



CenteringPregnancy - Medicaid Enhanced Payment for Group Prenatal Care



Location	Focus Area	Policy Type
Maryland, New Jersey, Ohio, 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 been rising annually since 2014. Further, the CDC documents that African

American 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 transforming healthcare delivery and outcomes for all families, beginning with pregnancy, by expanding access to our evidence-based framework for group 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 was recognized in both the inaugural and recently released second year Prenatal-to-3 State Policy Roadmap as an effective state strategy to reduce longstanding disparities in outcomes among racial and ethnic groups and socioeconomic statuses.

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 precious 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.

Model Policy:

More than 600 CenteringPregnancy® programs are in practice across 46 states + Washington, D.C. serving 50,000+ families. 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
- If a practice sees 2 new cohorts per month with ten patients per group, they will receive an additional \$168,000 Most states use code 99078 with a modifier. We recommend a unique

modifier for group prenatal care. Codes used range from 99078, 99078-TH, 9921x, and 99212, 99215

Sample Legislation:

(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 2021, there are five state Medicaid programs and 14 health plans 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 the satisfaction with the care experience by birthing people and healthcare providers, and reduce racial disparities.



KEY ELEMENTS & GOALS

Short Term:

- Addressed health disparities and health equity. This aspect can be used to meet equity / social determinants of health goals in state strategi plans around maternal health, infant and perinatal health, maternal substance use, and maternal mental health.
- Increases community-based connections for providers, patients, and patient’s support network.
- Increases provider collaboration – often brining behavioral health providers, nutritionists, lactation specialists, etc. into the community of care space.

Long Term:

- Provides an exciting example of how providers and payers can collaborate and effective move the needle toward more value-based care and vale-based payment models.
- Reduces health care costs: savings from averted NICU admissions, higher breastfeeding rate, lower rates of cesarian, lowered preterm birth rates, reduction in low-birthweight babies, increases in birthing people’s choice of contraception at postpartum visit, increases in vaccine scheduled adherence, increase in behavioral health screening, increase in pregnant person’s confidence and feelings of readiness, and decrease in birthing people’s risky behaviors like smoking. As compared to traditional individual prenatal care.
- Positive health outcomes, increased savings, and increased patient and provider satisfaction will be a result of incentivizing evidence-based group prenatal care in state Medicaid programs. We believe that private plans will follow suit as the model becomes better known and sought out by patients. This policy has the potential to serve as one of the first successful models of MCH shifting to the value-based payment arena where providers have historically been hesitant to opt into increased risk-sharing with payers.





EVIDENCE

- The United States faces a crisis of high maternal and infant mortality rates, with Black women at three to four times the risk as white women of death from pregnancy-related causes – risk that persists regardless of socio-economic differences. And Black infants have more than twice the rate of infant mortality as non-Hispanic white infants.
- 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 women relative to White and Hispanic women was virtually eliminated in this study. 26 In another, Black women 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 and group prenatal care have been the subject of more than 100 peer-reviewed studies. An annotated bibliography can be found here: [Centering Healthcare Institute Annotated Bibliography.docx](#)

HEALTH EQUITY

Research suggests that CenteringPregnancy holds promise especially for supporting improved birth outcomes for Black women 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 women relative to White and Hispanic women was virtually eliminated in this study. 26 In another, Black women 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 women 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.

By creating incentives for evidence-based group prenatal care, we create the opportunity to support birth equity, as a free-standing or complementary group prenatal care model 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. CenteringPregnancy is a care model in which facilitators support a cohort of eight to ten women 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

The biggest lesson learned has been the need to set the enhanced payment at an amount that makes the incentive a lucrative enough carrot to make it worth it to providers. The initial costs of setting up space and recruiting CenteringPregnancy participants seem less daunting when a robust enhanced payment or value-based payment is in play.

FUTURE CHANGES



General

Efforts to replicate this policy in the future might consider connecting with providers, state Medicaid, and private health insurance plans 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 Centering Pregnancy 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 pregnant 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 state provider associations who may have a bigger picture understanding of what providers are facing in the states. Additionally, connect with Centering Healthcare Institute for TA around implementation as needed.

