



Redesigning Maternity Care for the COVID-19 Era and Beyond

AUTHORS Yolande Pokam Tchuisseu
Rebecca Whitaker
Jeremy Jacobs
Susan Dentzer
Robert Saunders

Duke | MARGOLIS CENTER
for Health Policy

Redesigning Maternity Care for the COVID-19 Era and Beyond: *Policy Changes and Implications for Care and Payment Reforms*

Key Findings

- ▲ The COVID-19 pandemic dramatically shifted the maternity care model, moving more services to remote care, and upending a decades-old model of accepted best practice of frequent in-person prenatal and postnatal visits.
- ▲ It is too early to know the long-term impact on cost, quality, access, and patient and clinician satisfaction with these care model shifts, but preliminary findings suggest mixed results.
- ▲ COVID-19 has strained budgets and shifted health care priorities, but it has also introduced opportunities to integrate more patient-centered approaches to maternity care and to couple Medicaid coverage extensions with value-based care models.
- ▲ To maintain the innovations developed during the pandemic, maternity care and payment reforms need to enable more community-based supports through doulas, community health workers, and lactation consultants; more use of technologies such as remote monitoring; and continued support for interventions such as telehealth consultations and virtual group visits.

Introduction

The maternity care model in the United States is beset with [several challenges](#), which include dismal maternal health outcomes, rising maternity costs and persistent rural, racial, and ethnic disparities. At the same time, the U.S. maternity care system has seen limited structural changes over the years. For example, the conventional [prenatal care schedule](#) predates [World War II](#). In 2017, just 0.1% of prenatal visits were conducted via telehealth and fewer than 2% of American women gave birth outside of a [traditional hospital setting](#).

In an attempt to address these challenges, health care leaders have turned to care and payment [reforms](#). Early evidence on maternity care alternative payment models (APMs) from [Tennessee](#), [Ohio](#) and [Arkansas](#) have shown APMs' ability to reduce health care expenditures and improve health care quality. The onset of the COVID-19 pandemic and associated public health emergency have renewed focus on the need to reform maternity care models, building on the success of these earlier value-based care reforms.

The COVID-19 pandemic has, at least for the time being, upended health care norms and transformed health care, including for pregnancy care. For example, social distancing measures imposed by COVID-19 facilitated the implementation of new care delivery models with a hybrid of in-person and virtual visits instead of the standard 12-14 in-person prenatal visits. These care delivery changes have been supported by and accompanied by several policy changes. Although some of these changes will terminate with the end of the public health emergency, others, such as greater use of [virtual care](#), are likely to extend beyond the pandemic. Alongside changes in the health care delivery landscape is a renewed focus on health disparities and health equity, stemming from the disproportionate [impact of COVID-19](#) on communities of color, which exacerbated existing disparities.

This issue brief captures key Medicaid and commercial payer policy changes made to date in response to the pandemic, examines the preliminary impact of COVID-era policy changes, and makes policy recommendations for states and commercial payers to consider to help sustain access to care, improve outcomes and reduce disparities, and encourage smarter spending during the pandemic and beyond.

Approach

The findings reported in this brief are based on a targeted environmental scan and interviews with 24 key informants from state Medicaid agencies, commercial payer organizations, and national associations representing these groups from May – September 2020. Our environmental scan synthesized information from state Medicaid agencies' and commercial payers' benefit and policy documents, especially their maternity care policies, as well as peer-reviewed and grey literature. Through our scan and interviews, we aimed to capture key policy changes and their potential impact on maternal health and maternity care payment and care reforms. While this brief does not provide an exhaustive list of recent policy changes affecting maternity care, it highlights key trends across states and commercial payers with implications that might be generalizable to states, commercial payers, and practitioners seeking to transform maternity care and payment models.

