Maternal Health Advisory Group

January 20th, 2026

Today’s Agenda

1. **Value-Based Payment (VBP) 101 & Maternal Health** – 30 minutes
2. **State Case Studies: NJ & CT** – 20 minutes
3. **Discussion** – 25 minutes

TMaH Award Required Notice

This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $17,000,000 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

VBP 101

(30 minutes)

VBP 101 & Maternal Health VBP

Maternal Health Advisory Group - January 20th, 2026
Kevin Koenig, CMS

Impact of FFS on US Healthcare

Total and per capita **health spending in the US is increasing over time** at rates that exceed overall economic growth and is higher in the US than in any other country.

The **US has worse health outcomes** and wide disparities in health outcomes across different groups in part due to the way that US health care has traditionally been financed.

Most experts agree that the prevalence of **fee-for-service payments in the US is a contributing factor towards greater US health expenditures and diminished health outcomes.**

Fee-for-Service Incentives

Potential overutilization	Financial incentives for providers to increase the volume of services they deliver.
Incentivizing quantity over quality	Providers are rewarded for performing more procedures or tests, regardless of the actual health outcomes for patients.
Fragmented care	The fee-for-service model often leads to fragmented and episodic care, with limited coordination among health care providers.
Disincentive for investment in preventive care	Upstream Drivers of Health
Rising health care costs	The payment structure may contribute to escalating health care expenditures without necessarily improving patient outcomes.

VBPs Can Improve Provider Incentives

VBP is intended to realign incentives in a way that encourages "value over volume"

- **Health outcomes per dollar spent:** The intention is to reward providers for better health outcomes, lower costs, and increased value.
- **"Value over volume"** VBP can take a variety of forms (episodes, total cost of care models, pay-for-performance), but overall is focused on placing incentives to reward "value over volume."

Alternative Payment Model (APM) Framework*

Categorization tool to help payers, providers, and policymakers better understand what current payment models are and what future opportunities exist for VBP arrangements.

CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2
FEE FOR SERVICE – LINK TO QUALITY & VALUE

A – **Foundational Payments for Infrastructure & Operations**
(e.g., care coordination fees and payments for HIT investments)

B – **Pay for Reporting**
(e.g., bonuses for reporting data or penalties for not reporting data)

C – **Pay-for-Performance**
(e.g., bonuses for quality performance)

CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A – **APMs with Shared Savings**
(e.g., shared savings with upside risk only)

B – **APMs with Shared Savings and Downside Risk**
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N – Risk Based Payments NOT Linked to Quality

CATEGORY 4
POPULATION – BASED PAYMENT

A – **Condition-Specific Population-Based Payment**
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B – **Comprehensive Population-Based Payment**
(e.g., global budgets or full/percent of premium payments)

C – **Integrated Finance & Delivery Systems**
(e.g., global budgets or full/percent of premium payments in integrated systems)

4N – Capitated Payments NOT Linked to Quality

*Framework by Health Care Payment Learning Action Network (HCP-LAN)

Total Cost of Care (TCOC) Model

- Health care payment model, often used in conjunction with Accountable Care Organizations.
- Providers are responsible for managing the **total cost** and **quality of care** for an **attributed set of patients**
  - Providers who deliver care at lower costs while maintaining quality standards, can share the generated savings
  - Requires a range of design and data elements

Episode of Care (EOC) Model

- Cover a **defined set of health care services** delivered for a specific condition, procedure, or treatment event (e.g., maternity care, joint replacement, cardiac surgery) within a set timeframe.
- Use **bundled payments** where providers are reimbursed based on the **total cost of the episode** rather than individual services provided.
- Encourages **care coordination** by aligning financial incentives with quality outcomes, reducing unnecessary spending, and improving patient experiences.

Both TCOC and EOC Models Can Include

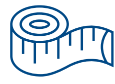
Patient attribution models to assign patients to providers.

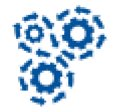
Risk adjustment to ensure fairness in payment.

