

Opportunities to Improve Maternal Health Through Value-Based Payments



The United States has one of the highest maternal mortality rates among high-income countries, despite significantly higher spending on maternity care.¹ Around 700 American women die each year as the result of pregnancy or its complications,² and more than 50,000 pregnant women experience a life-threatening complication.³

This problem is more acute among women of color. In 2020, the maternal mortality rate for black women was nearly 3 times higher than that of white women.⁴ Disparities also exist between rural and urban populations: The pregnancy-related mortality ratio in the most rural areas was 23.8 deaths per 100,000 live births, compared to a ratio of 14.6 deaths per 100,000 live births in large metropolitan counties.⁵

We need to work together across health care to improve outcomes for people who are pregnant, improve health equity, and increase affordability. Value-based payment and care delivery can help us make meaningful progress in achieving these goals.

Paying differently for high-value versus low-value care and tying reimbursement to maternal and infant quality outcomes as well as total costs can help address challenges in maternal care.

Value-based models can encourage evidence-based care throughout a pregnancy and post-partum periods,⁶ such as:

- Screening for health risks during pregnancy, such as hypertension or depression.
- Addressing health-related social needs, which can promote health equity.
- Timely prenatal and newborn care.
- Educating new parents, beginning in the pregnancy stage and continuing once a newborn arrives.
- Decreasing cesarean deliveries that are not medically necessary.
- Providing access to non-medical services not traditionally covered, including intensive patient education and coaching, environmental remediation, care coordinators, and home supports.

To strengthen the movement to a value-based care system, policymakers should partner with health insurance providers and undertake efforts to strive for greater alignment on best practices, such as quality measurement, and develop national content and exchange standards. All future policy and work to improve maternal health must also endeavor to promote health equity and reduce disparities.

Key Takeaways

- American women are dying at higher rates in pregnancy than women in other high-income countries, despite Americans paying far more for maternity care.
- Value-based care programs can improve health outcomes for those who are pregnant, advance health equity, and lower health care costs.
- Providers are increasingly engaging in value-based care for healthier patients.
- Congress and the Administration can take key steps now to further support the adoption of value-based care to encourage healthier pregnant people and babies.



What Is Value-Based Care?

Traditionally, providers in the United States have been paid through a “fee-for-service” (FFS) model – that is, they are paid for every covered service they provide, regardless of whether that service improves the health of the patient. This can create a perverse incentive to prescribe more care, regardless of quality.

Relying on a FFS model can result in increased use of low-value services, such as non-medically indicated early elective deliveries and cesarean sections, which can lead to complications for both parent and child.^{7,8,9} It can also lead to underuse of high-value services, such as education services, care coordinators to answer questions from new or expectant pregnant individuals, and screenings for gestational diabetes.

Value-based care arrangements, which are becoming increasingly more popular, promote high-value, patient-centric care since providers are paid to deliver cost-efficient, high-quality care in a coordinated manner. In contrast to FFS, value-based arrangements can provide physician practices and systems with additional flexibility in the provision of patient care, alleviate pressures to increase the volume of patient visits, and reduce administrative burden.

Though payment mechanisms differ across models, the lynchpin of value-based care is the use of evidence-based quality performance goals and financial accountability. Physicians agree to take on a certain amount of financial risk,



while gaining a more flexible payment structure that permits them to tailor patient care for the people they serve. This might include providing services that are not traditionally reimbursed in FFS, such as providing care coordinators to manage chronic disease or offering nutrition support or transportation assistance.

Physician participation in value-based models has increased steadily over time. In 2020, a study conducted by the American Medical Association (AMA) showed one third of physicians (66.8%) participated in at least one value-based contract, compared to 59.1% in 2016.¹⁰

Key Components of Value-Based Care Arrangements

Quality Performance: Value-based care models include evidence-based quality measures tied to patient care outcomes and experience of care. Models often pay bonuses to those providers who achieve certain quality performance goals and withhold payments from those who do not. By tying payment to quality performance, value-based care models can avoid stinting of care in favor of generating cost savings.

The Core Quality Measures Collaborative ([COMC](#)), a public-private partnership between AHIP and the Centers for Medicare & Medicaid Services (CMS) operated by the National Quality Forum (NQF), brings together health insurance providers, clinicians, employers, consumers, and regional collaboratives to align measures for use in

value-based care programs and includes obstetrics and gynecology consensus core measures that address key clinical concepts in maternal and fetal medicine.¹¹

Financial Risk: Models tend to tie greater financial risk with greater potential shared savings payments and more significant flexibilities. Risk adjustment helps ensure providers are not held accountable for costs they cannot control. For example, payments should be higher for providers caring for patients with complex needs or patients facing socioeconomic challenges. In addition, payment models may exclude certain services, patients, or conditions from bundled or population-based payments as a risk mitigation strategy and to ensure sustained provider participation.

