MATERNITY CARE

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Comprehensive Maternity Care (CMC) Common Purchasing Agreement 1.0

Purchaser Business Group on Health

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About PBGH and Its Engagement Model of Public and Private Purchasers

Purchaser Business Group on Health (PBGH) members collectively spend more than $350 billion annually buying health care for their employees. For more than three decades, PBGH has partnered with both private and public health care purchasers to promote higher quality, more affordable health care for America's workers and their families.

PBGH leads employer-driven innovations to improve the value of U.S. health care with quantified success lowering total spend, improving quality and holding the health care system accountable to those who receive and pay for care. Aligning public and private purchasers has the power to create a higher quality and more equitable health care system by working collectively to achieve these goals.

PBGH used its proven consensus-building process to develop comprehensive maternity care attributes, purchasing principles, a measure set and a common purchasing agreement. These purchasing standards can be implemented by public and private purchasers in partnership with health plans and/or providers directly. Private and public PBGH members were engaged in the development of strategies to develop strategies that are practical, innovative and ready for implementation. PBGH has successfully demonstrated its success in accelerating advanced primary care and pharmacy benefit manager (PBM) reform using this proven model. This document is intended to be used to accelerate the advancement of maternity care and birth equity in the employer-sponsored insurance market.

Purchasing Comprehensive Maternity Care

The U.S. is facing a crisis in maternity care outcomes, and women today are more likely to die from complications of childbirth than the previous generation. Moreover, pregnancy-related mortality rates are more than four times higher for Native Hawaiian or Pacific Islander women and three times higher for Black women.[1] Lack of access to maternity care is exacerbating this crisis, with 36% of U.S. counties identified as maternity deserts,[2] (a region with limited maternity care services and/or providers) and a new report[3] shows more than half of U.S. rural hospitals no longer offer birthing services.

The unacceptably poor quality, coordination and equity of care are particularly impactful for employers because maternal and newborn care is consistently among the top three areas of spend for PBGH members. Moreover, because employer-sponsored insurance funds over half of all births annually in the United States, the actions employers take to address maternity care can help improve maternal and newborn outcomes for all populations, regardless of income, education or employment status. This Comprehensive Maternity Care Common Purchasing Agreement aims to help employers promote and implement both evidence-based and innovative practices to address the maternity care and birth equity crisis.

Members of PBGH are assuming an active leadership role in health care purchasing by clearly articulating the quality, value and experience that they expect for workers and their families for whom they purchase health care. PBGH members are setting purchasing standards on behalf of their employees and creating mechanisms for provider and health plan accountability. Purchasers will seek health care partners that are willing to meet the Comprehensive Maternity Care Purchasing standards. Moreover, the current fee-for-service payment system creates barriers to achieving a coordinated pregnancy and postpartum care experience and encourages unnecessary interventions and overmedicalization of maternity care. PBGH members are seeking to drive change through the design and implementation of payment models that do not reward providers (via higher payment) for unnecessary C-sections and that instead support access to high-value maternity services, including midwives, doulas and birth centers, and interventions that prevent maternal mortality and morbidity such as screening and treatment for hypertension.

The Comprehensive Maternity Care Common Purchasing Agreement represents a collaborative effort among employers and public purchasers, led by leaders at Qualcomm Incorporated and Walmart, to help address the maternity care and birth equity crisis. It is a guide to set quality standards and create mechanisms for purchaser action and health plan/provider accountability. The aim of these standards is to achieve high-value, affordable and equitable maternity care and outcomes for all employees and families of PBGH member organizations. The agreement is organized around maternity care principles reflecting purchaser consensus that embody the attributes of comprehensive maternity care: person- and family-centered, relationship-based, accessible, team-based, integrated, coordinated, equitable, accountable and whole-person wellbeing.

To achieve these aims, the Comprehensive Maternity Care Common Purchasing Agreement includes a set of clearly defined health plan and provider purchasing standards and accountability expectations with a three-year implementation timeline. The strategies in this document are based on evidence-based approaches to achieve the goal of truly comprehensive maternity care. Some recommendations will take time to implement, and PBGH members are eager to partner directly with health plans and providers to operationalize these strategies. PBGH and its members are committed to evolving these standards based on new evidence and priorities.

These proposed purchasing agreements are not intended to be all-inclusive and are educational in nature. Please use the standards as a discussion guide for your engagement with qualified legal consultation.

1 https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#:~:text=Since%20the%20Pregnancy%20Mortality%20Surveillance,100%2C000%20live%20births%20in%202018.

2 https://www.marchofdimes.org/maternity-care-deserts-report

3 https://jamanetwork.com/journals/jama/article-abstract/2815499#:~:text=%E2%80%9CThere%20are%20both%20greater%20workforce,is%20unfortunately%20an%20optional%20service.%E2%80%9D

Purchasing Comprehensive Maternity Care (Continued)

Meeting these standards will require significant changes in benefits, health plan contracting, provider contracting and operations and is essential to impacting maternity care outcomes in the U.S. for all purchasers, including the 170 million Americans who receive their health care through employer-sponsored insurance. While many of the tenets in this purchasing agreement will require multi-step and multi-year actions to achieve, these principles, measures, actions and contracting standards seek to advance a collective goal to provide comprehensive maternity care.