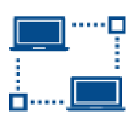
Outlier management to control for expensive patients outside a provider's control.

Cost calculation to measure the provider costs associated with the model.

Benchmarking and targets for providers to meet.


Quality measurement to link payment to outcomes.


Payment design for how providers are paid and incentivized.


Data infrastructure to track performance and outcomes and provider feedback.

Supplement payments to complement core payment mechanisms.

Patient Attribution

Process by which Medicaid enrollees are assigned to a payment model.

Methods

- **Retrospective** attribution (claims-based)
- **Prospective** attribution (assigned at enrollment)
- **Hybrid** models (combining retrospective & prospective)
  - Often involves assessment throughout year after initial prospective attribution
- **Event-Driven** Attribution
  - Patients are assigned at a trigger or anchor event

Risk Adjustment

A process used to account for differences in the health status and expected medical costs of patients when comparing outcomes, setting payments, or evaluating performance.

Why is risk adjustment necessary?

- Providers serving sicker populations shouldn't be unfairly penalized.
- Helps compare spending across different patient risk levels.
- Risk adjustment models are statistical regression models that use claims/ICD data to create relative risk scores based on diagnoses.

Outlier Claims and Costs

Why do outliers matter? A few extremely high-cost patients can **skew financial performance** outside of the control of provider. Medicaid populations can include catastrophic cases (e.g., transplant and severe accidents).

Common Approaches

- **Cost Truncation** (excluding or capping high-cost cases at a fixed amount).
- **Exclusion of certain costs or conditions** (removing rare high-cost services or diagnoses from TCOC or EOC).

Total Cost of Care Calculations

TCOC includes **all covered health care expenses** for the attributed population.

Expenses typically include:	
	Inpatient costs (hospital stays, surgeries, etc.)
	Outpatient costs (specialist visits, urgent care, imaging, etc.)
	Primary care costs (office visits, annual checkups)
	Pharmacy costs (prescription drugs if included in the ACO contract)
	Post-acute care (skilled nursing, home health)
	Emergency department visits
	Behavioral health and mental health services
	Preventive care costs
	Ancillary services (labs, durable medical equipment)

Risk adjustment and outlier cost caps/removals are applied.

- Typically normalized to a per-member-per-month (PMPM) or per-member-per-year (PMPY) by dividing by the # of attributed patients.
- Used to compare to the benchmark/target spend.

Episode of Care Calculations

For EOC models, costs are calculated for all relevant services included in the episode or bundle.

- **Historical Cost Benchmarking** – Initial episode payments are typically based on **historical claims data for similar conditions, procedures, or patients**, adjusted for inflation.
- **Risk Adjustment & Patient Complexity** – Payments are adjusted to account for **patient risk factors**, such as severity of illness, comorbidities, and upstream drivers of health.
- **Service Inclusion & Episode Duration** – Costs are totaled for **all relevant services** (e.g., hospital stays, physician cost, post-acute care) within the **defined episode period** (for example, 60 or 90 days).
- **Performance-Based Adjustments** – Final reimbursement is **adjusted based on quality measures**, such as complication rates, readmissions, and patient outcomes, to ensure cost control does not compromise care quality.

Quality Measures

Incorporating quality measurement into the VBP design is meant to ensure that providers aren't meeting cost targets by skimping on care and helps ensure that the quality of care and outcomes are improved.

Common Medicaid Quality Measures

- **Clinical outcomes** (e.g., diabetes control, maternal health, preventable hospitalizations)
- **Utilization metrics** (ER visits, readmission rates, ambulatory care-sensitive conditions)
- **Patient experience & access** (Consumer Assessment of Health care Providers and Systems (CAHPS) scores, timeliness of care)
- **Upstream drivers of health-related measures** (stable housing, food security)

Quality impacts payment: Providers must meet quality thresholds to be eligible for performance-based payment and the degree of payment can be tiered based on quality performance.

Payment Design

TCOC Financial Incentives

Shared Savings Model (*Upside & Downside Risk*).

