EVIDENCE-INFORMED POLICY DEVELOPMENT

CenteringPregnancy - Medicaid Enhanced Payment for Group Prenatal Care

MCH Innovations Database

Location	Focus Area	Policy Type
Arizona, Maryland, Michigan, Missouri, Montana, New Jersey, Ohio, North Carolina, South Carolina, Texas	Access to Health Care/Insurance; Data Assessment/Evaluation; Health Care Financing; Health Equity; Health Screening/Promotion; Mental Health/ Substance Use; Preconception/Reproductive Health; Service Coordination/Integration	Big P Policy

Target Population
Providers who can be incentivized by the enhanced payment and policymakers who can use this policy lever to expand access to evidence-based group prenatal care.

SECTION 1: POLICY DESCRIPTION

According to the Centers for Disease (CDC), one in ten babies born in the U.S. are preterm, meaning they are delivered prior to 37 weeks of pregnancy. Babies born early are at greater risk of not only early death, but also health and developmental problems that may present lifelong challenges. The U.S. preterm birth rate has Declined 1% from 2021 to 2022, to 10.4%, following an increase of 4% from 2020 to 2021. However, the CDC documents that Black women are 50 percent more likely than White or Hispanic women to experience preterm birth.

Centering Healthcare Institute (CHI) is a registered 501(c)3 charitable organization with national reach. CHI is improving health, transforming care and disrupting inequitable systems through the evidence- based Centering group model for prenatal care. CenteringPregnancy® brings birthing people out of the exam room and into a group setting where they learn from their providers and each other. In each two-hour visit there is ample time for health assessment, interactive learning and community building. Visits meet nationally recognized clinical standards and are facilitated by a credentialed healthcare provider.

According to the American College of Obstetricians & Gynecologists (ACOG), group prenatal care has "demonstrated reductions in preterm birth and neonatal intensive care unit (NICU) admissions; increased birth weight for term and preterm infants; increased rates of breastfeeding initiation and continuation; decreased emergency department visits in the third trimester; improved pregnancy-related weight management; an increase in patients presenting in active labor and at greater cervical dilatation; increased patient and obstetrician and other obstetric care provider satisfaction; and improved knowledge of childbirth, family planning, postpartum depression, and early child rearing"

CenteringPregnancy has been recognized in both the inaugural and recently released 2024 Prenatal-to-3 State Policy Roadmap as the predominant model of group prenatal care an effective state strategy to Impact access to needed services, parental health and emotional wellbeing, and optimal child health and development.

We recommend an enhanced payment for evidence-based group prenatal care as an effective policy to incentivize providers to utilize this model of care that reduces health disparities and increases birth outcomes while saving payers reinvestment dollars. Most healthcare payment and coverage policies are made at the state level, both by Medicaid and other governmental insurance regulators and individual health plans. CenteringPregnancy is the billable healthcare visit and prenatal care through the 6-week postpartum visit has near universal coverage, making this an easily replicable policy and good candidate for the AMCHP MCH Innovations Database: Evidence-Informed Policy Track at a time when maternal and infant health is front of mind for many lawmakers, providers, patients and advocates.

<u>Model Policy:</u>

Nearly 600 CenteringPregnancy® programs are in practice across 46 states + Washington, D.C. serving 500,000 patients. Centering Healthcare Institute has put forth a model policy recommendation for states to use when crafting their enhanced payment for CenteringPregnancy and group prenatal care policies:

- $45 per patient per visit (for 10 visits, the 10th is most likely the post-partum visit)
- $250 provider retention payment (a one-time payment paid to the provider upon the patient's completion of five CenteringPregnancy visits)
- This creates a $700 per patient per pregnancy enhanced maternity bundle
- Most states use code 99078 with a TH modifier. We recommend a unique modifier for group prenatal care. CPT odes used range from 99212 - 99215.