The Comprehensive Maternity Care Common Purchasing Agreement was led by purchasers with expert feedback from key stakeholders, including physicians, midwives, doulas, health plans, consumer advocacy groups, equity experts and payment reform experts. PBGH thanks the reviewers for sharing their time and expertise; a list is available at the end of this document.

In this document, the term “birthing people” acknowledges that not all people who become pregnant and give birth identify as women. “Mom,” “woman,” “women,” and “maternal” are also used to conform with the language in externally published reports.

Defining Standards

The Comprehensive Maternity Care Workgroup, a purchaser-led initiative of PBGH, has articulated attributes to define Comprehensive Maternity Care which require the health plan and providers to adopt practices that will help to ensure high-quality, equitable maternal and infant health outcomes. This definition of Comprehensive Maternity Care includes current industry standards, aspirational targets and future areas for development. Childbirth is a physiologic/natural process, and maternity care and services should be guided by affordable, patient-focused polices and should not be overmedicalized.

Care purchasers want to buy	How purchasers know we have it
Person and family-centered	Health disparities eliminated
Relationship-based	Quantifiably improved clinical outcomes
Accessible	Positive member and family experience of care
Team-based	Easy access to timely and appropriate care
Integrated	Reduced total cost of care
Coordinated	
Equitable	
Accountable	
Focused on whole-person health and well-being	

Maintaining Accountability

To ensure accountability and adherence to purchasing principles and actions outlined in this document, purchasers will use the following tactics: health plan and Provider contractual requirements, performance standards, transparent reporting and measurement and value-based payments.

Purchasers hope to partner with plans and providers to improve maternal health outcomes. This document identifies responsibilities of all parties — including employers — to enable better care. Public and private purchasers have responsibility to ensure employees and their families have access to safe, high-quality and equitable care. This accountability necessarily extends to their partners.

Principles for Comprehensive Maternity Care

Purchasers will commit to certain actions to achieve each principle. Purchasers are asking health plans and their direct-contracted providers to commit to achieving the described actions for each principle to ensure delivery of comprehensive maternity care.

Principles:

1. Equitable care that promotes cultural humility and respect.
2. High-quality care and payment for evidence-based care models and care coordination that optimizes favorable and equitable clinical outcomes.
3. Access to timely patient-centered care, including resources for members living in maternity deserts.
4. Accountability and transparency through the use of data on quality, patient-reported outcomes and patient experience stratified by race, ethnicity and language (REaL) and sexual orientation and gender identity (SOGI) indicators.
5. Value-based payments that enable maternity care providers to deliver equitable, timely, affordable, high-quality, patient-centered maternal and infant care and that hold providers accountable for delivering coordinated, evidence-based services and for reducing avoidable complications.

Measure Set

To encourage hospitals and practices to provide care with the desired attributes of comprehensive maternity care, PBGH utilized a multi-stakeholder process to define a comprehensive maternity measure set to evaluate whether workers and families are receiving high quality and equitable experiences and outcomes. These measures were selected based on their alignment with national measure sets and accreditation organizations and their ability to identify and evaluate high performance in maternity care.

	Measure
1	Nulliparous, Term, Singleton, Vertex C-section
2	Prenatal depression screening and follow-up & Postpartum depression screening and follow-up
3	Maternity care: postpartum follow-up and care coordination
4	Social need screening and intervention
5	Patient experience – Consumer Assessment of Healthcare Providers & Systems (CAHPS) and Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) for maternity population
6	Severe obstetric complications
7	% of midwife deliveries
8	% of maternity patients who used a doula

All measures will be required to be stratified by race, ethnicity and language (REaL) and sexual orientation and gender identity (SOGI) data where available.
A future measure of interest and development is the measurement of severe obstetric complications prior to 20 weeks of birth.

The midwifery and doula care measures are not yet part of a national measure set. Data specifications for these measures will be developed in partnership with PBGH members and their health care partners.

Attributes

The Comprehensive Maternity Care Workgroup has articulated attributes to define Comprehensive Maternity Care which ensure high-quality, equitable maternal and infant health outcomes. This definition of Comprehensive Maternity Care includes current industry standards, aspirational targets and areas for development.

Person- and family-centered

Care is designed around the needs and priorities of patients and families, encourages patient and family participation in improvement efforts and incorporates feedback. Patients share preferences and goals of treatment, engage in shared decision-making with their care team and should be made to feel their choices are respected and integrated into care plans. Patients are educated by their care team on their care options to ensure their preferences are fully informed.

