Comment Report

HF 265
A bill for an act relating to midwife licensure, providing for fees, and making penalties applicable. (Formerly HSB 80.) Effective date: 07/01/2023.

Subcommittee Members: Kaufmann-CH, Golding, Nielsen

Date: 02/27/2023
Time: 04:30 PM
Location: House Lounge

Name: Sarah Costello

Comment: Please vote yes to HF265 to license Certified Professional Midwives.My name is Sarah Costello and I am from Solon, Iowa. I am a third year Medical Student at University of Iowa apply to Family Medicine. I am also a mother to three children aged 8, 5 and 3 all born at home in Solon. I am asking you to support the passage of HF 265 because it will increase access to safe maternity care for families who chose to give birth out side of the hospital setting. This is important to me both as a home birth mother and as a future primary care provide who hopes to stay in Iowa. When I found out I was pregnant with my first child, I was overwhelmed with stories from colleagues and acquaintances who had had traumatic birth experiences in the hospital. I am privileged to have been raised by a midwife in both Australia and the UK, where midwives are the primary maternity care providers for most pregnant people, and I knew that giving birth could be both a safe and empowering experience when done at home with the support of a qualified midwife. However finding a home birth midwife was not easy in my area of Iowa! I learnt that there are two kinds of certified midwives, Certified Nurse Midwives (CNM) and Certified Professional Midwives (CPM), and only CNMs are licensed in Iowa. There were only two CNMs in my area who attended home births at the time of my first pregnancy. By the time I had my third baby, there were no licensed midwives in my area at all. The most recent report from the Center for Disease control and prevention indicates the number of home births in Iowa are continuing to increase. There is strong evidence that home births are safest when attended by a licensed midwife who is integrated into the larger healthcare system. We need more licensed providers to care for these Iowa families. As a medical student, I have been an active member of the medical community, joining specialty, state and national medical societies. I have spoken to physicians, midwives and families about directentry midwife licensing as well as becoming familiar with the evidence in the literature. I have heard concerns from the medical community, my community, that CPM education is not adequate to ensure safe maternity care. This concern is not based on evidence and merely stems from the fact that CPMs do not require nursing training. Globally, training in nursing is not a requirement for midwifery education. My mother currently teaches at a directentry midwifery program at Griffith University in Australia and their program is ranked 2nd in the world. The International Confederation of Midwives sets standard for midwifery education, and HF 265 will require that midwives practicing in Iowa meet those education standards. This bill also provides protections for physicians accepting consultations, collaboration and emergency transfers of licensed midwife clients. These protection could improve relationships between out of hospital midwives and hospital providers. As a future family physician I hope to collaborate with licensed midwives to work together to ensure the highest quality maternity care for Iowans. When a family comes to me asking about options for home birth, I want to be able to recommend a licensed midwife who I can trust is qualified, whose practice is regulated by a licensing board, and who I can be confident will provide the best quality care to my patient. Please help me make this happen by voting yes

for HF 265. Thank you for your time!

Name: Courtney Collier

Comment: I support HF265. Thank you for giving more choice to parents when it comes to maternal health in Iowa. Thank you for providing more options for maternal healthcare access. Licensing Midwifery is a positive decision for the state of Iowa to increase maternal health accessibility and also provided employment and business growth for birth workers in Iowa.

Name: Rachel Bruns

Comment: Please vote yes to HF265 to license Certified Professional Midwives. This bill will improve access to quality maternal health care options in Iowa. Planned homebirth is on the rise in Iowa and across the country and research demonstrates it is safe with similar or better outcomes for both moms and babies for healthy pregnancies. Based on other states, when the state provides licensure, more midwives follow. With Iowa ranking 11th as a maternal health care desert and a shortage of OBGYNs, we need more options for evidence based health care, especially in more rural settings. Iowa ranks 42nd (in the top 10 worst states) for midwifery integration. The integration of midwives, which includes licensure for Certified Professional Midwives, is associated with improved outcomes. Currently, we have Certified Professional Midwives practicing in our state and they are unable to access the lifesaving medications within their scope of practice that they otherwise could access if they practiced in one of the 37 other state (plus DC) that offer a license. As a volunteer chapter leader for the International Cesarean Awareness Network (ICAN) of Central Iowa, we are one of 100 chapters around the world that support midwifery integration and licensure for Certified Professional Midwives. You can read ICAN's statement on licensure here: https://www.icanonline.org/wpcontent/uploads/2020/08/ICANMidwiferyPositionStatement.pdf In my role as an ICAN chapter leader, I provide support to pregnant people across the state and know this bill will improve access to care for many Iowa families.I've attached a new issue brief on "Medicaid Maternity Strategies" that just came out last week from the Maternal Health Hub that references Certified Professional Midwives. Per the issue brief "Acknowledge the Need to Move Away from Reliance on a High Intervention Model of Care: It is imperative to recognize that the high intervention medical model particularly when its use is not evidencedriven or personcentered is not superior to the traditional model that views pregnancy and childbirth as a natural process that does not require intensive intervention. Less than one percent of all pregnancies are considered to be high risk, in which an OB/GYN andhospital birth is warranted. Yet, because the medical model dominates in the U.S., the majority of pregnancies are managed by physicians, not by midwives, potentially leading to more harm for birthing people."