<u>Sample Legislation:</u>

(Expenses incurred for the provision of group prenatal care services to a pregnant woman [between the ages of 12 and 55 years of age], provided that: (a) the provider of such services, which shall include, but not be limited to, a federally qualified health center or a community health center operating in the State (i) is a site accredited by the Centering Healthcare Institute, or is a site engaged in an active implementation contract with the Centering Healthcare Institute, that utilizes the CenteringPregnancy model; and (ii) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit; each group prenatal care visit is at least 1.5 hours in duration, with a minimum of two women and a maximum of 20 women in participation; and no more than 10

group prenatal care visits occur per pregnancy. As used in this paragraph, “group prenatal care services” means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model, an evidence-based model developed by Centering Healthcare Institute and which include health assessments, social and clinical support, and educational activities. Expenses incurred include an enhanced payment for CenteringPregnancy services as outlined below:

A $45 enhanced payment for each of the 10 prenatal visits per patient per pregnancy and a one-time $250 provider retention payment after the completion of 5 prenatal visits per patient per pregnancy resulting in a $700 enhanced maternity bundle for CenteringPregnancy per patient per pregnancy.

Considerations:

This example is for an enhanced payment under fee-for-service, however, for capitated and global payment models, we recommend a similar set of value-based payment incentives for providers utilizing the CenteringPregnancy model in their practice.

SOCIAL & POLITICAL CONTEXT

While all providers are reimbursed for the patient encounter that occurs as part of a CenteringPregnancy session, not all are reimbursed for the related costs and time associated with providing group prenatal care. We seek to build upon the success in thirteen states where substantial progress has been made toward payment for group prenatal care through Medicaid-managed care organizations or a model that pays for group prenatal care in excess of individual prenatal care. As of 2024, there are ten state Medicaid programs that participate in payment strategies for CenteringPregnancy. Centering Healthcare Institute tracks these and other efforts to establish payment for group prenatal care through value-based payment such as alternative payment models (APMs), enhanced reimbursement, and other funding mechanisms including grants and one-time funding streams. Incentivizing group prenatal care will improve birth and maternal health outcomes, promote satisfaction with the care experience by birthing people and healthcare providers, and reduce racial disparities.

KEY ELEMENTS & GOALS

Short Term:

- Address health disparities to meet state social determinants of health objectives in perinatal, maternal, and infant health, maternal substance abuse, and maternal mental health.
- Increase community-based connections for providers, patients, and support networks.
- Increase provider collaboration bringing behavioral health providers, nutritionists, lactation specialists, and other care providers into the space.

Long Term:

- Encourage states to join elected leaders and state Medicaid departments in recognizing that CenteringPregnancy results in healthier pregnancies, improved birth outcomes, closes the disparity gap, and provides a better overall experience for birthing individuals and their healthcare providers
- Reduce healthcare costs by lowering NICU admissions, cesarean sections, preterm birth rates, birth weight and increases breastfeeding rates, vaccine schedule adherence, behavioral health screening, confidence and feeling of readiness, and choice of contraception at their postpartum visit compared traditional individual prenatal care.
- Incentivize evidence-based group prenatal care in state Medicaid departments and private payers by showing improvement in health outcomes and increased savings and patient/provider satisfaction.
- The U.S. healthcare system is transformed with equitable policies and provision of group prenatal care that is rooted in community, responsive to needs, high quality and patient-centered.

EVIDENCE

- The United States faces a crisis of high maternal and infant mortality rates. Black birthing individuals are 2.6 times more likely to die than White birthing individuals from pregnancy related issues. Multiple factors contribute to these disparities such as variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias. Non-Hispanic Black infants have more than twice the rate of infant mortality than Non-Hispanic White infants.
- CenteringPregnancy reduces the risk of preterm birth by 33- 47%, further reduced risk for Black birthing people, increases breastfeeding initiation, reduced risk of NICU admissions by 37%, and reduces emergency room utilization.
- CenteringPregnancy and group prenatal care have been the subject of more than 150 peer-reviewed studies. An annotated bibliography can be found here: CenteringPregnancy and CenteringParenting Annotated Bibliography (December 2022)

