Getting Payment Right: How to Unlock High-Value Care Through Appropriate Birth Center Reimbursement

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Executive Summary

Interest in birth centers is growing rapidly among system stakeholders in response to evidence showing improved outcomes and reduced costs with birth center care. Enhancing access to birth center care is a strategy that could serve multiple policy aims, including addressing health disparities, providing primary maternity care access in maternity care “deserts,” and reducing cesarean and preterm birth rates and costs at the population level. However, as most current payment systems do not align payment with high-value care, inconsistent and inadequate fees and payment systems serve as a barrier to the growth and integration of the birth center model. This report outlines the birth center model of care, provides an in-depth analysis of the birth center payment system, and presents guidance to birth centers, payers/purchasers, and health systems to ensure equitable access to and financial viability of the birth center model.

Part 1 of this report describes the birth center model of care, delineates maternal and newborn services provided in the model, and reviews current payment structures for these services. The identification of problematic and inconsistent practices within the current payment system requires a deeper understanding of the birth center as both a facility and a high-value model of care.

Part 2 of this report identifies and examines the structural challenges presented by the current payment system, and proposes solutions to sustain and grow the birth center model:

**CHALLENGE**: There are no national standards for contracting and coding.

**Solution**: Establish standard facility codes for birth center birth, intrapartum transfer, and newborn care (“Core Birth Center Codes”) and move toward global rates that cover all related facility costs under these codes.

**Rationale**: A standard set of Core Birth Center Codes will simplify contracting processes for payers, increase transparency and simplicity for clients, and establish more predictable revenue and reduce administrative burden for birth centers.

**CHALLENGE**: Contracting requirements are burdensome and costly.

**Solution**: Align contracting requirements with American Association of Birth Centers (AABC) National Standards and remove unnecessary or burdensome contracting rules.

**Rationale**: Contracting requirements do not improve birth center quality of care, and birth center access should not be determined by entities that have a financial incentive to restrict consumer choice. Payers should align with AABC National Standards for evidence-based best practices.

**CHALLENGE**: Facility payments are often tied to state licensure, but not all states license birth centers, and many that do have complex regulations resulting in birth centers operating legally without separate facility licensure.

**Proposed Solution**: Accept Commission for Accreditation of Birth Centers (CABC) accreditation in lieu of state licensure.
Rationale: CABC accreditation enables birth centers to demonstrate to payers their compliance with AABC National Standards and appropriate governance and administration of the facility. These standards are widely recognized by health insurance companies and Medicaid programs as well as other stakeholders.

Solution: Adopt AABC Model Licensing Regulations.

Rationale: States with no licensing regulations for birth centers, as well as those with restrictive or outdated licensing regulations, should seek to align state regulations with the comprehensive and evidence-based AABC National Standards for birth centers.

CHALLENGE: Payments are inequitable and often inadequate to cover costs of midwifery care and facility services.

Solution: Set prices based on the value of the model and ensure they cover costs.

Rationale: Multiple studies have demonstrated that midwife-led care and a birth center option for low-risk birth are associated with lower overall cost of care compared with physician-directed care and universal hospitalization for birth. Payments that are equivalent to or even higher than physician and hospital rates can be justified based on these savings, which are driven by improved outcomes and personalized care and attention.

Solution: Pay for newborn services that may occur in the birth center or at home.

Rationale: Unlike hospitals, birth centers do not receive facility or nursery fees for newborns that are separate from maternal room and board. Facilitating payment for necessary and fundamental newborn services is needed in order to enable appropriate integration and coordination of newborn care in the birth center model.

Solution: Offer enhanced professional payments to midwives providing the birth center model of care, regardless of location of birth.

Rationale: The birth center model still benefits those who ultimately give birth in a hospital, either by choice or clinical circumstances. These benefits are robust and both clinically and economically significant.

Solution: Pay for services provided by educators, birth assistants, doulas, lactation consultants, behavioral health counselors, and care coordinators.

Rationale: Birth center care is often midwife-led, but services include other trained and/or certified professionals to provide perinatal support services. These professionals’ services are integral to the birth center model and should be paid for so the costs are not borne by families.

Solution: Pay for additional and after-hours visits for those who need them.