Lessons Learned from a Multi-Stakeholder Roundtable on Medicaid Maternity Strategies

Tanya Alteras, MPP, Senior Director at the Health Care Transformation Task Force

Background

In October 2022, the Maternal Health Hub convened a roundtable for maternity subject matter experts and CMS/CMMI leadership to dialogue on specific strategies and design elements that could comprise a Medicaid maternity model that addresses the ongoing racial and ethnic inequities in morbidity and mortality. With a goal of significantly improving outcomes for Black, Indigenous, and People of Color (BIPOC) birthing people and newborns, the purpose of this roundtable was to come up with specific ways Medicaid – either via existing policies or new policies and models - can achieve the following:

- Increase equitable maternity care delivery with the goal of improving outcomes for birthing people and newborns.
- Expand data collection and quality measurement to reflect patients' experience across the population of birthing people, and to capture concerns regarding maternal health inequities.
- Expand the scope of maternity care alternative payment models (APMs) as a tool for improving prenatal and postpartum care equity, quality, and outcomes.

This document summarizes the topics and recommendations that emerged from the three-hour discussion and is organized as follows: (1) Key Challenges, (2) Foundational Elements to Support Maternity Care Transformation; (3) Designing Solutions, and (4) Data Sharing, Performance Measurement, and Accountability.

Terminology

Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[1]

Culturally congruent care respects different values, understands cultural differences and responds effectively, shows empathy, and treats patients equally while applying knowledge of different beliefs into various practices.[2]

Birthing persons is a term used to describe pregnant persons that is inclusive of all genders and gender identities. Not all birthing people identify as ***women*** or ***mothers***.

This resource uses both gendered and non-gendered language such as birthing persons, pregnant people, mothers, and women to reflect the terminology used by various stakeholders and found in the referenced literature.

Gender neutral language is used when not directly citing an external resource to be inclusive of all birthing persons.

Key Challenges

The following specific challenges were raised by the group:

Significant challenges exist when it comes to accessing respectful high quality maternity care that is responsive to the birthing person's preferences. The difficulty that BIPOC birthing people face in accessing respectful care stems from a number of challenges, including the following:

- ***Workforce Composition*:** There was a consensus among participants that the most significant challenges center around the workforce, with the following specific concerns expressed:
    - Patients should have the ability to access all provider types, including OB/GYNs, family physicians, certified nurse-midwives, certified professional midwives, certified midwives, and others. Birthing people's choice of who to go to for care should not be determined by lack of access and coverage.
    - Among the typical maternity care clinical providers and systems (*i.e.* OB/GYNs and hospitals) there is still resistance to the idea of including what will be referred to in this document as the "community-led maternity workforce," comprised of midwives, doulas, and community-based perinatal health workers (PHWs) as integral actors in a maternity health care team. The typical, or medical, maternity care model can be described as risk-based, with risk being defined as owned by the obstetrics community and hospitals, which leads to lack of access to community-based options. The medical model, centered on risk identification and ownership/control, has created a culture that makes it difficult to access midwives, doulas, birth centers, etc. This model has created a culture in which seeking care from community-led workforce is not easy to access or is intentionally or unintentionally deprioritized. There is a critical need for recruitment and training of a more diverse work force that better reflects the targeted service population.
    - The current community-led workforce that is available through insurance does not reflect the race, ethnicity, and primary language of the populations most significantly impacted by inequities in maternity care delivery. There is a critical need for recruitment and training of a more diverse workforce that better reflects the target population.
    - Reimbursement for the community-led workforce is unstable, not reflective of a living wage, and does not allow for sustainable business practices.
- ***Predominant Culture of Maternity Care Delivery*:** The predominant, or typical, maternity care model relies primarily on OB/GYN practices and their clinicians, monthly prenatal visits that occur after pregnancy is detected, and one clinician visit six-weeks postpartum. Participants noted that this is distinct from what they viewed as the true traditional maternity model, which includes midwives, doulas, birth centers, and other elements that comprise the community-based model.
    - In addition to the lack of information and support for seeking care from a community-based provider, there is the perception that midwives and doulas are "cheaper" or worth less because they are not physicians; this perception leads to their being undervalued in terms of reimbursement, something that should be recognized and rectified.
    - The predominant maternity care model has a record of not providing culturally congruent care (defined as respecting different values, understanding cultural differences and responding effectively, showing empathy, treating patients equally while applying knowledge of different beliefs into various practices)[3]. Lack of access to appropriate care