HEALTH EQUITY

Research suggests that CenteringPregnancy holds promise especially for supporting improved birth outcomes for Black birthing people and their babies, particularly reducing the risk of preterm birth. One study found that CenteringPregnancy reduced very early preterm delivery (before 32 weeks) to 1.3% compared to 3.1% for individual care, and preterm delivery to 7.9% compared to 12.1% for individual care. The racial disparity in preterm birth for Black birthing people relative to White and Hispanic women was virtually eliminated in this study. 26 In another, Black birthing people were substantially less likely to have a preterm birth in group prenatal care as compared to individual care – the rate fell from 15.8% to 10%. CenteringPregnancy participants were less likely to have inadequate prenatal care than birthing people who received individual care, felt more prepared to give birth and more knowledgeable about perinatal topics, had higher satisfaction with their care, and were more likely to breastfeed (66.5% vs. 54.6%). No groups are disadvantaged or harmed by this policy or by the CenteringPregnancy model of care.

CenteringPregnancy is a care model in which facilitators support a cohort of eight to ten birthing people of similar gestational age through a curriculum of ten 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions covering medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding, and infant care. “In order to achieve birth equity, we have to listen to what the community wants, and that is the core of what CenteringPregnancy offers,” Dr. Crear-Perry [of the National Birth Equity Collaborative, NBEC] said of the model.

According to a 2020 study published in the Journal of the Georgia Public Health Association titled, *Effects of CenteringPregnancy on Pregnancy Outcomes and Health Disparities in Racial Groups versus Traditional Prenatal*

Care, “the CenteringPregnancy group prenatal care program may be especially valuable for African American mothers and may help reduce racial/ethnic disparities with respect to important pregnancy outcomes. Our results have implications that full adoption of CenteringPregnancy in clinical practice at the Anderson Clinic will better service communities of mothers who are underserved, at-risk and vulnerable.”

SOCIAL & POLITICAL CONTEXT

This is a non-partisan issue and has advanced with unanimous bi-partisan support. Additionally, Medicaid agencies have found it a win-win policy to implement with no known-push back for any political or social reasons.

SECTION 2: CONSIDERATIONS FOR FUTURE POLICY DEVELOPMENT

LESSONS LEARNED

We have seen success in bringing awareness for the need to develop policy around enhanced reimbursement for group medical care. States that prioritize health equity or maternal and child health share our goals to eliminate racial disparities and address the current public health crisis facing birthing people and their families.

FUTURE CHANGES

General

Efforts to replicate this policy in the future might consider connecting with providers, state Medicaid, and private payers before implementation to increase support for the policy and identify best practices for policy implementation.

Ensure that an evaluation plan is laid out during the policy development process so that implementers can track the impact and roll out of the policy.

Consider exploring what this policy could look like in a value-based care model.

Health Equity

There is clear evidence that the CenteringPregnancy model can support improved birth outcomes for Black mothers and reduce disparities in maternal and infant mortality rates between Black and non-Hispanic White mothers. Future policy implementation efforts might explore:

- How this model could be adapted to fit the needs of other populations experiencing high rates of infant/maternal mortality, such as American Indian/Alaska Native populations.

Ensure that reimbursement matches program delivery costs, identify what other potential financial support may be needed to ensure full participation and retention of birthing people in group prenatal care.

- Connect with birthing people to increase health and financial health literacy skills so they can access a CenteringPregnancy program without financial concerns. Invest time and resources to ensure providers working in zip codes with high preterm and infant mortality rates adopt and lead a Centering Pregnancy group.

Stakeholder/Advocacy Efforts

Connect with advocates in states who may have an understanding of what providers are facing in the states.

Connect with providers, state Medicaid, and private payers before implementation to increase support for the policy and identify best practices for policy implementation. This ensures that reimbursement matches program delivery costs and identifies what other potential financial support may be needed to ensure full participation

Connect with birthing people to increase health and financial health literacy skills so they can access a CenteringPregnancy program without financial concerns.