Options for Value-Based Care

Health insurance providers have created a variety of innovative value-based care approaches for maternal care, which range in the degree to which providers are held accountable for performance, the scope of services included, and the patient populations covered by the model.

Value-Based Maternal Care

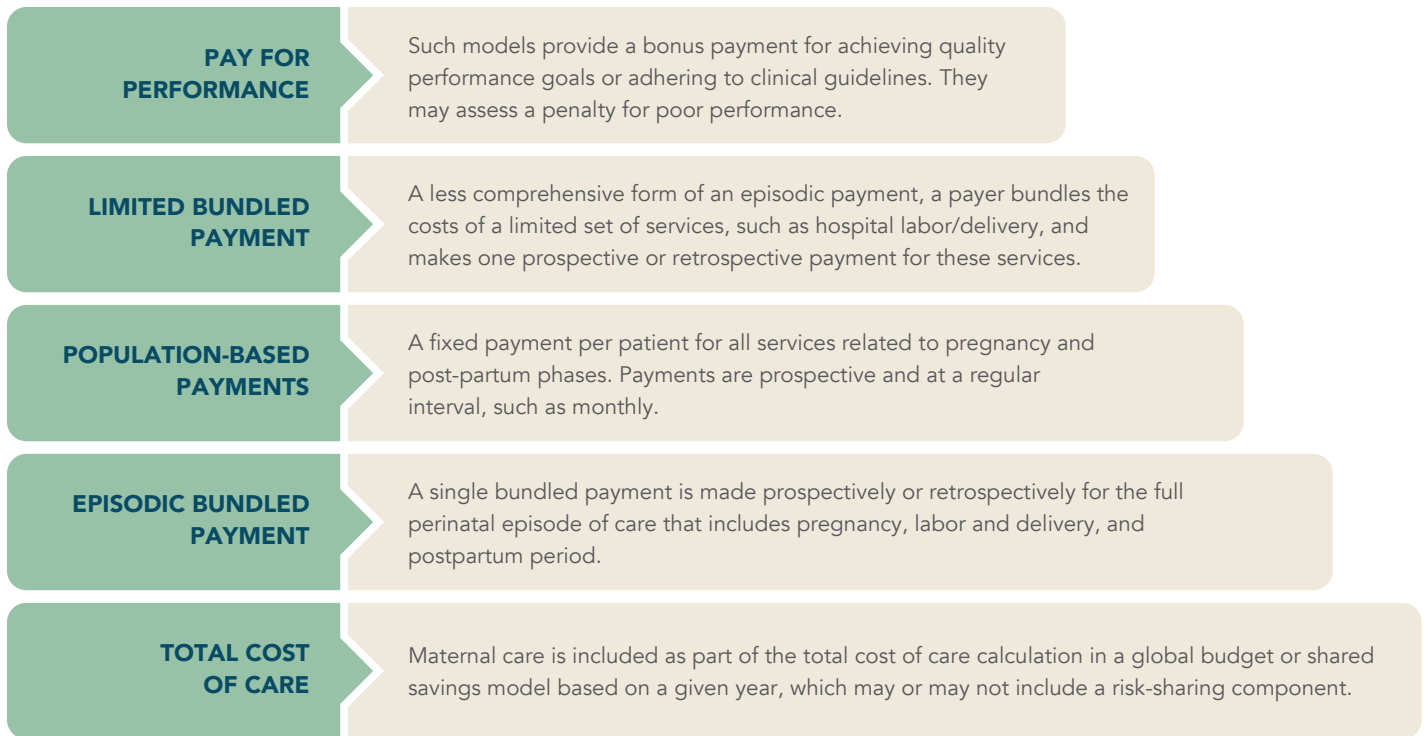
In the current environment, there are many options for designing value-based care to meet the needs of a community and other stakeholders. As government and the private market continue to experiment with value-based care models, they should identify and rely on common design attributes so they may be scaled to improve care for as many pregnant people as possible.

Several health insurance providers and state Medicaid programs have implemented pay-for-performance programs that include maternal care.¹² Under such models, incentive payments are generally predicated on attaining certain performance thresholds or achieving certain levels

of improvement on a set of quality measures. For example, an obstetrician may be rewarded for increasing depression screenings and decreasing cesarian sections. Some pay-for-performance programs will decrease payments to providers for poor quality performance, in addition to offering the opportunity for enhanced payments.