and/or experiences of bias from care providers often leads to mistrust between patients and providers. This topic is explored further below, looking at the intersection between culture and reimbursement.

- ***Workforce shortages:*** Whether due to geography, workforce burnout, or a combination of both, there is an emerging challenge of connecting birthing people to comprehensive and respectful care in what are being referred to as maternity care deserts. In these communities, the supply of the maternal health workforce is not sufficient to meet the desired demand, which raises a macro-level policy issue related to recruiting and training a more diverse maternal health workforce. In rural areas, some family physicians and OB/GYNs have adopted a midwifery model of care to reduce risk of c-section and NICU admissions, as these resources are not readily accessible. This example reflects the importance of educating the physician workforce alongside midwives in the midwifery model of care, and underscores the concept that it takes every type of clinician to create a comprehensive care team.

Post-partum care access and utilization is low and the process of transferring from maternity care to post-partum care is broken. The predominant maternity care model is slow to recognize the need for care coordinators, social workers, and patient navigators to assist birthing people in transitioning from the prenatal, labor, and birth phases to the post-partum care phase. The transition from maternity care to post-partum care that includes access to any needed behavioral health services as well as primary care requires a care team, as well as other strategies, such as strong links to telehealth.

Attempts to implement value-based payment models to transform maternity care have not succeeded for a variety of reasons. The Maternal Health Hub has highlighted efforts by states to design and implement bundled payment or episode models that covers all services from a birthing person's first prenatal care visit to post-partum period.[i] While the impetus behind these models has been to improve outcomes, they have not yet had a significant impact on transforming maternity care. One reason for this is that they often do not include the highest risk, and/or the most marginalized patients, and thus are not addressing the core systemic problems of health inequities. Another is the concern that, by excluding neonatal risk from a value payment model, providers may face too much financial instability.

Health equity has not been the focus of existing maternity alternative payment models (APMs). Federal strategies to improve maternity outcomes – such as the recent high quality birthing hospital designation implemented in the FY 2023 Medicare Inpatient Prospective Payment System (IPPS) rule - are centered on the medical maternity model. Participants spoke to the need for, and the challenges of, developing payment approaches that support and expand upon the community-based maternity model, including the following components:

- Ensure that the midwife/midwifery model is not put at financial risk if the patient is clinically indicated to move to an OB/GYN and/or hospital for labor and birth.
- Use capitated payment to avoid constraints of fee-for-service payment.
- More seamlessly allow for the use of CHWs trained in perinatal work.
- Move away from models that use retrospective payment, in recognition of the need for upfront money to invest in redesigning care. The institutions and players that have the upfront capital to

[i] An episode payment in this context refers to the alternative payment model described in https://www.iha.org/wp-content/uploads/2020/10/Issue-Brief-Transforming-Maternity-Care-A-Bundled-Payment-Approach.pdf; it does not refer to the concept of bundling the professional and facility fee-for-service fees into a global payment.

implement an alternative payment model are usually large hospitals, which are often not properly incentivized to reduce costs or address inequities.

It must be noted that alternative payment designed to reduce inequities in maternity care should not be viewed as synonymous with identifying midwives, doulas, and birth centers as cheaper options and creating value out of paying less for the same services as physicians in a hospital. The models need to pay equitably for equal services regardless of type of clinicians or setting.

Progress is being made in Medicaid reimbursement for community-led maternity care, but there are still many obstacles. There is no denying that Medicaid has sought to address the need for improved access to midwives, doulas, and post-partum care through optional coverage expansion. However, the implementation of these coverage expansions varies and puts birthing people at risk of not having access depending on where they live.

