidities or conditions that would make the pregnancy higher risk are excluded, for example 3+ gestations.
Episode time period	280 days before birth to 60 days postpartum	
Services included / excluded	All relevant maternity-related services during the prenatal, birth and postpartum phases.	
Estimated volume	Approximately 7,800 births annually	
Care delivery redesign elements	**Equity-forward elements** ☒ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☒ other: UnitedHealthcare's episodes allow for health equity stratification to further close diversity gaps in care and provide quality care to all.	
	Other care delivery redesign elements: UnitedHealthcare does not contractually obligate providers to any care delivery redesign elements but encourages best practice guidelines and provides data to assist with closure of identified health inequities. In addition, UnitedHealthcare is piloting Q4/2022 a next generation/ dual quarterback episode of care program which allows providers or a dual quarterback (second provider) to offer value-add services to their patients. These value-add services may include screening for social determinants of health and depression and care.	

Profile continued ›

xxiv The template for this profile was modified by UnitedHealthcare and does not contain the same design elements as other program profiles.

xxv This profile describes UnitedHealthcare's episode-of-care arrangement and does not describe the state Medicaid arrangements that UnitedHealthcare is mandated to participate in as a condition of its managed care contract with specific states.

xxvi Ibid.

Payment incentives and structure	**Equity-forward elements** ☒ one-time bonus payments for achieving episode gateway quality measures
	Other payment incentive and structure design elements: In the current retrospective upside only model: Participating providers continue to be paid FFS, but their retrospective claims data is processed through a proprietary episode engine to simulate the maternity episode based on sophisticated algorithms. A historical cost target/budget is created and used as the baseline in which their future performance is measured against. The target budgets are based on historical performance and are adjusted for claims-based risk. UnitedHealthcare has several other model types available based on provider experience with value-based episode programs. These models are designed for providers to be simple to implement, low administrative lift and provide meaningful data reporting; all with the aim to enhance quality of care and collaboration with the provider groups. United Healthcare Community and State (Medicaid) Episode Team meets with groups on a regular basis to review reports and discuss transformational opportunities and resources.
Performance measurement	**Stratified Performance Measures:** Quality measures can be stratified by race and ethnicity for reporting. UnitedHealthcare has offered micro incentives or value-added payments to providers to help fill any gaps or inequities.
	Other performance measurement elements: Providers participating in UnitedHealthcare's maternity episode must improve a certain percentage over their individualized baseline on the following three measures: • Timeliness of prenatal care • Postpartum care • Total cesarean reduction UnitedHealthcare also tracks quality measures for monitoring only: • Low birth weight (LBW) • Preterm birth • Severe maternal morbidity
Model performance	Performance data has demonstrated reduction in c-section rate as well as reduced episode cost.
Future of the model	**Equity-forward anticipated changes:** United has incorporated stratification of race and ethnicity to its quality measures for future programs.
	Other anticipated changes: UnitedHealthcare offers a separate NICU/Newborn episode which may tie back to the associated maternity episode or OB/GYN provider in the future.
For more information	For more information, contact your local UnitedHealthcare representative at csepisodes@uhc.com

MATERNITY CARE HOME PROGRAMS

North Carolina Pregnancy Management Program (PMP)[xxvii]

Maternity APM type	Maternity Medical Home. Pay for Performance Category 2C	
Date started	2011	
Program participants	All providers that bill global, packaged, or individual pregnancy services	
Provider participation	Mandatory (Before July 1, 2021 providers had to opt-in to the program. After July 1, 2021 all providers who offer perinatal services were included in the program).	
Patient population	Included	☒ **birthing person:** Birthing people who are enrolled in Medicaid ☐ **newborn**
	Excluded	
Time period	Not applicable to this payment model	
Services included / excluded	Not applicable to this payment model	
Estimated volume	Not reported	
Care delivery redesign elements	**Equity-forward elements** ☒ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum: providers are required to complete a state-standardized screening tool that screens for chronic conditions which may complicate pregnancy, substance use, social health needs, such as housing and food security, depression and other health needs that may affect pregnancy. ☐ partnership with community-based organizations ☐ access to high-performing care models at a minimum, optimally proactive provision of access ☐ other	
	Other care delivery redesign elements: North Carolina Medicaid providers participating in this incentive payment are required to complete a standardized risk screening tool at the initial visit, and as biopsychosocial needs change, and refer those at-risk patients to local health departments for the state's Care Management for High-Risk Pregnancies (CMHRP) program.	