Changes in Coverage, Practice, and Policy Affecting Maternity Care during the Pandemic

Public and private health care payers nationwide implemented numerous and wide-sweeping policy changes during the pandemic to maintain access to care and prevent exacerbation of health disparities. While few of these changes targeted maternity care, they do have major implications for maternal care delivery. Among the policy changes, as highlighted in Table 1 below, were increased access to Medicaid insurance coverage, relaxation of select workforce regulations, additional flexibility and payment for telehealth and virtual care visits, and clinical policy and practice changes affecting labor and delivery.

Table 1.

Select COVID-era Policy and Practice Changes Affecting Maternity Care

Types of Policy Changes	Policy Change	Examples of Policy Changes
Access to Medicaid Insurance Coverage	Medicaid Moratorium on Disenrollment	The Families First Coronavirus Response Act issued a freeze on Medicaid disenrollment , requiring states to maintain continuous enrollment for all members after March 18, 2020 in exchange for an increase in the federal match rate. Especially in non-Medicaid expansion states, this disenrollment freeze allowed many pregnant people to maintain Medicaid coverage beyond the typical cut-off of 60 days postpartum.
	Streamlined Eligibility Processes	Many states have simplified the Medicaid enrollment process. Some states, such as California , now allow for telephonic “signatures,” instead of in-person attestation.
Workforce Changes	Cross-State Licensure & Practice Flexibilities	Nearly all states implemented temporary cross-state licensing flexibilities to allow and facilitate delivery of remote care and in-person care delivered by out-of-state clinicians. States have also relaxed practice regulations for advanced practice clinicians.
Telehealth	Changes to Eligible Services and Providers	State Medicaid programs and commercial payers alike have modified telehealth policies , which include changes to telehealth reimbursement and expansion of telehealth services across different specialties. For example, the state of Colorado has passed a bill expanding access to tele-behavioral services . These expansions broadly enabled access to remote services, including for pregnant and postpartum individuals.
	Payment Changes	Some states have issued payment parity regulations for telehealth services. For example, the Governor of Washington issued an Executive Order in March 2020 that established payment parity within state-regulated insurance carriers in the state of Washington. Medicaid programs in about 20 states have also issued guidance to waive or lower telehealth copayments.
Clinical Policy and Practice Changes	Minimizing Virus Transmission	To reduce the risk of COVID-19 transmission during labor and delivery, health care provider organizations implemented various clinical policy and practice changes. Example of changes included restrictions on visitors allowed during labor and delivery.

Maintaining and Expanding Access to Health Insurance Coverage

The COVID-19 pandemic has led to massive increases in unemployment and subsequent losses of employer-sponsored health [insurance](#). To protect individuals from losing existing sources of coverage, Congress, under the Families First Coronavirus Response Act, required states to maintain continuous enrollment for all members after March 18, 2020 in exchange for an increase in the federal match rate until one month after the public health emergency ends. All 50 states have accepted the enhanced Medicaid match and are now subject to this moratorium on [Medicaid disenrollment](#). Especially in states that have not expanded Medicaid where income thresholds for qualifying adults are typically much lower than pregnancy-related thresholds, this disenrollment freeze allowed many pregnant people to maintain Medicaid coverage beyond the typical cut-off of 60 days postpartum.

These coverage extensions and flexibilities could have potentially positive implications for long-term health outcomes for the new parent and the baby. For example, [extending postpartum coverage](#) increased access to needed physical and behavioral health services beyond the standard Medicaid eligibility cut-off of 60 days postpartum, which can [facilitate the transition to primary health care](#), and [improve outcomes for infants](#). Future research should determine the cost and health outcome implications of the natural experiment associated with the moratorium on Medicaid disenrollment.

States have also used various strategies to streamline Medicaid insurance application processes. Many states, [such as California](#), now allow for “telephonic signatures” to enable better accessibility to Medicaid applications; in the past, applications had to be done in-person.