Relationship-based

Patients choose a maternity care provider who best meets their needs and have access to providers who share demographic characteristics as it relates to self-reported race, ethnicity, language, socioeconomic status, sexual orientation and gender identity. Patients consistently communicate with (using their preferred means of communication) and receive care from their selected maternity care provider and supporting care team members, who work collaboratively with the patient, their family and their extended care team to build trusting relationships.

Accessible

Patients get high-value care with the right provider and care team in the right setting. Accessible care includes same-day care for urgent needs through in-person and virtual services with their care team, care provider availability after appointment hours, secure messaging with the team and an online medical record. Patients should be educated on all maternity provider types, and each provider should leverage evidence-based best practices (labor support including movement, caloric intake, allowing sufficient time, etc.) to reduce the need for interventions such as labor induction and C-sections.

Team-based

Patients receive care from a primary maternity care provider, such as an OBGYN, midwife or family medicine doctor, who is supported by and supports members of an interdisciplinary care team, such as doulas, mental health specialists, maternal fetal medicine specialists, lactation consultants, pediatricians, family planning specialists, primary care providers or community health workers. Under the direction of the maternity care provider, care team members communicate and coordinate to address patients' needs and provide care appropriate to their training and expertise.

Integrated

Patients' physical, mental and social needs are assessed, screened and communicated across their maternity, pediatric and primary care teams and with other care providers and settings. Care teams reach out proactively to identify and address patients' care needs and to offer additional support for patients at high or rising risk. Health information and care activities outside of the maternity care team are integrated into patients' care plans.

Coordinated

Patients are guided through care transitions between hospitals or birth centers, specialty care and their maternity care teams. Patients can navigate across settings with established referral pathways to high-value specialty providers with whom the maternity care team exchanges information and coordinates care.

Equitable

Patients receive and experience care services and health outcomes that do not vary in quality or access due to personal characteristics, such as self-reported race, ethnicity, language, socioeconomic status, sexual orientation or gender identity. Maternity care teams proactively monitor their care to identify, eliminate and prevent disparities in the care experience and health outcomes.

Accountable

The performance of maternity providers and their provider partners is measured and incentivized to ensure optimal maternal and infant outcomes are achieved. Measurement includes access to care, physical and mental health outcomes, patient-reported outcomes and experience and stratification by self-reported race, ethnicity, language, socioeconomic status, sexual orientation and gender identity.

Whole-person wellbeing

Maternity care should focus not just on the maternity episode but also consider other factors, including social determinants of health, to promote health and treat diseases. Maternity providers should coordinate with primary care, mental health specialists and social services to provide special consideration for high-risk patients with mental health needs and/or substance use disorders. Comprehensive maternity care includes restoring health, promoting resilience and preventing diseases in the lives of the birth participant, children and supporting spouse/family.

Terminology

To establish a clear and shared understanding among all parties, common terminology used in the recommended purchasing standards is defined below:

- **Birth Center:** A birth center is a health care facility for childbirth where care is provided in the midwifery and wellness model. (AABC)
- **Certified Nurse Midwives (CNM)** are registered nurses who have graduated from a nurse-midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and have obtained board certification through the American Midwifery Certification Board (AMCB) to receive the professional designation of certified nurse-midwife. The CNM credential is recognized in all 50 states.
- **A Certified Midwife (CM)** credential includes a graduate degree in midwifery from a program accredited by the Accreditation Commission for Midwifery Education (ACME) and board certification through the American Midwifery Certification Board (AMCB). CMs differ from Certified Nurse-Midwives (CNMs) only in that they are not also licensed as nurses. CMs and CNMs meet the same core competencies, sit for the same board exam, and have identical scopes of practice, including prescriptive privileges. As of May 2024, the CM credential is recognized in 11 states with other states likely to follow.
- **Certified Professional Midwives (CPM)** are professional independent midwifery practitioners who have met the certification requirements of the North American Registry of Midwives (NARM). Applicants can qualify to take the NARM exam by either apprenticing with a qualified midwife and completing an Entry-Level Portfolio Evaluation Process or graduating from a midwifery program or school. As of May 2024, the CPM credential is recognized in 36 states with other states likely to follow.
- **Doulas** are either trained and/or experienced professionals who provide continuous physical, emotional and informational support before, during and after childbirth.
- **Health Plan:** For a self-funded health plan, the third-party administrator (TPA) for the health plan. For an insured plan or HMO, the insurance company or HMO.
- **Member/Patient:** The beneficiaries of the purchaser who are obtaining health care coverage through employer-sponsored insurance.
- **Perinatal:** The time period from the start of pregnancy to one year after giving birth.
- **Postpartum:** The period of time following birth.
- **Prenatal:** Before birth, pregnancy period.
- **Provider:** The clinicians, practices, non-clinical health care professionals and facilities that have contractual agreements with the health plan, or are in a direct contract with the purchaser, to provide direct health care services to patients.
- **Purchasers:** This refers to plan sponsors, such as employers and public purchasers, who sponsor health plans for enrollment of members (e.g., employees) and their families. The terms “purchasers” and “employers” are often used interchangeably.