Health insurance providers and state Medicaid programs have also been experimenting with more advanced models such as bundled payments for maternal care. Each initiative defines the episode of care somewhat differently. The historical trend was to bundle only the hospital-based costs (i.e., the facility fee and labor and delivery services) and establish one rate for vaginal births and one rate for cesarian births. More recently, health insurance providers have established what is referred to as a blended case rate, which is a single payment for hospital-based costs regardless of the type of birth to discourage unnecessary cesarean delivery.^{13, 14} Alternatively, health insurance providers are expanding the episode duration to cover the entire perinatal period (e.g., the pregnancy, labor and delivery, and post-partum care for both parent and baby).¹⁵

Popular Forms of Value-Based Care Arrangements



Maternal payment reform may benefit from a hybrid approach that blends population-based payments with a bundled payment.¹⁶ For example:

- **Pre-natal period:** During the pregnancy, a health insurance provider makes pre-determined monthly payments per eligible patient to the care team to cover all professional services, procedure costs, ancillary services like laboratory or diagnostic testing, care coordination, and patient education or engagement efforts.
- **Labor and delivery:** A bundled payment is made for all hospital costs associated with the labor and delivery and is triggered by the hospital admission.
- **Post-partum period:** For a fixed number of days/months following delivery, monthly care management fees resume for all services associated with post-partum care. Models may include newborn care as well.

While maternal care services could be included as part of total cost of care models, there are some arguments for separate or layered models for maternity care. There is not the same concern with a maternal bundle as there is with, for example, an orthopedic bundle where a patient may be inappropriately steered into an unnecessary procedure. In addition, pregnancy is inherently of a limited duration and thus lends itself to episodic payments that are geared toward specific targets for specialists as opposed to year-long targets across a population geared toward primary care physicians. The two models are not mutually exclusive, however, as a specialist can be paid based on an episode by an accountable entity that is ultimately responsible for those costs under a total cost of care model. And, as noted above, both a combination of episodic and population-based payment may be employed. Thus, these models may be implemented on their own or in combination, such as nested within a total cost of care model.

How Health Plans Are Innovating

Health insurance providers are committed to improving maternal health and have implemented several initiatives aimed at improving outcomes for people who are pregnant and babies in a cost-effective manner.

Anthem Blue Cross Blue Shield Solutions instituted a global obstetric care package and payment model that covers the entire perinatal period for patients with Medicaid coverage.¹⁷ To improve outcomes for people who are pregnant and newborns in the hospital setting and encourage evidence-based care, Anthem also created quality and patient safety measures that encourage proactive approaches to common complications, such as obstetric hemorrhage,



severe hypertension, and deep vein thrombosis. From 2015 to 2017, hospitals using the quality measures reduced early elective deliveries by 5% and reduced low risk cesarean section deliveries by 2%. By 2018, over half (58%) of participating hospitals had an early elective delivery rate of 0%.¹⁸ In addition, Anthem offers an Episode-Based Payments Value Based Care Program that promotes coordination and management of care related to women's health including maternity. The program empowers providers to identify and act on opportunities to improve efficiencies in maternity care delivery, while maintaining or improving quality. The model evaluates the practices historical maternity episodes (including all services related to the pregnancy) to establish cost and quality targets. When practices demonstrate improved quality outcomes (prenatal timeliness visit rate, cesarean section rate, complication rate) and generate savings relative to cost targets, the practice is eligible to share in the savings generated.

Cigna collaborated with perinatal groups across the country to create a perinatal bundled payment program that rewards physicians for improving maternity safety, clinical guideline adherence, and episode cost control. Performance measures are aligned with national guidelines and industry standards including reduced primary cesarean deliveries, increased screening rates, increased vaccination rates, review of quality and cost-efficiency measures for the practice compared to other practices in the market, and use of cost-efficient settings for certain surgical or diagnostic procedures.¹⁹

Horizon Blue Cross Blue Shield of New Jersey implemented an episode-based upside payment model for pregnancy care with 2 practices in New Jersey in 2014.²⁰ The model has since expanded to 17 practices in New Jersey and a practice in Philadelphia. The model initially applied only to low-risk pregnancies, but now includes high-risk pregnancies. A newborn care episode was added to the pregnancy episode in 2017, as practices in the episode wanted to better understand newborn outcomes compared to care provided during the maternity episode. The episode's target is calculated from 2 years of the practice's historical data. The target is the same regardless of whether delivery is vaginal or via caesarian section. The pregnancy newborn episode includes care provided during the duration of the episode. This includes the doctor's professional fees; facility fees; ancillary fees; newborn care services 30 days post-delivery; and other related costs, such as diagnostic services. Performance measures include caesarian section rates for first time parents, tobacco screening and counseling, all cause readmissions, and surgical site infections. Between July 2018 and June 2020, practices in the episode reduced the cesarean section delivery rate by 2%.