- The variation across states in terms of how their Medicaid programs reimburse midwifery care creates significant challenges. Currently all 50 states reimburse nurse-midwives. Only 17 of those states also reimburse certified professional midwives, and a smaller sub-set reimburses certified midwives.[4] However, reimbursement of nurse-midwives (CNMs) doesn't equal access to midwifery care in a community setting. Many states have restrictions requiring physician supervision or signed agreements to use a midwife, which makes it difficult for a CNM to provide services in a community setting. The midwife must find a physician who will agree to supervise them in a birth center or home birth practice, or even to work in smaller community hospitals. Further, in Medicaid Managed Care Organization (MCO) states, it is hard to decipher the extent to which midwives are being reimbursed due to a lack of access to provider network contracting data.
- Despite the fact that coverage of deliveries in birth centers is also required under Medicaid, the actual reimbursement, and other critical regulations and policies, create significant barriers to Medicaid beneficiaries delivering in birth centers. A study by the Milbank Memorial Fund found that low Medicaid reimbursement rates not only create access challenges for Medicaid enrollees, but also threaten birth centers' sustainability.[5]

A history of inconsistent funding and non-parity reimbursement for community-based providers and care settings continues to create roadblocks to true maternity care transformation. The community-led workforce and free-standing birth centers are often challenged by the lack of sustainable, continuous funding *(i.e.* time-limited grant funding and philanthropic donations). Despite the inclusion of these services and providers as reimbursable under Medicaid, there are multiple barriers to creating a sustainable funding stream:

- ***Systemic Barriers:*** There are a number of systemic barriers that create challenges for Medicaid beneficiaries who wish to receive care at a birth center. These include inadequate reimbursement rates (described in more detail below under "Solutions"), limited, or lack of, negotiating power between birth centers and MCOs, and limits on coverage for home births, lactation consultants, and childbirth education. At the regulatory level, Certificate of Need requirements, mandated relationships with physicians, transport/transfer agreements with local hospitals, and stricter-than-necessary structural facility elements make it difficult for birth centers to become licensed.[6]
- ***Reconciling Medicaid Systems with the Design of Community-Based Organizations*:** Medicaid was not designed for ease of forging community partnerships. Participants spoke to the lack of investment in both staff and technology that is necessary to implement and operate data

collection and sharing infrastructure, that effectively enables care coordination both within the clinical system and between the clinical and community systems.

Lack of interoperable data infrastructure and meaningful health equity-based performance metrics make it difficult to address inequitable outcomes. Infrastructure for data sharing between providers (including midwives, and free-standing birth centers) and community-based organizations creates enormous roadblocks to providing whole person care. In addition, the current set of perinatal care measures is inadequate for assessing whether birthing people are receiving evidence-based, culturally congruent,[7] respectful, high-quality care. Significant investment is needed for development of perinatal quality measures, and patient-reported experience measures of birth equity.

Foundational Elements to Support Maternity Care Transformation

As noted above, participants spoke to the idea that Medicaid was not designed for the kind of comprehensive, whole-person care that is so critically needed by birthing people, many of whom receive inappropriate care that reflects entrenched biases and/or fails to address birthing people's social risk factors and social drivers of health. To bridge the chasm between Medicaid and an environment that supports a community-based maternity model, CMS and states should consider how the following elements can be built into any approaches or models designed:

- ***Acknowledge the Need to Move Away from Reliance on a High Intervention Model of Care:*** It is imperative to recognize that the high intervention medical model – particularly when its use is not evidence-driven or person-centered – is not superior to the traditional model that views pregnancy and childbirth as a natural process that does not require intensive intervention. Less than one percent of all pregnancies are considered to be high risk, in which an OB/GYN and hospital birth is warranted. Yet, because the medical model dominates in the U.S., the majority of pregnancies are managed by physicians, not by midwives, potentially leading to more harm for birthing people.
- ***Recognize the Importance of Culture Change*:** Addressing inequitable access, unconscious bias, and poor outcomes requires a change of mindset and culture. Critical to this culture change is the constant focus on centering the needs of underserved individuals who are impacted by structural racism and inequities. Culture change also requires acknowledging that community-based organizations do not have the same funding streams and financial stability as health care institutions do. If community-based organizations are to be equal partners in a CMS-designed approach to improving maternity outcomes, they need a sustainable financial stream that removes the long-term instability that comes from having to rely on time-limited grant funding.
- ***Address Regulatory Barriers*:** Removing regulatory barriers emanating from restrictive scope of practice policies, incident to billing, certificate of need rules, and other roadblocks are key to addressing access and reimbursement issues.
- ***Eliminate Silos and Look for Cross-Agency Budget "Braiding" Opportunities:*** Explore opportunities to "braid" Medicaid, the Center for Disease Control and Prevention, and public health funding in a cross-agency effort.
- ***Leverage Existing Tools, While Acknowledging Their Potential Limitations:*** Participants agreed to the importance of leveraging Medicaid waiver authorities and State Plan Amendments to achieve health equity goals, but also noted that these tools are an option only when something is an existing optional benefit under Medicaid. This applies to community health workers,

doulas, and remote patient monitoring. To support services or providers that are not yet optional under Medicaid, states will need different levers.