Principle 1:

Equitable care that promotes cultural humility and respect.

Patients should experience care tailored to the diversity of their lived experiences with unwavering quality to optimize favorable outcomes. Access and clinical quality should not be compromised based on personal characteristics, such as race, ethnicity, language, disability, socioeconomic status, sexual orientation, age, gender identity or health conditions. Maternity care providers should prioritize care around the expressed needs of patients and families to achieve positive health outcomes.

Health plans and providers should enable member self-selection of providers based on cultural and linguistic data shared with patients (e.g., via a comprehensive provider directory that lists all provider types, including midwives), ensure provider training for cultural humility/diversity, equity and inclusion (DEI), implicit bias, trauma-informed or trauma-responsive respectful care, care for people with disabilities and provide education to members on the benefits of doula, midwifery and physician care.

Purchaser actions to advance Principle 1:

- Collect, share and use available self-reported race, ethnicity, language, socioeconomic status, sexual orientation and gender identity data to identify and address disparities in access and outcomes for members.
- Provide coverage for doula care (virtual or in-person) at adequate rates inside and/or outside of medical plans with doula-friendly and flexible enrollment policies.

Health plan/provider requirements:

Proposed Purchasing Agreements:

The health plan/provider shall take the following steps to ensure adequate access to high-quality pregnancy and postpartum care based on the personal characteristics of the member, including but not limited to race, ethnicity, language, socioeconomic status, sexual orientation, gender identity or health conditions:

1. Collect self-reported race, ethnicity, language, socioeconomic status, sexual orientation, gender identity and data for at least 80% of its enrollees to ensure equitable care can be measured and improved upon where disparities are identified.

2. Collect and report relevant cultural and linguistic data from in-network maternity care providers and care professionals and include that information in provider directories. The health plan shall commit to recruiting in-network diverse providers and care professionals, including physicians, midwives, doulas, mental health providers and lactation consultants, that reflect the ethnic/racial/gender/LGBTQ+ makeup of the lives it covers.

3. Pay for qualified trainers for in-network providers on cultural humility/DEI as well as trauma-informed and trauma-responsive respectful care. The health plan/provider shall invest in provider completion of these trainings and include designation in their provider directories.

4. Provide network access to and appropriate payment for doula care, recognizing the valuable support doulas provide during pregnancy, childbirth and postpartum:
    - 4.1 Pay for doula services at an adequate rate to attract and retain doulas who can deliver high-quality care. Allow flexibility in the reimbursement process to accommodate payment being sent to the doula in intervals, i.e., not making the doula provider wait to receive payment until after all services have been provided.
    - 4.2 Include doulas in directories, indicating their training/certifications/experience
        - 4.2.1 Note: There are currently no mandatory licensure, certification, or credentialing requirements for doulas to practice in the U.S., but to receive payment from a state's Medicaid program, doulas must meet the state's relevant qualification standards.[1]
    - 4.3 Provide members with information on which hospitals allow or provide doula care per Leapfrog reporting.
    - 4.4 Provide members with education on the benefits of doula care (virtual and in-person).

1 https://healthlaw.org/doula-medicaid-training-and-certification-requirements-summary-of-current-state-approaches-and-recommendations-for-improvement/

Purchasing Principles

Principle 2:

High-quality care and payment for evidence-based care models and care coordination that optimizes favorable and equitable clinical outcomes.

Comprehensive maternity care includes member choice of care team, location and education regarding appropriateness of care, and birthing options. Health plans should remove payment and administrative barriers and incentivize coordination across the maternal care team, pediatrics, family medicine, primary care and behavioral/mental health providers (e.g., prenatal summary delivered to hospital, discharge summary delivered to outpatient provider, comprehensive postpartum care plan developed). These efforts will include access and payment for navigators, coordinators or doulas to coordinate care, especially for high-risk patients (chronic conditions management, behavioral health referrals, social services, nutrition services, etc.).

Purchaser actions to advance Principle 2:

- Provide educational resources to individuals/families to ensure they receive appropriate and patient-centered care and to prevent unnecessary care.
- Ensure midwifery care, birth centers and home birth are covered benefits and accessible in your network.
- Ensure access to mental health and substance use disorder (SUD) care by providing adequate coverage for mental health services, including virtual care options.
- Add coverage for maternity care coordination services from a navigator, coordinator or doula to support patients across all pregnancy outcomes.
- Reimburse for mental health screenings that may include but are not limited to depression, anxiety, substance use and intimate partner violence.
- If necessary, contract directly with organizations that can arrange for and coordinate the delivery of comprehensive maternity care.
- Cover travel benefits to ensure that all individuals have access to needed reproductive care, regardless of geography.
- Evaluate leave policies to ensure policies are in place for all pregnancy outcomes.