Profile continued ›

xxvii In July 2021, North Carolina Medicaid commenced a three-year transition to managed care. As part of that transition, North Carolina Medicaid required its new managed care organizations to keep the state's maternity medical home program in place for three years, with some modifications. During this transition, health plans are permitted to offer additional innovative payment programs and incentives beyond the Pregnancy Medical Home (PHM). As of July 2024, managed care organizations may continue the program, end the program, or establish a new maternity care home program. We are reporting the state's maternity care program and did not interview managed care organizations to assess their intent for the future of the program.

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk ☐ other
	Other payment incentive and structure design elements: The North Carolina Pregnancy Medical Home is an incentive program that pays eligible providers $50 for completing a standardized risk screening tool at the initial visit and $150 for conducting a postpartum visit within 60 days of the birth. In addition, participating providers receive the same rate for vaginal and cesarean births.
Performance measurement	**Equity-forward elements** ☒ collection of disaggregated data: the standardized high-risk pregnancy screening form collects race and ethnicity data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements: To participate in this incentive program, providers must agree to: • Maintain or lower the rate of elective deliveries prior to 39 weeks gestation; • Decrease the cesarean section rate among nulliparous women; • Decrease the primary cesarean birth rate if the rate is over the Department's designated cesarean rate; (Note: The Department will set the rate annually, which will be at or below 20 percent); and • Ensure comprehensive postpartum visits occur, consistent with ACOG guidelines for what care should be delivered during the six to eight-week periods following delivery. In addition, managed care organizations must agree to provide regular reports to participating practices. Specifically with information on performance for: • Prenatal and postpartum care • Live births weighing less than 2500 grams
Model performance	Not reported
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes: On July 1, 2021, North Carolina Medicaid transitioned to managed care, but importantly continued certain existing programs. Managed care organizations are required by the State to contract with OB providers using the same payment incentives and requirements that were offered under the Pregnancy Medical Home program.
For more information	For program requirements, see: https://medicaid.ncdhhs.gov/1e-6-pregnancy-management-program/download?attachment

NYC Health + Hospitals Maternal Medical Home Initiative

Maternity APM type	Maternity Medical Home. Foundational payment Category 2A	
Date started	2019	
Program participants	Ten hospital-based maternity care clinics within the NYC Health + Hospital System, the largest municipal health system in the US	
Provider participation	N/A: (This field is used to indicate whether the program is voluntary or mandatory and does not apply to this model).	
Patient population	Included	☒ **birthing person:** Pregnant people who seek care at one of the ten participating NYC H+H hospital clinics. ☐ **newborn**
	Excluded	N/A
Time period	Initiation of prenatal time care through postpartum	
Services included / excluded	Pregnant people are stratified into three tiers and offered services based on risk needs.	
Estimated volume	About 17% of all births at NYC H+H (~3,800)	
Care delivery redesign elements	**Equity-forward elements** ☒ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum: pregnant individuals are screened prenatally to determine their speciality-referral care needs, mental health and/or emotional support needs, pharmaceutical needs, socioeconomic needs, and parenting support/education needs. Pregnant individuals are also screened using standardized assessment tools to identify depression, potential for adverse childhood experiences, alcohol use disorder, drug abuse, anxiety, and intimate partner violence ☐ partnership with community-based organizations ☐ access to high-performing care models at a minimum, optimally proactive provision of access ☐ other	
	Other care delivery redesign elements: After risk screenings have been completed pregnant people are stratified into three categories: typical risk, elevated risk and high-risk. Individuals in the typical risk category receive screening services, health education, development of a birth plan, and postpartum assessment and screenings. Individuals in the elevated risk tier receive all the services in the typical risk category plus development of a care plan/patient goals, standardized screening for depression, family violence, drug use each trimester, referral and linkage monitoring and outreach each trimester, and postpartum to review service plan needs. Individuals in the highest risk receive services in the lower two risk categories plus monthly outreach to address urgent service plan needs, higher levels of care coordination, and warm hand-offs to other support teams.	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental, and social risk ☐ other
	Other payment incentive and structure design elements: NYC H+H receives funds from New York City to support this initiative, and was chosen, in part, as the recipient of the funds to promote health equity in NYC.
Performance measurement	**Equity-forward elements** ☒ collection of disaggregated data: NYC H+H does collect data on race and is beginning to examine outcome measures stratified by race. ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services, and community-level data
	Other performance measurement elements
Model performance	Postpartum visit rate is much higher among maternal home patients than those not participating, but the program model was too new at the time of study to determine whether it had other impacts.
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes
For more information	