Designing Solutions

Roundtable participants offered numerous suggestions for how to create and sustain a transformed maternity care delivery system that supports all birthing people. These strategies are all geared towards significantly reducing the BIPOC maternal morbidity and mortality rate and improving outcomes for BIPOC birthing people and newborns.

Leverage Existing Policies and Funding Opportunities

- Add birth centers to the "birthing friendly" designation program in the Medicare IPPS. Also, expand the criteria for the designation to require birth settings to include the midwifery model of care and doula and perinatal community health worker support.
- Continue to promote and educate states on the ways Medicaid 1115 waivers and State Plan Amendments can be leveraged to address health equity and disparities in access to care and outcomes.
- Coordinate with the Health Resources and Services Administration to use Title V funds for the training and payment for doulas and perinatal community health workers. This is particularly important for states that are still far from being able to implement doula coverage; perinatal community health workers are an important component that are already embedded into the Medicaid program.

Reform Medicaid Reimbursement Policies to Create Greater Parity for Midwives and Birth Centers

- Establish payment and delivery policies and regulations – such as a standardized reimbursement facility code – that make it possible for free-standing birth centers to succeed financially. This includes not only in cases where patients receive care from a midwife throughout their pregnancy and delivery in the free-standing birth center, but also in cases where the patient is transferred to an OB and/or a hospital for care and delivery due to clinical indicators.
- Reimburse freestanding birth centers at rates that reflect the value that birth centers bring to the labor and birth process. The birth center facility provides more than it is reimbursed for, including: training for staff and the equipment to provide a safe setting for labor and birth; continuous screening of the birthing individual; emergency training; medications on hand; equipment for two patients (the birthing person and the newborn); staff highly trained in management of the newborn transition; and initiating breastfeeding at a highly successful rate compared to hospitals. The room and board rate for one night does not begin to adequately cover the expenses of the birth center.

  It should be noted that hospitals are reimbursed for both room and board, and they use a facility rate for the labor and birth. As referred to in the previous bullet, no such facility code exists for birth centers. The concept that birth centers, because they do not include medical interventions such as induction or epidural, should not receive a reimbursement beyond room and board needs to be corrected. Further, as some participants described, birthing center deliveries routinely involve more one-on-one support and can cost more, due to higher staffing ratios and equipment.

Reflect the Unique Aspects of the Community-Based Maternity Model in Alternative Payment Model Design

- In any new payment approach, set payment incentives to levels where they truly motivate all providers to participate.
- Reduce or remove downside risk to allow community-based entities to participate in a model, keeping in mind the specific financial challenges faced by small, culturally-rooted entities.
- Include neonatal care given the impact that improving care delivery for newborns can have on both outcomes and costs. This would require MCOs to manage the birthing person and newborn as a dyad. Currently in Medicaid, the birthing person and newborn are independently enrolled and thus could become enrolled in two different Medicaid health plans. This could potentially create a scenario whereby only one MCO realizes the financial benefits of the alternative payment arrangement.
- Scale successful elements of existing models such as Tennessee's mandatory value-based payment arrangements for perinatal health; in this example, state stakeholders had to determine ways to create sustainable perinatal models, with resulted in several choosing to focus on midwifery-led models of care.[8] Similarly, support sharing learnings with states on Medicaid 1115 waivers in Oregon, Arizona, and Massachusetts that are using Medicaid funds to support housing and nutrition services.
- Put payers at risk by holding them accountable for postpartum care utilization and outcomes.