Increases in Medicaid enrollment have strained some state budgets, and as a result, certain states may consider cutting provider reimbursement or benefits to offset the increase in enrollment. There are states that have submitted Section 1115 demonstrations requesting the ability to extend Medicaid coverage for pregnant people from 60 days to 1 year postpartum. CMS has not acted on these requests and it will be interesting to see how the new Biden Administration will respond. There are additional states that were interested in pursuing an extension of postpartum coverage; however, limited budget and bandwidth have stalled multiple state Medicaid agencies’ interest in pursuing this strategy.

When the public health emergency is over, many states will revert to their previous Medicaid eligibility policy. However, the COVID-era coverage extensions may spur reflections on ways to address coverage gaps during and beyond the pandemic—such as expanding Medicaid coverage as permitted under the Affordable Care Act, extending [prenatal insurance coverage](#) to undocumented pregnant people, or extending postpartum coverage up to one year. Prior to the pandemic, Texas and California provided and continues to provide Medicaid coverage to undocumented pregnant people during their pregnancy and postpartum period. However, in many states, undocumented individuals only qualify for time-limited presumptive Medicaid coverage for prenatal care and for emergency labor and delivery. Since COVID-19 is known to disproportionately affect the [Latinx community](#), this model could provide an opportunity to extend coverage to a high-need group. Finally, coverage expansions can still leave pregnant people subject to insurance churn if Medicaid coverage for pregnant people is substantially higher than coverage for working-age adults or parents. For those whose incomes are above the eligibility threshold for working-age adults or parents, subsidized coverage may be available through the [Health Insurance Marketplace](#), but a change in insurance coverage could disrupt continuity of care during the postpartum period. Extending postpartum coverage to allow for 12 months of continuous eligibility will greatly reduce the likelihood of insurance churn in this population.

Maintaining Access to Care through Workforce Changes and Expansions in Telehealth and Virtual Care

Workforce Changes: Cross-State Licensure & Practice Flexibilities

Changes in cross-state licensure and practice flexibilities expanded access to in-person and remote care during the pandemic. The vast majority of states (all but four) have [waived state licensure requirements](#) for out-of-state licensed clinicians. Although these flexibilities are not specific to maternal health, there are some states that focused on this population. For example, Governor Cuomo issued an [Executive Order](#) allowing all licensed midwives in good standing in the United States or in Canada to practice in New York. The Centers for Medicare & Medicaid Services issued an [emergency declaration](#) granting greater practice flexibility for advanced practice nurses. Of the 28 states that required advanced practice nurses (e.g., nurse practitioners, certified nurse midwives, clinical nurse specialists) to practice with physician supervision, 21 states temporarily relaxed various [practice regulations](#) during the pandemic, though states varied in the [scope of their changes](#). While these workforce-related changes are not specific to maternity care, they can serve as an [impetus](#) for greater integration of non-physician maternity care providers within the health system.

Expansions in Telehealth and Virtual Care

Of the COVID-era policy changes, expansion of telehealth and virtual care access has produced the most pronounced shifts in payment and care delivery. State Medicaid agencies and commercial payer organizations facilitated massive expansions in telehealth and virtual care access by waiving co-payments, allowing for some telehealth visits to be reimbursed at parity with an in-person visit, and expanding definitions for eligible services and providers. The Kaiser Family Foundation's [Medicaid Emergency Authority Tracker](#) found that Medicaid programs across all 50 states and the District of Columbia have issued guidance to expand coverage of and/or access to telehealth and virtual care services. Forty-three (43) states have payment parity for at least some telehealth services compared to face-to-face services, and about 20 states have waived or lowered telehealth copayments. Similar policy changes have occurred among [commercial payer organizations](#). States and commercial payers granted these telehealth flexibilities on different timelines, though most policy changes were retroactive to the start of the economic shutdown in March. Some states and commercial payers are [beginning to remove these flexibilities](#), infusing uncertainty into the future of virtual care.