Connect with providers, state Medicaid, and private health insurance plans before implementation to increase support for the policy and identify best practices for policy implementation. To ensure that reimbursement matches program delivery costs, identify what other potential financial support may be needed to ensure full participation and retention of pregnant 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.





FUNDING

To date, no fiscal note has informed a true funding assessment for such a policy. The New Jersey Assembly released a fiscal note for their enhanced payment policy for CenteringPregnancy, though it was not so exhaustive as to include a funding amount and rather determined the fiscal impact would be 'indeterminate².' The New Jersey Office of Legislative Services did note, however, "that there may be long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants under the bill. For reference, a study performed in collaboration between the South Carolina Department of Health and Human Services, which as noted above provides a Medicaid group prenatal care visit benefit, and the University of South Carolina estimated that CenteringPregnancy participation reduced the risk of premature birth and of a neonatal intensive care unit stay, as well as the incidence of delivering an infant with low birth weight. The study concluded that, after considering the state investment of \$1.7 million to provide group prenatal services to Medicaid beneficiaries, there was an estimated return on investment of nearly \$2.3 million³."

Centering Healthcare Institute is looking forward to collaborating with state legislative offices to better determine what fiscal impact, and likely fiscal savings, can be associated with creating incentives for evidence-based group prenatal care.

ADDITIONAL RESOURCES

- [Aligning Value-Based Payment with CenteringPregnancy](#): In this independently prepared whitepaper by Health Management Associates, evidence suggests CenteringPregnancy reduces costs, improves outcomes and leads to high satisfaction. This holistic model can be sustainably financed along the continuum of value-based payment using a variety of approaches. In Medicaid, the largest payer for maternity care, states have the opportunity to offer CenteringPregnancy to more women as part of their emerging payment and delivery system reforms.
- Centering Saves Life: [Centering Cost Savings Flyer](#)
- [How CenteringPregnancy can Support Birth Equity](#): The U.S. faces a crisis of high maternal and infant mortality rates, with Black women at 3 to 4 times the risk as white women of death from pregnancy related causes. Black infants have more than twice the rate of infant mortality as non-Hispanic white babies. CenteringPregnancy is one of the interventions shown to improve outcomes and reduce preterm birth particularly for Black women.
- [Podcast, Emerging State Policy, CenteringPregnancy – Group Prenatal Care, 10/2019](#): Reduce preterm birth rates & related racial disparities, improves our children's health, saves money, and capture bipartisan support with Centering Pregnancy, a research-supported model of



group prenatal care. Addressing the impact, state implementation strategies, and research supporting centering. Featuring interviews with NJ State Senator Thomas Kean Jr., Angie Truesdale – CEO of the Centering Healthcare Institute, and Family Medicine Doctor Valerie Good.

- [Payment Models to Support Sustainability of CenteringPregnancy in Federally Qualified Health Centers](#), Independently prepared by Health Management Associates for the Centering Healthcare Institute: As the health system shifts towards use of value-based payment, alternative payment methodologies could support implementation of Centering at FQHCs, leading to better health outcomes, higher patient satisfaction and a reduction in health disparities while also supporting FQHC financial sustainability.
- [Prenatal-to-3 State Policy Roadmap 2021: Building a Strong and Equitable Prenatal-to-3 System of Care](#): A comprehensive analysis from the Prenatal-to-3 Policy Impact Center of policies and tactics to increase access to critical services for mothers and babies and reduce racial disparities, including financial support for the implementation of group prenatal care through enhanced reimbursements for group prenatal care providers.
- [Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes](#): An issue brief from the Medicaid and CHIP Payment and Access Commission (MACPAC) explores how state Medicaid programs use payment incentives to positively impact maternal and birth outcomes, including bundled payments, blended payments for delivery, pay for performance and medical homes.
- [Accelerating and Aligning Clinical Episode Payment Models](#): Chapter four of Accelerating and Aligning Clinical Episode Payment Models from the Health Care Payment Learning & Action Network seeks to help speed the adoption of alternative payment models (APMs) for maternity care, including design and implementation of clinical episodes.
- ZERO TO THREE's Think Babies™: [Racism Creates Inequities in Maternal and Child Health, Even Before Birth](#)
- New Jersey Expands Medicaid Program: [To Include Coverage for CenteringPregnancy® to Improve Maternal Health and Birth Outcomes](#)

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