States with Enhanced Reimbursement and Rate

Arizona

- $45 per patient per session
- Up to 10 sessions

Maryland

- $50 per patient per session
- Up to 10 sessions

Michigan

- $45 per patient per session
- Up to 12 sessions
- Includes reimbursement for federally qualified health centers (FQHCs)

Missouri

- $40 per patient per session

Montana

- $30 per patient per session
- Includes reimbursement for federally qualified health centers (FQHCs)

New Jersey

- $7 per patient per session
- Up to 10 sessions

States with Enhanced Reimbursement and Rate

North Carolina

- $250 one-time provider retention payment on or after the fifth visit
- Includes reimbursement for federally qualified health centers (FQHCs)

Ohio

- $45 per patient per session
- Up to 10 sessions
- Includes reimbursement for federally qualified health centers (FQHCs)

South Carolina

- $30 per patient per session
- Up to 10 sessions

Texas

- $42.47 per patient per session

ADDITIONAL RESOURCES

- Centering Healthcare Bibliography I Annotated Bibliography: Centering research indicates dramatic improvements in maternal child health outcomes, enhancing the field's goals for cost savings and better health. Stay up to date with current Centering research with over 150 published studies and peer-reviewed articles. (June 2023 I December 2022)
- 2024 Prenatal-to-3 State Policy Roadmap: This roadmap guides state leaders on the most effective investment to ensure all children thrive from the start including strategies such as Group Prenatal Care which highlights CenteringPregnancy as the most prominent model of group prenatal care. (October 2024)
- Prenatal-to-3 State Policy Lever Checklist: Group Prenatal Care: This checklist covers the following policy levers states may consider to help maximize the reach and effectiveness of group prenatal care. (September 2023)
- Racism Created Inequities in Maternal and Child Health, Even Before Birth: ZERO TO THREE'S *Think Babies*™ recommendations for policymakers and practitioners to promote equity and improve maternal and child health. (May 2021)
- Centering Saves Lives & Money: Learn about how Centering can transform healthcare and save lives and money. (2021)
- Payment Models to Support Sustainability of CenteringPregnancy in Federally Qualified Health Centers: Learn how supporting implementation of Centering at FQHCs can lead to better health outcomes, higher patient satisfaction, and a reduction in health disparities.(July 2021)
- Ensuring Healthy Births Through Prenatal Support: The Center for American Progress (CAP) highlights the importance of providing group prenatal care and support to improve birth outcomes through programs such as, CenteringPregnancy, The JJ Way, and HealthConnect One Community-Based Doula Program. (January 2020)
- Maternal and Child Health Update 2020: The National Governors Association Center for Best Practices' (NGA Center) Maternal and Child Health Update (MCH Update) survey results from senior state and

territorial health officials regarding MCH policy topics. This update includes the importance for group prenatal care models such as CenteringPregnancy. (2020)

- CenteringPregnancy- Medicaid Enhanced Payment for Group Prenatal Care: Policy development summary from AMCHP on enhanced payment for evidence-based group prenatal care in Maryland, New Jersey, Ohio, South Carolina, and Texas. (2019)
- Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Care Model: Strategies to sustain a successful model of prenatal care and how aligning emerging value-based payment models reward providers for better outcomes. (May 2019)
- How CenteringPregnancy Can Support Birth Equity: An issue brief on CenteringPregnancy's role as one of the models supporting birth equity that is relationship-centered, holistic in its attention to non-medical aspects of health and wellbeing, provides time and opportunity for empowering group discussion, and creates a supportive environment that fosters trust. (October 2019)
- Testimony to Committee on Health, Council of the District of Columbia: Written testimony from CHI on supporting the Window Blind Safety Notification Act of 2019 (Bill 23-0322), the Perinatal Health Worker Training Access Act of 2019 (Bill 23-0341), and the Maternal Health Care Improvement and Expansion Act of 2019 (Bill 23-0362). (December 2019)
- Fostering Social and Emotional Health through Pediatric Primary Care: Common Threads to Transform Everyday Practice and Systems: Findings from the Center *for the* Study *of* Social Policy (CSSP) qualitative program analysis on the common practices used by innovative primary care sites implementing a variety of evidence-supported programs such as CenteringPregnancy and CenteringParenting. (October 2019)

CONTACT INFORMATION

Disha Patel, MPH
Senior Policy Analyst

dpatel@centeringhealthcare.org
Centering Healthcare Institute