Health plan/provider requirements:

Proposed Purchasing Agreements:

1. Prioritize expanding the number of in-network midwife providers, including taking the following actions:

- Include licensed midwives, including Certified Nurse Midwives (CNM), Certified Midwives (CM) and Certified Professional Midwives (CPM) as in-network providers (note that midwifery licensure varies from state to state).
- Eliminate any requirements that impose additional requirements for midwives to be included as an in-network provider. For instance, remove any mandates such as compulsory affiliation with a medical group or mandatory supervision for midwives, unless required by applicable law.
- Ensure that there is no limit to the number of midwives included in the network and take actions to increase the number of contracted midwives if there are fewer than two midwives per 1000 live births.
- Do not designate midwives as “mid-level providers” in any educational content or materials. Recognize that birth center care and midwifery care, whether administered in a hospital or birth center, encompass unique and specialized care modalities.
- Pay midwives adequately in order to attract and retain midwives who can deliver high-quality care. Payments for prenatal, birth and postpartum services should be commensurate with the time spent on these services and should reflect the longer visits/increased time that midwives spend with patients for counseling and care coordination.

Principle 2:

(cont).

2. Ensure an adequate number of in-network providers that perform vaginal birth after cesarean (VBAC).

3. **Discourage low-value care practices** at birthing facilities, including taking the following actions:

- Encourage birthing facilities to participate in Leapfrog's Maternity Care Safety Reporting by submitting a Leapfrog Hospital Survey.
- Use Leapfrog reporting to identify and discourage hospitals that do not meet standards for NTSV C-Section rates, early elective delivery policies, access to doulas, VBAC, high-risk deliveries and breastfeeding consultation.
- Discourage unnecessary utilization of observation units and referrals to obstetrics (OB) hospitalists from the emergency department that divert patients from their preferred maternity provider.
- Conduct audits to detect low-value care practices (e.g., monitor facilities with higher than expected levels of observation or inpatient stays) and mandate improvement plans when corrective action is needed.
- Provide the purchaser with annual reports demonstrating how low-value practices are being addressed.

4. Provide access to maternity care navigators, care coordinators and community health workers as a covered service, and recruit a culturally, racially and ethnically diverse network of care navigators.

5. Provide adequate network access to mental health providers with expertise in perinatal mood and anxiety disorders[1] and substance use disorder by taking the following actions:

- **Accurate Payment Structure:** Establish a transparent payment structure that adequately enables reimbursement for mental health and substance use disorder screenings and closed loop referrals outside of the global obstetrical billing fee – i.e., reimburse for mental health screenings separate from other obstetrics fees.
- **Provider education and training:** Provide or pay for comprehensive education and training opportunities for mental health providers to enhance their proficiency in diagnosing and treating perinatal mood and anxiety disorders and substance use disorder. Incentives shall be offered to encourage mental health providers to actively participate in these educational activities.
- **Work to expand in-network treatments:** Include in-network perinatal behavioral health specialists that offer a range of service options, including care such as virtual consultations, group therapy sessions and peer support.[2]

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7077785/#:~:text=Definition%20of%20perinatal%20mental%20illness,to%203%20months%20after%20delivery.

2 https://www.sciencedirect.com/science/article/abs/pii/S016383432100164X

Principle 2:

(cont).

6. The health plan/provider shall provide patient education on the following topics:

- Information and shared decision-making tools to assist members in making informed decisions regarding tests and procedures.
- Information on contraception options and availability of contraception services.
- The benefits of physiologic birth, including options for a less-medicalized birth experience and vaginal birth after cesarean (VBAC), such as the My Birth Matters brochure, the CDC's "Hear Her" campaign, TeamBirth and Choices in Childbirth.
- Resources to educate on perinatal mood and anxiety disorders, and substance use disorder (for both the birthing person and their partner).
- Resources to educate on hypertension and preeclampsia (for both the birthing person and their partner).
- Information regarding enterprise and local social support services available, such as food, housing, and transportation programs and resources.
- Leapfrog quality and safety reporting on maternity birthing facilities and their C-section rates, episiotomy rates, and whether they provide access to doulas, midwives, VBAC, contraception information, and breastfeeding consultation.
- Information and resources for navigating complications, pregnancy loss and all pregnancy outcomes.
- Education on care team and birthing site options based on the American College of Obstetrics and Gynecology (ACOG) Levels of Maternal Care.

Purchasing Principles

Principle 3:

Access to timely patient-centered care, including resources for members living in maternity deserts.

Patients should receive high-quality, patient-centered care from a provider and care team that are able to meet the member's needs in a convenient location. Accessible care includes same-day care for urgent needs through in-person and virtual services with their care team, care provider availability, after appointment hours, secure messaging with the team and an online medical record. Telehealth services are a key strategy to provide accessible and patient-centered care, including on-demand education, group sessions, assessments and check-ins to ensure the right care is coordinated with the right provider.