Explore Models that Embed Maternity Value-Based Payment within a Population Health/Primary Care Total Cost of Care Model

- Total cost of care (TCOC) models that integrate primary care and obstetric care, with the goal of delivering holistic care to individuals before, during, and after pregnancy, are a promising model — and an example of silo-bridging — for CMS and states to consider. Based on the example of CityBlock Health, this approach would comprise the following:
    - Provide incentives for primary care practices to contract with maternity health clinicians.
    - In a "maternity episode nested within a population health model" approach, acknowledge that the care provided prior to pregnancy and the first prenatal care visit will have an enormous impact on a birthing person's experience and outcomes.
    - Within this model, the maternity episode should be designed to include all birthing people and should not establish exclusions based on health needs or risk status.
    - Key to this model is data infrastructure that allows for continuous feedback loops, which enable data throughout the maternity episode to be used to strategically tailor the patient's post-partum care needs.
- Create a "wrap-around" delivery approach to address the needs of those who are high risk and/or have chronic care conditions. This approach could be modeled after the maternity home model, which has specific requirements and performance expectations like the patient-centered medical home model. CMMI could work with the National Committee for Quality Assurance to create a specific designation for these organizations.

Leverage the Medicaid Managed Care Organization Contracting Process

- Participants spoke to the importance of CMS and states viewing MCO contracts and the Request for Proposals process as a prime lever for change, that can augment or even replace demonstration models over time.[9]
- CMS could issue a new letter to state Medicaid directors that is more forceful about the importance of MCOs contracting with birth centers, providing equitable reimbursement for services, and removing incident to billing and certificate of need barriers. States could also consider how they can incentivize MCOs to contract with low volume clinicians (e.g., midwives) and birth settings (e.g., freestanding birth centers). Currently, under current state Medicaid contracting expectations, MCOs are incentivized to prioritize high volume clinicians and health systems. Finally, CMS could offer incentives for states to require birth centers be part of MCO networks.

Data Sharing, Performance Measurement, and Accountability

All of these solutions require infrastructure to collect and share data; measures to hold both providers and payers accountable and to assess patients' experiences of care; and disaggregated baseline information that provides current performance, stratified by race and ethnicity. Participants spoke to the serious gaps in all the above. However, there are several innovative efforts being pursued around the country that can be studied to share lessons learned with other states. Participants representing New Jersey shared that within the context of their perinatal care model, the state is 1) testing the incorporation of qualitative evaluation of patient experience; and 2) requiring participating providers to create a health equity action plan that includes a strategy to make measurable progress in an area with a disparity identified using disaggregated data.

CityBlock Health provides another example, as it is exploring various methods to measure member experience, and is developing a measure that can be used to assess care journeys that involve a birthing person changing providers or place of birth. Given that measure development is a very lengthy process, participants shared other ways that payers and providers can be assessed in the interim, including:

- Measure the percentage of members/patients that are utilizing doula services compared to the percentage that have access to those services.
- A payer-level utilization measure of how many new mothers see a primary care provider within a year postpartum.

A more fundamental concern is that available measures do not align with the comprehensive, whole-person care, delivered via a community-led workforce team, that comprises the community-based maternity care model. From an implementation standpoint, there were worries that new measures, even if well-suited to the community-based model, will be difficult for providers — who have already-established data collection and measurement systems — to implement. Related questions include how to attain payer and provider buy-in on new measures within the context of a voluntary model, and how much should providers be expected to pay — in terms of implementation, training, and operational costs — for new data systems.

Conclusion

The Roundtable's purpose was to share learnings, discuss future policy activities, and create synergies between the Maternal Health Hub, its sponsor the Commonwealth Fund, CMS/CMMI, state Medicaid agencies, and participants' organizations. The Maternal Health Hub continues to envision an environment in which state Medicaid and insurance officials, CMS, CMMI, consumer advocates, community-based maternity model representatives, commercial payers, all providers types, purchasers, and other health care stakeholders co-design innovative clinical and payment models to address current inequities in maternity care, and close the gaps in outcomes for birthing people and newborns.

Since 2021, the Biden Harris Administration has prioritized health equity, access, and affordability, and has expressed significant concern about the rates of maternal morbidity and mortality among BIPOC birthing people. CMS and CMMI investment in this area would undoubtedly give states additional capacity to take this on in Medicaid. With a potential design as a multi-payer model, the impact would be magnified in the commercial market as well.

The Health Care Transformation Task Force, which operates the Maternal Health Hub with support from the Commonwealth Fund, is grateful for the insights shared by all those who participated in this Roundtable. We look forward to continuing this work, with a shared vision and goals in striving for a more effective and efficient maternity care delivery system.

The Maternal Health Hub is run by the Health Care Transformation Task Force and supported by the Commonwealth Fund. The Hub leads a monthly Learning Community webinar series to identify and share learnings on essential components of equitable payment approaches that improve maternity care outcomes and lowers costs. To learn more about the Maternal Health Hub, and to join its learning community, please go to www.maternalhealthhub.org.

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References

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