Rationale: First-line assessment and management in the birth center setting has the potential to avoid emergency department visits, improve continuity and experience of care, and reduce costs.

Solution: Include facility, clinical, and non-clinical services in comprehensive bundles for each phase of care.
Rationale: Bundled payments would enable provision of the birth center model of prenatal and postpartum care to families who deliver in the hospital and have other benefits for community-based outpatient maternity care providers and facilities.

CHALLENGE: Timing of payments is mismatched with the costs of delivering care

Solution: Unbundle prenatal and postpartum care from the global professional fee and redefine comprehensive bundles of services for each phase of care.

Rationale: Payment structure should coincide with when costs are incurred in the birth center model. This would better align payment with the goals of the overall system and provide mobility and coordinated care for people who experience changes in their risk status, preferences, or team composition over the course of their care.

CHALLENGE: Families face high out-of-pocket costs.

Solution: Include birth centers in preferred provider networks.

Rationale: Families should be able prioritize the birth location that best suits them.

Solution: Designate all evidence-based maternity and newborn care as preventive care and not subject to deductible, copayments, or coinsurance.

Rationale: The Affordable Care Act designates a set of preventive care services that are not subject to deductibles, copayments, or coinsurance. While all maternity care is preventive in nature, birth centers and midwifery represent evidence-based preventive care that, under these principles, should not be subject to cost sharing.

Note: The above list of proposed solutions is not exhaustive. Alternative methods to address issues with the current payment system are possible.

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About AABC

The American Association of Birth Centers (AABC) promotes and supports the birth center model as a means to uphold the rights of healthy families, in all communities, to birth their children in an environment that is safe, sensitive, and cost-effective with minimal intervention. For more than 30 years, AABC has served as the nation's most comprehensive birth center resource. AABC educates parents, professionals, and policy makers on the birth center concept, and fosters excellence in birth centers through the development and evaluation of evidence-based standards of care. AABC membership includes birth centers, individuals, and organizations that support the birth center model. Members include certified nurse-midwives (CNMs), certified professional midwives (CPMs), physicians, nurses, and families. Learn more at BirthCenters.org.

About the Author

With a clinical background as a midwife, Amy Romano, MBA, MSN, CNM, FACNM, has spent her career working on maternity care system reform and innovation. Previously she led the development of clinical, wellness, and quality management programs for Baby+Co., a multi-state network of birth centers, and she has published many peer reviewed articles and book chapters on evidence-based maternity care and system transformation. She is Founder and CEO of Primary Maternity Care (www.primarymaternitycare.com), a consulting services company that works across the healthcare system to strengthen community-based maternity services and integrate high-value, team-based models of care.

About This Report

Getting Payment Right: How to Unlock High-Value Care Through Appropriate Birth Center Reimbursement was developed with input from a multi-stakeholder Expert Advisory Panel, who met twice during the project to help shape the report, gave input on the initial draft, and provided introductions to additional subject matter experts for stakeholder interviews. The author and AABC would like to thank the panel members for their valuable input, and the Yellow Chair Foundation for funding this initiative.

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Disclaimer: Prior to publication of the final report, the author sought input from independent clinical, scientific, and policy experts as peer reviewers. However, the conclusions and synthesis of information presented in this report do not necessarily represent the views of the individual peer reviewers or their organizational affiliation(s).

Photos courtesy of Dar a Luz Birth & Health Center (cover) and Premier Birth Center (p.7), Seasons Midwifery & Birth Center (p.11, 21, + 27), and Women’s Birth & Wellness Center (p.26)
Part 1: Background

Birth Centers: An underutilized high-value care model

In 2018, the Center for Medicare and Medicaid Innovations concluded a large, rigorous, national study of three different models of care involving over 45,000 pregnant participants. The study showed that care in midwife-led birth centers led to reductions in preterm birth, low birthweight, and cesarean birth; better patient experiences; fewer racial disparities in outcomes; and a 21% reduction in childbirth costs compared with other Medicaid participants with similar characteristics. Despite these outcomes and many previous studies with similar results, that year only 0.5% of births took place in birth centers and only 9% of births were attended by midwives.

Although not all people are eligible for or interested in birth centers, there is evidence of a large gap between demand and utilization. Among a state-wide sample of new mothers who had recently had hospital births in California in 2018, 40% reported being open to or definitely interested in the birth center model. Participants cited lack of availability or high out-of-pocket costs as reasons they did not use a birth center in their recent births.