Purchaser actions to advance Principle 3:

- Provide coverage for safe and effective virtual or hybrid models of maternity care, including maternity mental health experts and doulas, that coordinate with the patient's usual source of care and maternal care team to ensure care is coordinated.
- Provide coverage for remote monitoring (e.g., blood pressure cuffs, weight scale, at-home lab tests).
- Provide coverage for/incentivize an earlier postpartum visit (earlier than the comprehensive 6–8-week visit) and provide differentiated or additional payments for women who are at a higher risk of complications.
- Provide coverage for best practices to support lactation, such as outpatient lactation services, including in the home/community/virtual setting. Lactation consultants should be certified by the International Board of Lactation Consultant Examiners.
- Provide coverage for a nurse home visit in the week following delivery (if not already provided as part of the model of care).
- Require plans to measure and report on network adequacy and strategies to address rural access and maternity deserts.

Health plan/provider requirements:

Proposed Purchasing Agreements:

1. **Network Expansion:** Health plans should include birth centers and hospitals located in patients' communities as in-network providers unless data demonstrates that the quality of care is low or that the providers will only accept payments higher than necessary to support the cost of delivering high-quality care.

2. Guarantee network access to midwifery care at licensed or accredited freestanding independent birth centers and from home birth midwifery services. This commitment to birth center and home birth access shall be reinforced through the following actions:

- **Birth Center Payments:** Provide adequate facility payment to licensed or accredited independent freestanding birth centers.
- **Home Birth Midwifery Payments:** Provide adequate payment to home birth midwives to support the costs of delivering high-quality maternity care services.
- **Reimbursement for Newborn Services:** Provide payment for necessary newborn services provided in the birth center or at home.
- **Transparent Reimbursement for Transfers:** In instances where care is transferred from a birth center or home birth provider to a hospital provider, ensure adequate payment to the initial provider. This payment shall accurately reflect the customary time devoted to patient care, supporting continuous care coordination and valuing the contributions of birth centers and midwives. When transfers are made during labor, the reimbursement shall also include the facility and/or equipment utilized regardless of the amount of time

Principle 3:

(cont.)

spent under the care of the midwife before transfer. Reimbursement should not disincentivize appropriate and timely transfer during labor by utilizing reimbursement schemes based upon specific timeframes spent with the midwife before transfer.

- **Preferred Networks:** Include licensed or accredited birth centers in the preferred provider networks.

3. Establish and maintain a system for asynchronous consultation, ensuring timely access to health care advice and guidance, throughout pregnancy and up to 12-months postpartum. All provider contracts shall include a mandate to substantiate efforts through measurable actions, such as:

- **Telehealth Platform Implementation:** Demonstrate the provision of asynchronous consultation through the implementation and utilization of telehealth platforms or secure digital communication tools.
- **Response Time Commitments:** Establish and adhere to clearly defined response time commitments for asynchronous consultations, including the maximum allowable timeframe (e.g., no longer than 48-hour response time for non-urgent issues) within which a care team member shall respond to patient-initiated asynchronous inquiries.
- **24/7 Availability:** Ensure continuous availability of asynchronous consultation services, allowing patients to seek health care advice and guidance at any time, including weekends and holidays.

The effectiveness and utilization of these activities shall be regularly assessed and reported to the health plan, demonstrating providers' accountability in providing an asynchronous consultation platform.

4. The health plan shall highlight facilities that demonstrate successful and accountable implementation of the Alliance for Maternal Health patient safety bundles and/or participate in Leapfrog Patient Safety Reporting. Facilities that implement and adhere to these recognition programs will have that designation in the network directory.

5. Promote and reimburse providers for adopting effective clinical models, such as group prenatal visits, peer support, telehealth, in-home lactation visits and nurse home visiting programs.[1]

1 https://www.commonwealthfund.org/sites/default/files/2023-05/Rosenbaum%20Appendix%202%20-%20A%20Review%20of%20the%20Literature%20-%20Best%20Practices%20in%20the%20Coverage%20and%20Delivery%20of%20Maternal%20Health.pdf

Principle 3:

(cont.)

6. Provide support and payment for provider implementation of effective clinical models to better serve members living in maternity care deserts,[2] such as hub and spoke models[3], telemedicine, remote monitoring (e.g., blood pressure cuffs, glucose monitors) and virtual prenatal and postpartum care (including virtual and in-person home visits).

- **Measurable Impact:** Require providers to track adoption rates and utilization of these clinical models.
- **Network Adequacy Planning:** Increase access to services and providers for patients living in maternity care deserts as identified by March of Dimes Maternity Care Deserts Report or Maternity Care Target Areas (MCTAs), as defined by Health Resources and Services Administration (HRSA).[4]
- **Reimbursement:** Adequately reimburse for consultative care and use incentives to attract new providers to maternity care deserts or MCTAs.

2 https://www.marchofdimes.org/maternity-care-deserts-report
3 https://www.ajog.org/article/S0002-9378(21)02105-0/fulltext
4 https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mcta

Purchasing Principles

Principle 4:

Accountability and transparency through the use of data on quality, patient-reported outcomes and patient experience stratified by race, ethnicity and language (REaL) and sexual orientation and gender identity (SOGI) indicators.