Ohio Medicaid Comprehensive Maternal Care Program

Maternity APM type	Maternity care home HCP-LAN Category 4A	
Date started	January 1, 2023	
Program participants	Ohio Medicaid and independent and hospital-based maternity care practices (OBs, DOs, APRNs, CNMs), FQHCs/RHCs, and local health districts with sufficient capacity to coordinate patient needs across systems and to exchange and use electronic data from a variety of sources	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person** ☐ **newborn**
	Excluded	Administrative exclusions only, including the birthing person having third-party liability or being dually eligible
Payment/service period	Providers eligible for payments from the time the pregnant person is attributed to the practice until the end of the third month postpartum.	
Required activities / services	Providers participating in Comprehensive Maternal Care (CMC) must meet the following core requirements: • Identify patients, including completing a pregnancy risk assessment • Risk stratify patients into enhanced and routine tiers using multiple data sources • Engage patients and meet their social, cultural and linguistic needs • Manage population health, including by referring women in need of physical, mental health, or community support to the appropriate service • Offer team-based care, including primary care and pediatricians • Honor continuity in relationship with providers and community partners • Have a community engagement plan and collaborate on shared goals of improving maternal and infant health, and strengthening relationships between community and health care system • Assesses patient experience at least annually on at least access to care, cultural competence, holistic care and identifies and acts on improvement opportunities	
Estimated volume	Anticipated volume at full implementation is approximately 35,000 births annually	

Profile continued ›

Care delivery redesign elements	**Equity-forward elements** ☒ required screening for physical, mental and social health needs, and follow-up, at minimum prenatally, optimally postpartum: providers are required to complete a pregnancy risk assessment form and upload it to portal which will notify the state and contracted managed care organizations of an individual's physical, mental and social needs. ☒ partnership with community-based organizations: providers are required to have a documented community engagement plan including regularly scheduled opportunities for key local stakeholders to collaborate on shared goals of improving maternal and infant outcomes and strengthening relationships between the community and the health care system ☒ access to high-performing care models at a minimum, optimally proactive provision of access: eligible participating providers includes nurse midwives ☒ other: The CMC is one component of the larger Maternal and Infant Support Program with many adjacent elements designed to reduce and eliminate racial disparities in maternal and infant outcomes and to reduce infant mortality.
	Other care delivery redesign elements: Through CMC, payer will provide tools and resources for population health management and care transformation, by: • paying prospectively for enhanced access to services and supports • providing practice access to near-real time data to allow for better population management • requiring community connection • supporting practice-level improvement strategies • focusing on patient experience
Payment incentives and structure	**Equity-forward elements** ☒ prospective payment: providers receive a PMPM based on patient risk level ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships (note: at the time of this writing, OH Medicaid regulations do not permit direct payments to community-based organizations, but OH is considering offering providers a PMPM to make community connections) ☐ one-time or periodic infrastructure payments for care delivery transformation ☒ payment adjustment for physical, mental and social risk: the prospective PMPM varies by patient risk. Some pregnant people will be categorized as higher risk based on several factors that are still in development; these will include prior preterm birth, history of SUD or SPMI, and social risk such as living in low opportunity areas, housing or food insecurity (sources not limited to claims data). ☐ other
	Other payment incentive and structure design elements: In addition to the prospectively paid PMPM, providers are eligible for annual incentive payments for participating in health disparity reduction activities, such as participating in the Perinatal Quality Improvement Collaborative, implementing patient safety practices / bundles; integration and support of community partners, and integration of information from patient feedback processes.