Upside-Only (*One-Sided Risk*) If an ACO reduces costs below a benchmark, it shares in the savings but does not bear financial losses if costs exceed the benchmark.

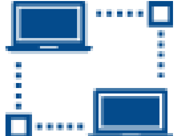
Downside Risk (*Two-Sided Risk*) The ACO shares in savings but also takes on financial accountability if costs exceed the benchmark.

Partial-capitation with upside or downside risk.

EOC Financial Incentives

Bundled Payments Providers receive a **fixed payment** for an entire episode, covering all services within a defined time window.

Can include Shared Savings and Financial Accountability Providers keep savings if they deliver care efficiently while maintaining quality.



Data Needs and Infrastructure

Why is data an important consideration in VBP design, operation, and success?

- Generally pulled from **claims and encounter data**.
- **Operationalization** of the models
  - E.g. Calculation of TCOC or EOC, quality measures
- Provider **practice management**
  - Flagging of high-cost cases
  - Feedback metrics on cost and quality
  - Risk stratification, socioeconomic status (SES), and risk score information

Challenges

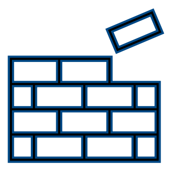
- **Closing the data lag gap** to provide meaningful close-to-real-time information to the provider organization.

Supplemental or Supporting Payments

Supplemental or supporting payments complement the core payment model and are used to ensure financial stability, support infrastructure investments, or reduce provider risk.

These payments can include:

- **Infrastructure Payments** – Funds to build capacity for value-based care (e.g., care coordination, health IT investments, quality reporting).
- **Performance Incentives** – Bonus payments tied to quality and efficiency metrics.
- **Safety-Net Adjustments** – Additional payments for providers serving high-risk, low-income, or rural populations.



What Role Does VBP Play in Transforming Maternal Health in the TMaH Model?

The TMaH VBP is designed to:

- **Provide maternal health providers with upfront funds** and predictable revenue to invest in prevention
- **Incent screening, identifying, and providing continuous care for high-risk patients** across the spectrum of physical and behavioral health and broader prevention
- **Reward maternal health providers for improved outcomes** and resultant cost savings

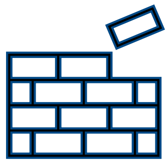
Outcomes of interest

Reduced rates of low-risk caesarean deliveries

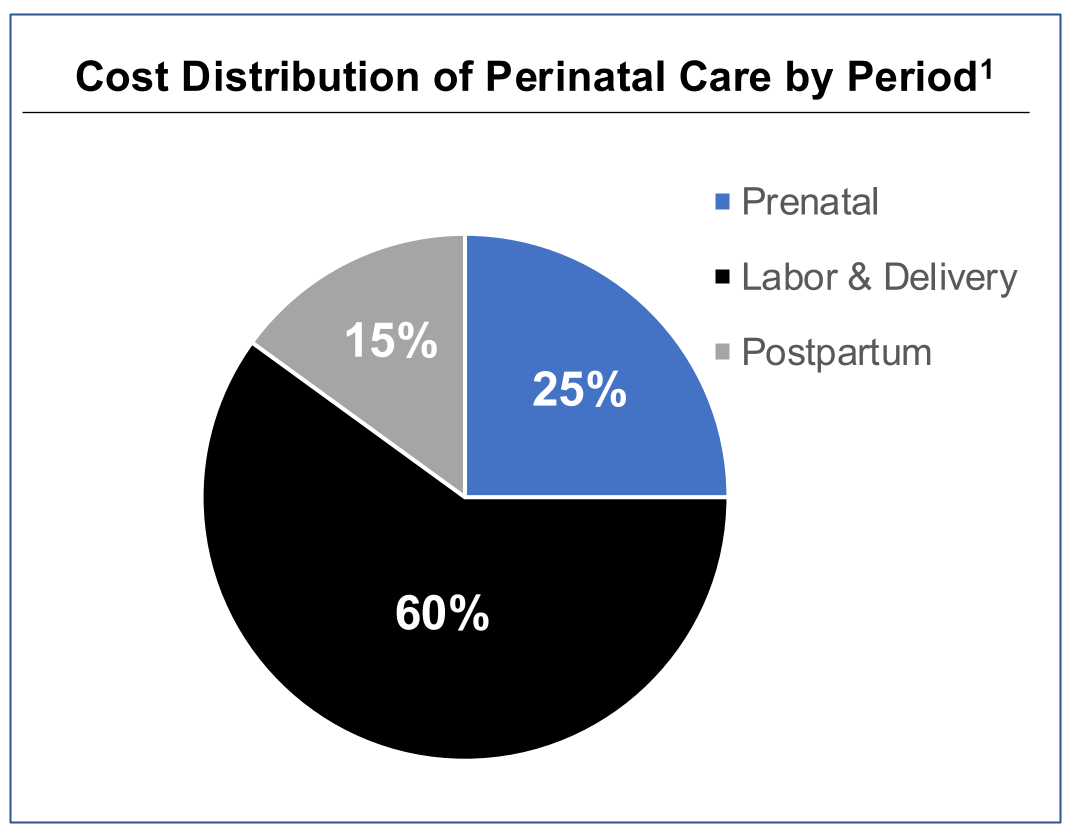
Reduced incidence of severe maternal morbidity