Health plans/providers will implement the PBGH Maternity Measure Set to ensure accountability and transparency of in-network performance and consider adopting new measures as recommended by PBGH. Partners will utilize and share comprehensive data to support quality and equity improvement, including managing individual members and the birthing population.

Maternity Measure Set

To measure whether members and their families are receiving care as defined by the Comprehensive Maternity Care Attributes, PBGH utilized a multi-stakeholder process to define a set of quality measures focused on equity, patient experience of care and health outcomes. The measures below were selected based on their alignment with national measure sets and their ability to identify and evaluate high quality performance in maternity care. All measures are to be stratified by race, ethnicity and language (REaL) and sexual orientation and gender identity (SOGI) data where available. These measures will be regularly evaluated and modified to reflect new measurement capabilities and priorities.

1. Nulliparous, Term, Singleton, Vertex C-section
2. Prenatal depression screening and follow-up & Postpartum depression screening and follow-up
3. Maternity Care: Postpartum Follow-up and Care Coordination
4. Social need screening and intervention
5. Patient experience – Consumer Assessment of Healthcare Providers & Systems (CAHPS) and Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) for maternity population
6. Severe obstetric complications
7. % of midwife deliveries
8. % of maternity patients who used a doula

Note: The midwifery and doula care measures are not yet part of a national measure set. Data specifications for these measures will be developed in partnership with PBGH members and their health care partners.

Future Measures:

Future measures of interest and development include the measurement of severe obstetric complications prior to 20 weeks of birth and a maternity specific patient experience measure.

Purchasers should work with health plans and providers to implement the Maternity Measure Set. These measures will create accountability and transparency to ensure the delivery of comprehensive maternity care for members and their families. Many of these measures have data available, while some are part of an aspirational data set to accurately represent the experiences and outcomes of individuals and families during their maternity journey. PBGH recommends implementation of the complete measure set but an incremental approach may be required for new measures.

Principle 4:

(cont.)

Purchaser actions to advance Principle 4:

- Require transparent reporting of PBGH's Maternity Measure Set in performance metrics to track plan and provider performance and develop improvement plans based on performance.
- Modify payments to providers based on performance based on the Maternity Measure Set.
- Measure disparities in care for birthing people by stratifying by patient-reported REaL and SOGI data and develop interventions to improve inequities identified.
- Ensure members and families can access needed information about the performance of providers on the Maternity Measure Set.
- Establish minimum performance standards for continuation of contracts (see below).

Performance Guarantees:

Purchasers should establish performance standards for maternity care that must be achieved in order to continue contracts with health plans and provider partners. The performance standards should be based on the Maternity Measure Set and require that specific levels of performance on the quality measures be met by the health plan and its network providers. For example:

> *NTSV C-section rate:*
>
> The purpose of this Maternity Measure Set is to reduce the number of births delivered by C-section for low-risk (Nulliparous, Term, Singleton, Vertex) birth participants in hospitals. The health plan must achieve a performance rate of 23.6% on the NTSV C-section rate measure for 80% of network hospitals, or there must be a demonstrated improvement in performance on the NTSV C-section rate compared to the prior year.

Performance standards will need to be purchaser-specific. In addition, purchasers may consider incremental approaches to improve performance annually instead of only by the end of a multi-year contract (X% by Year 1, X% by Year 2, etc.).

Principle 4:

(cont.)

Health plan/provider requirements:

Proposed Purchasing Agreements:

1. Create a comprehensive view of performance (dashboard) using the PBGH Maternity Measure Set containing the following key components:

- **Quality Reports:** Quality scores for purchasers across all PBGH maternity measures, benchmarked nationally, regionally and stratified by race and ethnicity (see measure set below).
- **Network Maternity Data:** Trends inclusive of race/ethnicity data, utilization rates for midwives, birth centers, doulas, care navigation services and adoption of value-based payment. Report on service and care utilization in maternity care deserts as identified in March of Dimes Maternity Care Deserts Report and/or in MCTAs.
- **Member Reporting:** Make performance on the measures included in the Maternity Measure Set available to consumers via member portals and other transparency tools.

2. Align provider and facility compensation to performance on the Maternity Measure Set using the provider appropriate measures.

3. Require health plans to:

- Collect patient-reported race/ethnicity/gender/language data on their patients and report identified disparities in performance on the Maternity Care Measures to purchasers. Allow patients to select more than one race and/or ethnicity.
- Develop an action plan to address health disparities and set targets for improving year-over-year performance on the Maternity Measure Set metrics.

4. The health plan should require hospitals to participate in their state's perinatal quality collaborative (PQC), to submit data to their maternal data center or similar quality improvement data hub. The health plan shall report hospital participation rates in their networks. Currently, Washington, Oregon and California all contract with The Maternal Data Center.

5. Health plans should use data specifications outlined by the measure stewards in reporting on the PBGH Priority Maternity Measure Set.