Even as some virtual care policies are withdrawn, the landscape shift has increased the adoption of hybrid remote and in-person maternity care models. Prior to the pandemic maternity care providers, even if they were reimbursed under a global fee for maternity care, did not commonly use virtual visits because these visits did not “count” as allowable prenatal visits. One of the most well-known hybrid maternity care models grew out of research at the University of Michigan Medical School, and is called the [4-1-4 prenatal plan](#). This model predated the COVID-19 pandemic and aimed to address the challenges of frequent in-person prenatal visits by shifting to 4 in-person visits, 1 ultrasound visit, and 4 virtual visits. Guiding this prenatal model are two principles: 1) designing care delivery around essential clinical services, and 2) creating flexible services and allowing patients to tailor support to meet their needs. While this model is early in its implementation, the principles guiding its design reflects a growing push towards a more patient-centered model of maternity care, where care is tailored to meet [pregnant people's needs](#). Maternity care clinicians adopted this 4:1:4 model early in the pandemic, though further work is needed to determine how this model has spread and changed over the course of the pandemic.

Telehealth Expansions Have Created New Opportunities but Also New Challenges in Maternity Care

Recent telehealth policy changes present three key opportunities to improve maternity care, which include: 1) increased access to services, especially behavioral health care, 2) shifts toward more patient-centered care models, and 3) expanded workforce to support a hybrid telehealth/in-person model with more community-based supports.

The traditional prenatal care model requires frequent in-person visits, which can be challenging for pregnant people facing transportation barriers or limited flexibility in daily schedules to accommodate an in-person visit. Moreover, demand for behavioral health services has grown during the pandemic, as the public health emergency has created incredible stress on families' health and well-being. Fortunately, greatly expanded telehealth services has created the opportunity to increase access to prenatal care and to behavioral health services for pregnant people.

The expansion of telehealth and the introduction of hybrid telehealth/in-person prenatal care visits have also created a shift toward developing more [patient-centered maternity care models](#), allowing patients to determine how frequently they would like to be seen in-person. Several stakeholders noted how subgroups of pregnant people appreciated the flexibility afforded by remote visits, especially since prenatal visits are frequent, and postpartum visits are challenging with a new baby.

Because pregnant women are coming into the office less frequently, payers and clinicians alike noted the need to increase access to community-based supports through doulas, community health workers, and lactation consultants to wrap around the hybrid telehealth/in-person models and support patients where they are. Evidence shows that pregnant individuals who received [doula support](#) had lower preterm and cesarean birth rates. For African Americans and Native Americans who are at higher risk of maternal mortality and morbidity, access to a doula and a midwife can be [lifesaving](#). Similarly, people who had [midwife-led models](#) of care were less likely to experience pre-term births and other complications. In addition to increased support for community-based supports, there has been a greater uptake of [childbirth education](#), another evidence-based service which had received inconsistent Medicaid coverage prior to the COVID-19 pandemic.

Despite consistent evidence showing the benefits of integrating midwives and doulas with the maternity care system, midwives and doulas have historically been excluded from [payment and care models](#). With opportunities to move toward a value-based care system that incorporates digital health care, rewards improved health outcomes, and favors team-based care, integrating maternity care providers such as doulas, midwives, and community health workers will be critical, both to expand the maternity care workforce and to reduce health disparities.

Other challenges associated with the expansion of telehealth in maternity care models include: 1) translation to remote maternity care may require changes to benefit design; and 2) clinicians are not uniformly supportive of hybrid remote/in-person maternity models given mixed evidence on the impact of telehealth on maternal health outcomes, quality and cost.

The transition to remote, home-based care has revealed important gaps in benefit design and risk assessment. Implementing remote prenatal visits has led public and private payers to facilitate remote monitoring through the distribution of blood pressure cuffs and scales. However, some plan designs have made acquiring these remote monitoring devices challenging for low-income people in particular as a result of transportation and financial barriers.

In general, obstetric providers were not uniformly supportive of maintaining a heavy emphasis on remote visits in the prenatal care model. Fewer in-person maternal health visits may also have important implications for risk assessment and managing maternal morbidity. As an example, fewer people, including pregnant people, are getting [screened](#) for sexually transmitted infections, increasing the risk of transmitting infections during childbirth. Clinicians also noted weighing the tradeoffs between individualized prenatal care with patient safety, and the challenges of standardization when there are so many visit modalities in a digital health model.