Reduced rates of low-birth weight infants

Improved experience of care for pregnant women

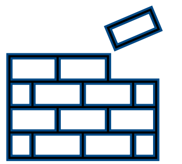


What Incentives Need to be Aligned in a Maternity VBP?



- **Most cost savings from improved prenatal and postpartum care are realized during labor & delivery**
- **The TMaH VBP is structured to support the delivery of enhanced prenatal care** which will reduce costly outcomes that occur during labor & delivery and the postpartum period
- **It is critical to align the incentives for the providers providing the perinatal care and the hospitals at which labor & delivery occur.** Quality metrics will be selected to incent optimal perinatal care results for both the practice and hospital tracks (*as seen on following page*)

1. HCCI Report Total Spending across the Prenatal, Childbirth, and Postpartum Periods among ESI Enrollees



Why Transform Maternal Health Care?

Maternal Mortality

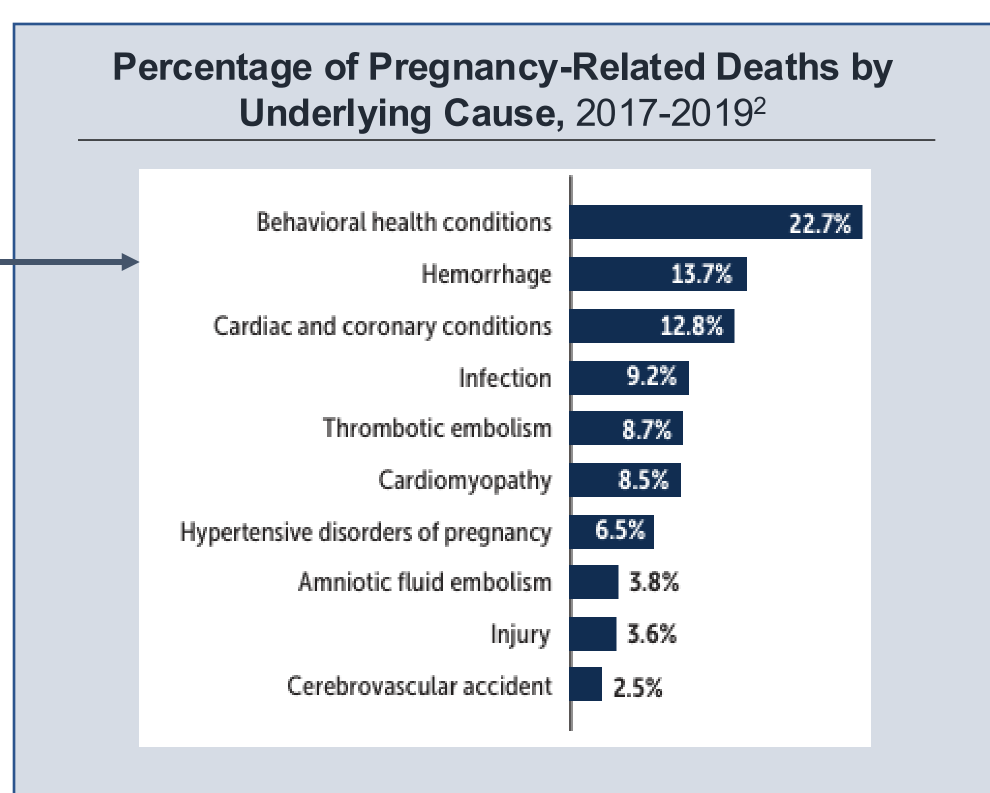
84% of maternal deaths are considered preventable[1]