Humana launched a national episode-based bundled payment model in 2018 for maternal care. The model holds one physician accountable for total cost of care and clinical outcomes for commercial patients with low-to-moderate risk pregnancies. Providers who are successful in reducing costs comparative to the episode's budget share in any savings generated if quality performance targets are also met. Quality performance is evaluated based on 3 quality measures: uncomplicated cesarian section rate, preterm birth rate, and cesarian section rate for patients giving birth for the first time. Targets for the quality measures are set by average performance in the state where the provider practices. The

model is "upside risk" only, meaning providers are not required to pay back losses if costs exceed the budget. Humana has implemented a number of supports for providers, such as routine performance reports.²¹

In 2014, **Providence Health and Services**, an integrated delivery system Oregon, developed the Pregnancy Care Package, a model of pregnancy care designed to facilitate physiologic birth by covering a variety of services over the perinatal period.²² The Pregnancy Care Package operated through a shared savings arrangement in which both payers and providers receive a share of the savings achieved. Providence redesigned the care approach to be team-based and centered around supporting a pregnant individual. With a nurse midwife as the team anchor, the core team includes a patient navigator to help a patient with provider and health plan needs; a doula who assists during labor and delivery; and other care team members include hospital nurses, obstetricians, pediatricians, and social workers. Doulas were not historically covered, thus this model brought about changes to coverage policies to benefit members. Results from the first year showed that, when compared to people with similar risk profiles, the Providence model resulted in 15% lower inpatient costs; cesarian section rates of 20% compared to a 33% national average; prenatal patient satisfaction rates of 98% compared to historical rates of 91%; and hospital satisfaction of patients in bundled models of 88% compared to 75% of patients in non-bundled models. Since the model implementation, Providence helped advocate for payment for living-wage reimbursement of doula services in the Medicaid population. This has allowed for a transition from the employed doula model to a community-based model with a focus on supporting the development of doulas who are from vulnerable populations.



Wisconsin has an OB Medical Home (OBMH) that enrolls high-risk pregnant individuals into a medical home model, which may be a clinic or network of clinics, through contracts with Medicaid managed care plans, including **Anthem** and **Molina**. High-risk is defined as meeting one or more criteria: patients who face homelessness; are younger than 18 years old; are African American; have a pre-existing chronic health condition; or had a prior birth with a poor outcome. Participating clinics must designate an OB care provider as a team leader, who is responsible for serving as the point of entry for new problems and coordinating care across a person's conditions, providers, and settings. Enrolled members must attend at least 10 prenatal visits and a postpartum visit within 60 days of birth. Participating providers can receive up to a \$1,000 bonus for each member that meets enrollment criteria and a second bonus of up to \$1,000 for each positive birth outcome, as defined by the state health department. Early results showed an improvement in the rate of postpartum care from 61% in 2013 to 85% in 2015 and increased delivery of timely postpartum care and behavioral health among enrolled women.²³ More recent results have not yet been released.

Policy Solutions to Support Value-Based Care for Healthier Parents and Babies

Together with our clinician partners, health insurance providers are working hard to deliver innovative and culturally competent approaches to improve maternal and infant care outcomes for all pregnant individuals and their babies.

AHIP and its members support the move from volume to value as a means of improving access to high quality, equitable, affordable care. Moving forward, we believe it is important to:

1. **Support multi-payer models.** The Center for Medicare and Medicaid Innovation (CMMI) should convene payers, employers/purchasers, and other stakeholder groups to collaborate on best practices for value-based maternity care and payment models that address the needs of different communities. While CMMI has tested maternal health initiatives, they have been narrowly crafted with a focus on opioid use, early elective delivery and prenatal care. Further development of alternative payment strategies, such as bundled or population-based payments, and how to best integrate those strategies into total cost of care models in a multi-payer fashion could materially advance maternal and fetal health.
2. **Align quality measures.** The Department of Health and Human Services (HHS), Defense Health Services, and Veteran's Administration should continue to work with
3. **Focus on achieving health equity.** With the aligned incentives in value-based payment models, flexibilities exist that allow for care transformations that are not achievable in FFS. Both measures and incentives can be used to create accountability for not only high-quality care, but equitable care. To facilitate success, the Administration and Congress should invest in supports that aid implementation of interventions that address social determinants of health (SDOH) and advance equity. This might include developing best practices that improve outcomes for historically marginalized populations and championing peer-support staff such as doulas or midwives who provide culturally appropriate care and assistance. These tools could support success within value-based programs. CMS could also structure models with up-front funding that can be invested in establishing new care patterns and developing relationships with community-based organizations and others.
4. **Develop the technological infrastructure.** To both support aligned measures and focus on equity, national content and exchange standards are needed. Data collection of demographic factors and SDOH in a standardized and interoperable fashion is necessary to reduce burden on payers, providers and consumers. By collecting the data once and using it many times, consumers will not need to repeat answers to these sensitive questions at each step of their health care journey. This information is key to identifying disparities and achieving equitable care. Moreover, standards for digital measurement of maternal and child health care will permit the integration of new data sources beyond claims such as directly from the medical record and patient-reported outcome measures, as well as significantly reduce the time and resources devoted to measurement.

Endnotes

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