Additionally, clinicians noted that telehealth, while it can be a tool to increase access to maternity services, can also exacerbate pre-existing disparities in access and maternal health outcomes depending on how services are delivered and reimbursed. Limited broadband access, particularly in rural areas, and lower reimbursement for audio-only telehealth visits represent key threats to health equity. Some states allowed audio-only visits to be paid at parity early on in the pandemic but have since shifted to a lower reimbursement for audio relative to video visits given a perceived differential in quality of care. While preferred by clinicians relative to audio-only visits, video care requires a webcam and broadband, or a significant data plan. Low-income, pregnant people are less likely to have access to these resources. For example, even if they have a smartphone, low-income individuals may not have a data plan sufficient for a video visit. Additionally, for some health care organizations, the web-based platform to access video visits is only available in English, limiting access for non-English speakers. Clinicians also noted the challenge of video visits for people with low digital literacy. The lack of equitable access to remote visits could potentially exacerbate health disparities faced by low-income populations and non-English speakers.

Clinicians, payers, and national association representatives all underscored that it is still too early to assess the impact of COVID-era telehealth policy changes on the cost and quality of maternity care. Claims-based research to evaluate the effect of telehealth on maternity care is complicated by global billing and by variation in COVID-era maternity care models. In some state Medicaid programs, low-risk pregnancies are billed under a global fee encompassing prenatal care and delivery (excluding hospital costs), so individual services are not submitted for reimbursement, complicating payers' ability to identify the impact on cost and quality. However, high-risk pregnancies still fall under fee-for-service reimbursement models for many payers. Clinicians remarked that greater variation in practice patterns and billing for high-risk pregnancies during COVID-19 could complicate how payers are interpreting the impact of telehealth on cost and quality for high-risk pregnancies.

Anecdotally, stakeholders noted that the massive expansion of telehealth did not increase costs. Some noted the possibility that the decreased frequency of in-person visits may have reduced the amount of unnecessary, and potentially low-value, care. Clinicians noted these reductions have mostly been related to gynecologic services rather than obstetric services, however. At the same time, some stakeholders expressed concern that patients are avoiding high-value care, such as antenatal immunizations and post-partum well-child visits.

Opportunity to Integrate Telehealth into New Care Models under Value-Based Payment

Most states and payers remarked that some telehealth flexibilities would sunset after the public health emergency, but most expected telehealth and virtual care access to remain an essential part of health care delivery going forward. Medicaid agencies and commercial payers are evaluating which telehealth flexibilities to maintain after the public health emergency ends, largely along the [Quadruple Aim](#) dimensions of cost, quality, access, and patient and clinician satisfaction.

Importantly, maternity care providers will need to determine how telehealth and virtual care can complement traditional in-person prenatal and postpartum visits—how this technology can provide a digital care [model](#). The University of Michigan’s 4:1:4 hybrid prenatal care model provides an early example for how to do this, but the program needs to be evaluated for its impact on cost, quality, access, patient and clinician satisfaction, especially among people of color and with higher-risk pregnancies. Similarly, more research is needed to understand the role of telehealth in reducing or exacerbating [disparities](#), especially in maternity care.

If evidence supports the continuation of these care models, payment models will need to evolve to support the delivery of telehealth and digital care, and policy makers will weigh what is feasible under fee-for-service versus under value-based payment models that allow greater flexibility and more accountability.

Minimizing the Risk of Virus Transmission during Labor and Delivery

Individual health care provider organizations implemented clinical policy and practice changes to help reduce the risk of COVID-19 transmission during labor and delivery. Some provider organizations instituted visitor restrictions that limited the in-person presence of birth partners, including doulas and family members. In addition, clinicians and payers noted changes in delivery preferences. One clinician also noted a marked decrease in postpartum length of stay, which may be attributable to some combination of provider policy and patient preference.