Over 50% of deaths are caused by behavioral health, cardiac and coronary conditions, and hypertension[2]

Maternal Morbidity

Severe Maternal Morbidity (SMM) affects 3.6% of the Medicaid population[3] and is associated with a high rate of preventability[4]

SMM can increase delivery costs by 20-50%[5] and impact a woman's health in the short- and long-term



Improving maternal and infant health outcomes requires preventive continuous care starting in the prenatal phase and into postpartum

1. CDC; 2. ;3. CMS; 4. ACOG; 5. Women's Health Report, Commonwealth Fund

State Case Studies: NJ & CT

(20 minutes)

HUSKY Maternity Bundle Payment Program

Program Overview

March 2024

Program Overview

Program Start Date: January 1, 2025

Eligible Providers: Maternity practices who deliver 30 or more births per year

Key Design Components:

- Provider-specific prospective **"Case Rate" payments** to encourage flexibility in care delivery
- Episode cost calculated through **retrospective reconciliation**
- **Quality measures** to ensure high-quality care and improvements in care
- **Social and clinical risk adjustment** to reward providers who care for Medicaid members with greater social and health needs

Program Highlights:

- New coverage of **doula and lactation support** services
- Opportunity for **"incentive" payments** (shared savings) without downside risk

Maternity Episode

An episode of care describes the total amount of care provided to a patient during a set timeframe. In this program, the maternity episode includes services across all phases of the perinatal period, spanning 280 days before birth to 90 days postpartum.

Maternity Episode

- **Pregnancy** – 280 days prior to delivery
- **Labor and Delivery**
- **Postpartum** – 90 days post delivery
- **Newborn (Reporting only)** – 30-90 days post delivery

Reconciliation

Quality Methodology

Incentive Payment

First trimester: Fee-For-Service payment

Case Rate Payment

A Case Rate may begin in the second trimester and continues until 90 days postpartum. (Fee-For-Service payment will continue for services not covered by the Case Rate.)

New Covered Services

Reimbursed via Case Rate Add-on Payment

Maternity Episode Services

Pregnancy

- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Genetic testing
- Doulas
- Care navigators
- Group ed meetings
- Birth ed classes
- Preventive screenings (chlamydia, cervical cancer, etc.)

Labor & Delivery

- Vaginal delivery
- C-section delivery

Postpartum

- Breastfeeding support
- Depression screening
- Contraception Planning
- Ensure link from labor and birth to primary and pediatric care occurs for birthing person & baby

Accountable Providers

Ambulatory maternity providers who have the greatest role in delivering obstetric care will be designated as the episode's Accountable Provider.

Accountable Providers

- Ambulatory maternity providers (i.e., qualified licensed physicians, nurse practitioners, and nurse-midwives) who have the greatest role in delivering obstetric care will be designated as the episode's Accountable Provider.
- Accountable Providers must meet a minimum volume threshold of 30 or more deliveries annually to participate.
- Accountable Providers will be eligible to receive Case Rate and incentive payments.
- Accountable Providers will be transitioned from the OB Pay for Performance (OBP4P) program to the Maternity Bundle Program.

Non-Participating Providers

- FQHCs and providers who perform fewer than 30 deliveries annually will be ineligible to participate in the program and will be paid according to their current payment methodology.
- Non-participating providers may still opt to participate in the OBP4P program.