Although the number of birth centers has doubled over the last decade, they remain both scarce overall and geographically clustered, with more than half of birth centers in just 4 states—California, Florida, Texas, and Washington, which comprise 29% of the population but have 52% of birth centers. Eleven states have no birth centers at all. The complex and highly variable regulatory environment for birth centers explains much of this variation.

Many birth centers are not financially sustainable and are vulnerable to closure, and new investment in birth centers will be stifled until the payment landscape shifts.

In 2020, families expecting babies during the COVID-19 pandemic navigated a new world where many hospitals had policies that limited visitation and labor support, and that led to a higher chance of mothers being separated from their newborns. Many looked for alternatives to hospital-based delivery services. As a result, communities around the country saw surges in demand for both birth centers and home birth providers. This precipitous increase in demand highlighted the dire lack of access to midwifery-led care and safe, affordable community-based birthing options that are integrated into the broader healthcare system.

This report will demonstrate—and other authors have shown—that the complex contracting environment for birth centers, including the lack of billing and coding standards, creates potent barriers to entry for new centers, while the low reimbursements for services and high fixed costs threaten long-term financial viability of the centers that do exist. Many birth centers are not financially sustainable...
and are vulnerable to closure, and new investment in birth centers will be stifled until the payment landscape shifts.

New payment approaches are needed in order to fill critical access gaps and enable broader utilization of a model of care that improves outcomes, reduces overall costs, and is associated with high satisfaction. This report details key structural challenges related to birth center payment and proposes solutions and standards that will enable sustainable contracting in the short term while paving the way for more participation of birth centers and midwives in emerging value-based payment models.

**What is a birth center?**

A birth center is both a type of facility and a model of care, and understanding how to structure payment requires understanding both. As a place of service, a birth center is defined by federal statute as “a facility, other than a hospital’s maternity facilities or a physician’s office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.”

Birth centers are outpatient settings limited to low-risk childbirth. They typically have 2-4 birthing suites and assist with fewer than 500 births per year, with many birth centers, especially those that are new or in rural areas, having fewer than 150 births per year.

Birthing suites are designed for mobility, comfort, family involvement, and active labor support and are equipped for first-line clinical care and emergency response. They are typically larger than hospital inpatient rooms and are appointed with beds generous enough to accommodate support people, a hydrotherapy tub, and a private bathroom with shower. Once admitted, the family normally spends the entire labor, birth, and postpartum recovery period in the same suite.

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**A birth center is both a type of facility and a model of care, and understanding how to structure payment requires understanding both.**

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In addition to the birthing suites, the facilities feature clinic rooms equipped for basic gynecological and primary care, classrooms, common spaces for families, a limited laboratory, and clinical supply and laundry areas. There are no surgical suites or anesthesia capabilities, although both nitrous oxide (an inhalable anti-anxiety medication) and local anesthetics (for routine laceration repair) may be present. Table 1 lists features and equipment in birth centers.
Birth centers may be co-located with or situated near other outpatient services including general or high-risk obstetrics and gynecology, reproductive health, pediatrics, family health, and/or alternative and complementary providers. Some birth centers are attached to a hospital but remain separate from general labor and delivery services. This type of birth center is known as an alongside midwifery unit (AMU). Most birth centers, however, are freestanding and not on hospital grounds. This report focuses on freestanding birth centers (FSBCs), because the payment considerations are different and more complex for this type of center. In addition, structuring payment for FSBCs is crucial for addressing the growing problem of maternity care deserts and is a key solution for communities, especially in rural areas, that cannot sustain hospital-based maternity services.19