Principle 5:

Value-based payments that enable maternity care providers to deliver equitable, timely, affordable, high-quality, patient-centered maternal and infant care and that hold providers accountable for delivering coordinated, evidence-based services and for reducing avoidable complications.

Health plans should use payment methods and amounts that are adequate to support convenient access to affordable, high-quality maternity care for all plan members, in both rural and urban areas, and that provide the flexibility to deliver care in the most appropriate way for each individual member. Health plans should replace traditional fee-for-service payments for maternity care with value-based payments that better support delivery of affordable, high-quality care and improved maternal and neonatal outcomes.

Purchaser actions to advance Principle 5:

- Consider benefit incentives and specialty referrals for specific providers and/or facilities to encourage utilization of high-quality providers.
- Choose health plans that use payment amounts and methods that support access to affordable, high-quality, patient-centered maternity care for all of members.
- Contract directly with maternity care providers if necessary to ensure access to high-quality and equitable maternity care services for all members.
- Work collaboratively with other purchasers, including state Medicaid agencies, to increase multi-payer alignment on value-based payments for maternity care.
- Educate and encourage members to utilize maternity care providers that take accountability for delivering coordinated, evidence-based services.

Health plan/provider requirements:

Proposed Purchasing Agreements:

1. Health plans should commit to creating value-based payment methods that better support delivery of affordable, high-quality maternity care and improved maternal and neonatal outcomes, instead of traditional fee-for-service payment methods, including:

- Monthly payments to support care management, navigation and behavioral health support services through maternity care homes and other evidence-based care models.
- Clinical risk adjustment to ensure the payment does not dis-incentivize the appropriate use of medically necessary, higher intensity care for high-risk and complex pregnancies and for individuals with barriers to accessing care.
- Payments that support extended postpartum care with integrated behavioral health care services for all pregnancies.
- Blended case rates for labor and delivery, i.e., paying the same amount for both a cesarean section and a vaginal delivery for pregnancies and deliveries with similar risk factors.
- Identical payments for physicians and licensed midwives performing normal vaginal deliveries.
- Adequate payments for labor support services provided prior to a necessary transfer for delivery by a different provider or in a different facility.
- Reductions in payments to providers when there are avoidable complications, when unnecessary or low-value services are delivered, when the provider fails to deliver evidence-based care and when the provider performs poorly on the quality metrics defined in Principle 4.
- Standby capacity payments designed to support the minimum fixed costs

Principle 5:

(cont.)

of essential community services (i.e., cesarean delivery capacity in rural communities, midwife-led birth centers serving small communities and underserved populations and regional neonatal intensive care services and specialty consultations), such as payments that are partially based on the number of women of childbearing age in the community rather than solely based on the number of deliveries or services provided.

2. Health plans should provide documentation to purchasers demonstrating that the methods and amounts the health plan uses to pay providers are both adequate and sufficiently flexible to support convenient access to affordable, high-quality maternity care for all plan members, in both rural and urban areas, including:

- Labor and delivery services at small rural hospitals.
- Midwife-led birth centers.
- Specialized maternal and infant care for high-risk pregnancies and complicated births.
- Care coordination and support services during and after pregnancy.

3. The documentation of payment adequacy should include:

- A list of the specific amounts that will be paid to each maternity care provider in the network for the maternity care services it delivers.
- Letters from small rural hospitals, from midwife-led birth centers and from providers that serve minority populations, each affirming that the payments they receive from the health plan are timely and adequate to support delivery of high-quality maternity care services to the patients they serve.

4. If a purchaser has members residing in communities where there are no network providers of labor and delivery services located within a 15-minute travel time, the health plan should describe what payment amounts and methods will be used to encourage providers to fill these gaps.

5. Health plans should not require maternity care providers to take accountability or financial risk for outcomes or costs that they cannot control, nor should small maternity care providers be required to accept high levels of financial risk. As an example, birth centers and small rural hospitals cannot be responsible for the amount a receiving hospital charges for a patient who needs to be transferred.

6. Health plans should provide information to purchasers on:

- The number and types of maternity care providers that are contracted to be paid using each type of value-based payment.
- The number and proportion of plan members who are receiving maternity care services from each of these providers using the value-based payment methods.
- The health plan's timetable for expanding the number and types of providers participating in each type of value-based payment.

Closing

Employers and public purchasers are dedicated to improving maternity care outcomes and equity in the U.S. In order to truly improve care outcomes and the care experience for individuals and families, stakeholders must change the way maternity care services are designed, delivered and compensated. Most importantly, purchasers, health plans, providers and patients must work together to achieve change on a broader scale and positively impact maternity care outcomes and equity. The PBGH Comprehensive Maternity Care Common Purchasing Agreement reflects PBGH member priorities for higher quality, more equitable maternity care and identifies needed changes from all parties. Next steps will be to develop implementation strategies for how purchasers, health plans and the maternity care team can work together to deliver comprehensive maternity care to better serve families.

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Purchaser Business Group on Health

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