Case Rate Payments

Accountable Providers will receive monthly case rate payments for a subset of office-based prenatal and postpartum services.

- **What?** For a subset of services, DSS will make monthly "case rate" payments for the majority of prenatal and postpartum care that a birthing person receives.
  - Each provider's initial Case Rate is based on historical second trimester, third trimester, and postpartum claim expense for historically attributed episodes.
  - The rates will be rebased, not more frequently than once every 12 months.
  - A Case Rate may begin in the 2nd trimester. Claims submitted in the first trimester will be paid fee-for-service.
  - If/when a different provider takes over the patient's case within the second or third trimester, the Case Rate for the original Accountable Provider will cease.
- **Who?** Case Rate payments will be paid to the Accountable Provider to which the birth is attributed.
- **Why?** DSS designed the maternity bundle's Case Rate payment to give providers greater flexibility in how they deliver care.

Incentive Payment

Accountable Providers can earn incentive payments when total cost of care is lower than the target price, if they also meet quality performance criteria and comply with under-service prevention requirements.

- If episode costs are below the "target price" (the target benchmark), providers will receive a retrospective (i.e., at the end of the bundle) "incentive payment" (shared savings) based on their quality performance.
- This program is upside only, which means providers can only earn incentive payments as a bonus for delivering high-quality, cost-efficient care; there are no penalties if the provider's costs exceed the target price.

Additional Resources

For additional information about this program, see the following resources:

- DSS Maternity Bundle Website
- Program Overview
- Program Specification
- Draft Code List

NJ’s Perinatal Episode of Care Program

- **Overview:** A pilot program that launched in 2022 and aims to incentivize clinicians to take on accountability for the quality and cost of their patients’ maternity care.

- **Providers:** A voluntary program of obstetrical care providers who serve as the accountable provider and have 15 births during a performance period
  - FQHCs can participate but are not permitted to serve as the accountable provider

- **Key Design Components:**
  - Retrospective payments
    - Shared Savings
    - High performer bonus
    - SUD participation incentive
  - Attribution to a billing obstetrical provider
    - Preferentially attributed to the **prenatal provider**, but can also be attributed to the **delivering** provider

NJ’s Coverage Criteria

- **Episode of Care Inclusion Criteria:** Most births covered by an MCO are included.
  - The relatively small number of fee-for-service births are excluded.
  - A small number of births will be excluded from the episode for clinical reasons (e.g., patient has an AIDS diagnosis)
  - A small number of births will be excluded from the episode for business reasons (e.g., patient has other health insurance in addition to Medicaid)

- **Services Included:** Services delivered from 280 days before birth through 60 days after birth are included.
  - Includes physician services, inpatient and outpatient hospital (including emergency department visits), imaging, labs, and prescription drugs.
  - Includes services delivered by the episode participant and services delivered by other providers
  - Services unrelated to pregnancy are generally excluded.
  - Services provided to the infant do not count towards episode cost-of-care, but do contribute to quality-of-care assessment.

NJ’s Payment Approach

Incentive	Feature	Specifications
Shared Savings Payment	Quality	Meet or exceed **minimum** threshold for all 5 metrics
	Cost	Reduce risk-adjusted spend by at least 3%, relative to a provider’s prior year performance
	Gain sharing	50% of spend below the benchmark
High Performer Bonus	Quality	• Meet or exceed **minimum** threshold for all 5 metrics; AND • Meet or exceed **commendable** threshold for at least 2 metrics
	Cost	Provider’s risk-adjusted spend must meet or be below 50th percentile of risk-adjusted peer spend
	Bonus, per episode	$1,500
SUD Participation Incentive	Eligibility	Top 20% of providers with patients with an SUD diagnosis for the birthing individual or neonate
	Bonus, per episode	$300

Quality Improvement Activities

- **Quality Measures**
  - Prenatal depression screening
  - Gestational diabetes screening
  - Low-risk c-sections
  - Postpartum clinical visit within 3 weeks
  - Neonatal visit within 5 days