Profile continued ›

	Equity-forward elements ☒ collection of disaggregated data: Ohio collects disaggregated data by race ☒ stratified and risk-adjusted performance measures: OH stratifies performance measures by race and ethnicity, but is still determining how or if it will affect overall payment ☒ integration of state, public health, social services and community-level data: OH may tier payments based on where a pregnant person lives based on the OH Opportunity Index, a measure that compares opportunities across seven domains at the census tract level.
Performance measurement	**Other performance measurement elements:** At the time of this writing, OH was still developing a comprehensive outcome reporting and monitoring framework. It intends to use desk and onsite reviews of practice activity requirements, quarterly reporting on quality and efficiency performance measures, annual performance monitoring, and patient satisfaction surveys. Analytics will inform payment and reporting. The quality measures OH is using, which will be stratified by race and ethnicity, include the following: • Potential measures tied to payment • HEDIS Postpartum care • HIV Screening • Hepatitis B Screening • TDAP vaccination or counseling • Tobacco Use: Screening or cessation intervention • Maternal postpartum primary care visits (between 4-12 weeks postpartum) Reporting only measures in year 1 • TDAP vaccination (counseling not included in this measure) • Prenatal visit by nine weeks gestation • Breastfeeding during the 90 days after birth • NTSV Cesarean Birth rate • High risk composite – Behavioral health services – New opioid fill rate – Opioid use disorder treatment • Rate of solid dose opioids dispensed following birth • Maternal depression screening • WIC enrollment rate Reporting only measures • Preterm birth rate • Low birth weight rate • Annual dental Visit • Infant well care visit • Influenza Immunization • Severe obstetric complication rate
Model performance	Not yet available

Profile continued ›

Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes
For more information	https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/maternal-and-infant-support/maternal-and-infant-support

Wisconsin Obstetric Medical Home Initiative

Maternity APM type	Pay-for-Performance HCP-LAN Category 2C	
Date started	2011	
Program participants	Medicaid HMOs, OB providers, hospital-based providers, midwifery groups and FQHCs in the eight counties where most there are the Medicaid births and greatest birth outcome disparities.	
Provider participation	Voluntary	
Patient population	Included	☒ **birthing person:** The program is targeted toward pregnant people who are under 18, Black, homeless, has a chronic medical or behavioral health condition which will negatively impact the pregnancy, or had a prior poor birth outcomes (e.g., low birth weight baby) ☐ **newborn**
	Excluded	N/A
Time period	Prenatal time period to 84 days postpartum	
Services included / excluded	Incentive payments are made to enhance payments for prenatal care visits, individual care plan creation and postpartum visits.	
Estimated volume	Approximately 800 per year.	
Care delivery redesign elements	**Equity-forward elements** ☐ required screening for physical, mental, and social health needs, and follow-up, at minimum prenatally, optimally postpartum ☐ partnership with community-based organizations ☐ access to high-performing care models at a minimum, optimally proactive provision of access ☐ other	
	Other care delivery redesign elements: WI requires participating providers to develop a care management plan in conjunction with the care coordinator, the primary care provider, and the member. The care management plan must include a patient self-management or self-care component. WI also requires a minimum of 10 prenatal visits, one postpartum visit (within 60 days), and offering of home visits by a nurse, social worker or care coordinator. It also requires care coordination and discharge planning in the postpartum period, including any follow-up care necessary for birthing people with chronic conditions.	

Profile continued ›

Payment incentives and structure	**Equity-forward elements** ☐ prospective payment ☐ payments to community-based organizations providing perinatal services to fund collaborative partnerships ☐ one-time or periodic infrastructure payments for care delivery transformation ☐ payment adjustment for physical, mental and social risk ☐ other
	Other payment incentive and structure design elements: Providers are eligible for two $1,000 pay-for-performance incentive payments, passed through Medicaid HMOs.
Performance measurement	**Equity-forward elements** ☐ collection of disaggregated data ☐ stratified and risk-adjusted performance measures ☐ integration of state, public health, social services and community-level data
	Other performance measurement elements: The two performance measures providers are held accountable to for the first $1,000 incentive payment include: a. A completed prenatal appointment within the first 16 weeks; b. Enrollment into the OB Medical Home within the first 20 weeks, and continuous enrollment throughout the pregnancy; c. Completed a minimum of 10 medical prenatal appointments with the OB care provider; d. Has a member-centric comprehensive care plan that has been reviewed by the member and, at a minimum, the OB provider; and e. Has continuous enrollment through 60 days postpartum The performance measures providers are held accountable to for the second $1,000 include having a healthy birth outcome. Criteria that would exclude the provider from the second incentive includes: a. Preterm birth (<37 weeks), b. Low-birth weight (<2500 grams), c. Neonatal death, or d. Stillbirth
Model performance	WI publishes results of the program's external quality review organization (EQRO) annual report, available here: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Managed%20Care%20Organization/Managed_Care_Medical_Homes/pdf/OBMHAnnualReport2021.pdf.spage
Future of the model	**Equity-forward anticipated changes**
	Other anticipated changes
For more information	https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/OBMH/OBMHome.htm.spage

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for women & families