Little is known regarding the pervasiveness of COVID-era provider organization-level policy changes for labor and delivery, or their effects on outcomes. For hospital births, increased labor inductions and increased cesarean deliveries may result in pregnancy complications. These new practice patterns and health behaviors also contradict [core maternity care quality measures](#).

More people are considering [home births](#) to avoid the increased risk of COVID transmission in a hospital, and to avoid the limitations on labor and delivery support. Future empirical research will undoubtedly explore the impact of COVID-era policy changes, including both telehealth expansions and changes to labor and delivery, on maternal and infant health.

Implications: Where We Go From Here

Opportunities for Value-based Payment and Care Reforms

Coverage extensions, workforce changes, and telehealth expansions alone will not be sufficient to improve health outcomes, reduce disparities, and encourage smarter health care spending. Meaningful shifts away from fee-for-service reimbursement will be needed to encourage and sustain care delivery reforms. The shift in maternity care patterns during the pandemic, and the need to chart future policies, present opportunities for additional adaptation and innovation in maternity payment and care models.

Increasingly, Medicaid and commercial payers are moving to alternative payment models such as [episode-based payments](#), which can entail giving providers a lump sum payment for the [total episode of care](#). For example, [Arkansas, Tennessee, and Ohio](#) have adopted bundled payments for perinatal care in their Medicaid programs. Additionally, [United HealthCare](#) has piloted bundled payment within a small number of practices in New Jersey and Texas.

However, several payers noted postponing scheduled transitions to alternative payment models in light of COVID-19. For example, one state Medicaid agency noted they did not receive a budgetary appropriation to implement maternity care bundled payments due to the costs of COVID-19. Similarly, a commercial payer postponed the implementation of a maternity care APM due to the immediate need to address the acute impact of the public health emergency.

At the same time, health care organizations are facing incredible financial stress given their reliance on fee-for-service reimbursement and the dramatic reductions in patient visits during COVID-19, though obstetric providers have been more insulated from these initial shocks.

One way to help advance payment reforms and reduce providers' financial stress in the Medicaid program is to couple Medicaid coverage extensions with up-front financial support to states and providers, along with a tiered approach to advanced payment reform models that both acknowledges states' current financial constraints and helps ensure that coverage extensions translate to meaningful and sustained improvements in care. In exchange for up-front financial support, states can agree to move toward more advanced value-based care reforms with substantial shifts away from fee-for-service models. Commercial payers can adopt a similar tiered model with up-front support for providers. This approach can help providers make incremental changes in care models initially, with a clear commitment to more meaningful changes over time. Evidence suggests that [more advanced payment models lead to more meaningful care reforms](#). Without the requirement to make meaningful progress in payment reforms, it is hard to sustain investments in new care models that produce real improvements in care.

Conclusion

COVID-19 has highlighted challenges in our maternity care system, but it also brought opportunities to redesign maternity care and payment models. We sought to understand the challenges and opportunities associated with reforming maternity care and payment in light of COVID-era policy changes.

While many COVID-era policy changes were not focused on maternity care, efforts to expand access to insurance coverage and access to care had direct implications for pregnant people and their families. In some states, COVID-era extensions in Medicaid coverage may result in more permanent changes in Medicaid coverage for pregnant people. The growth of telehealth and virtual care models fundamentally changed the maternity care model and created greater impetus for expanding the maternity care team to include more community-based supports, such as doulas and community health workers.

Although we do not yet know the long-term impact of COVID-19 and recent policy changes on maternity care costs and outcomes, there is consensus among payers and clinicians on the need to become less reliant on a fee-for-service infrastructure. Coupling coverage extensions in the Medicaid program with opportunities to expand value-based care models represent one opportunity for incentivizing the shift to value-based care.

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For more information about this brief, please contact: Rebecca Whitaker at rebecca.whitaker@duke.edu.