- **Quality Improvement Activities**
  - Participate in a multidisciplinary review of clinical outcomes
  - Create a health equity plan to address the racial health disparities identified in provider reports
  - Participate in New Jersey Health Information Network
  - Upon request: Participation, as appropriate, in case study-based research projects

NJ and CT Side-by-Side Comparison

Design Element	CT	NJ
Overall Approach	Maternal Health Episode of Care	Maternal Health Episode of Care
Accountable Providers	Qualified Licensed Physicians, Nurse Practitioners, and Nurse-Midwives	Ob-Gyns and Midwives
Minimum Patient Panel	30 births	15 births
Performance Period	280 days before birth through 90 days after birth; case rate starts as early as second trimester	280 days before birth through 60 days after birth
Attribution	Based on prenatal care	Prenatal care preference
Quality Performance Measures	• Maternal Adverse Events • Cesarean Birth • Low Birth Weight • Prenatal Care • Postpartum Care	• Prenatal depression screening • Gestational diabetes screening • Low-risk c-sections • Postpartum clinical visit within 3 weeks • Neonatal visit within 5 days
Outpatient Payment	Prospective Case Rate	Fee-for-Service
Total Cost of Care	Shared Savings	Shared Savings + Performance Bonuses

Discussion

(25 minutes)

Discussion

#1: What benefits and/or challenges does shifting to a VBP model present to delivering high quality pregnancy care? What aspects of the APM frameworks presented may be a better or worse fit for DC?

#2: Based on today's presentation of case studies from NJ and CT, what program components from those states could be replicated in DC? Are there components of the presented programs that may not be a good fit for our population?

#3: How can the TMaH partners leverage this opportunity to best support innovation to identify and serve the needs of DC's most vulnerable pregnant persons?

Infrastructure Funds Will Support Providers in Implementing the TMaH VBP Model

Provider Incentive Program:

Distribute funds to providers for completing assessments and participating in technical assistance.

CMS-Directed Infrastructure Payment Program:

Distribute funds to support infrastructure payments related to patient safety, quality measure reporting, data integration, team-based care, access, and HRSNs

DHCF Quality Improvement Program:

Distribute funds to support quality improvement projects.

2025-2026

2027

2028-2032

CMMI-Designed Value-Based Payment Model Launches in 2028

Next Steps

Next Meeting: February 17th, 2026, 11am-12:15pm

- Topic: Value-Based Payment in Maternal Care (cont.)
- Subsequent Meetings: Every 3rd Tuesday from 11am-12:15pm (monthly)

End-of-year Survey:

- Please fill out this survey to inform '26 meetings: https://forms.office.com/g/8cMyKGseA5

Stay in Touch

- Questions: Send questions or requests to dhcf.maternalhealth@dc.gov
- Meeting Materials: Available at https://dhcf.dc.gov/page/transforming-maternal-health

Background Info

The District Must Meet Milestones for 10 Key Care Elements by End of Year 3

Pillar 1 Access, Infrastructure & Workforce	Pillar 2 Quality Improvement & Safety	Pillar 3 Whole Person Care Delivery
• Increase access to the midwifery workforce • Increase access to birth centers • Cover doula services • Improve data infrastructure • Develop payment model	• Support implementation of AIM patient safety bundles • Support "Birthing-Friendly" hospital designation	• Increase risk assessments, screenings, referrals, and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and health-related social needs (HRSN) • Increase home monitoring of diabetes and hypertension • Develop health promotion and disease prevention plan

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The District Can Elect Up To 8 Optional Care Elements; Milestones TBD

Pillar 1 Access, Infrastructure & Workforce	Pillar 2 Quality Improvement & Safety	Pillar 3 Whole Person Care Delivery
• Cover certified midwives (CMs) and certified professional midwives (CPMs) • Cover perinatal community health workers (CHWs) • Create regional partnerships in rural areas • Extend Medicaid eligibility to 12 months postpartum	• Promote shared decision-making	• Expand group perinatal care • Increase use of home visits, mobile clinics, and telehealth • Expand oral health care