TABLE 1: Selected Features of Birth Center Facilities and Equipment

<table>
<thead>
<tr>
<th>GENERALLY PRESENT</th>
<th>OFTEN PRESENT</th>
<th>GENERICLY ABSENT (requires hospital transfer)</th>
</tr>
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<tbody>
<tr>
<td>• 2-4 private birthing suites with space to accommodate labor support companions and a private full bathroom*</td>
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<tr>
<td>• Large tub(s) for hydrotherapy and water birth</td>
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<tr>
<td>• Props and tools for mobility and comfort</td>
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<tr>
<td>• Maternal and neonatal emergency kits, medications, and transport protocols*</td>
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</tr>
<tr>
<td>• Co-located midwifery or multi-specialty clinic</td>
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<tr>
<td>• Client and family waiting and nourishment areas*</td>
<td></td>
<td></td>
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<tr>
<td>• CLIA-certified laboratory for microscopy and/or point-of-care testing*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Designated areas for clinical supplies and clean and soiled laundry*</td>
<td>• Nitrous oxide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Injectable or intravenous medications for pain relief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ultrasound capabilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Classroom(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Capabilities to perform cesarean or operative vaginal births†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Anesthesia capabilities other than local anesthesia for routine laceration repair†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continuous fetal monitoring in the birthing suite†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(intermittent auscultation is used for fetal assessment)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Separate newborn nursery†</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Advanced imaging, laboratory, or blood bank</td>
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</tbody>
</table>

* The Commission for the Accreditation of Birth Centers (CABC) requires these attributes for accreditation.20
† CABC forbids these services/equipment in accredited birth centers.
What is the birth center model of care?

While the birth center is a facility for low-risk birth and associated outpatient services, the birth center model is the program of care that extends across the preconception, prenatal, labor, birth, postpartum, and newborn periods. This program comprises comprehensive primary maternity care for low-risk pregnancy and birth, includes both clinical and non-clinical components, and is rooted in a midwifery philosophy of care. Table 2 lists the services included in the model.

The midwifery philosophy views pregnancy, birth, and lactation as normal parts of a person's life, fundamentally healthy processes, and sensitive periods connected to the lifelong health of the newborn, birthing person, and family. Professional standards of midwifery value autonomy, empowerment, education, relationship-based care, prevention and health promotion, shared decision making, family involvement, community-based access, culturally aligned care, interdisciplinary collaboration, and support for physiologic labor, birth, and postpartum/newborn transition.

Midwifery care is relationship-based and education-intensive. Midwifery prenatal visits in birth centers typically last at least 30 minutes, providing time for individualized education and care planning; engagement of the client's partner, family members, or support people; and relationship- and trust-building. Birth centers also provide supplemental classes and programs to prepare clients for unmedicated labor and birth (without medications for anesthesia or to speed up labor), lactation, and newborn care.

Although as a birth facility it may serve only low-risk clients at the time of delivery, the birth center may also be a location for outpatient maternity care for a mixed-risk population, all of whom benefit from the midwifery model of care.

Although physicians work in, direct, or own some birth centers, the typical birth center model involves having all or the majority of clinical care provided by a midwife or small team of midwives. Birth center midwives use established eligibility criteria and scope of practice guidelines to determine when physician consultation and/or hospital birth are warranted, and coordinate this care when needed. People who remain healthy throughout pregnancy, meet eligibility requirements, and desire a birth without anesthesia medications may give birth at the birth center.

Birth center accreditation standards require written plans for transfer to a hospital for a higher level of care when appropriate, including planning for emergency transport, which is required in approximately 1-2% of birth center births. Birth centers collaborate with hospitals to support smooth transitions and continuity of care, and in some cases the birth center midwife continues care at the hospital.

Birth center midwives, in collaboration with physicians, may also provide care to people with moderate risk factors (e.g., late preterm birth or gestational hypertension) having planned hospital births. Thus,
although as a birth facility it may serve only low-risk clients at the time of delivery, the birth center may also be a location for outpatient maternity care for a mixed risk population, all of whom benefit from the midwifery model of prenatal and postpartum/newborn care.

**TABLE 2: Maternity Services Included in the Birth Center Model**

*Note: Services in **bold** are uncommon in physician-led/hospital-based models of care and represent points of differentiation for birth centers.*

<table>
<thead>
<tr>
<th>PRENATAL</th>
<th>LABOR &amp; BIRTH</th>
<th>POSTPARTUM &amp; NEWBORN</th>
</tr>
</thead>
<tbody>
<tr>
<td>10+ prenatal visits, <strong>30-60 minutes</strong> each (90-120 min group visit option is common). Relationship-based care with an individual or small team of midwives. Risk screening and coordination of necessary social, behavioral, clinical, or mental health services. Routine and indicated labs, typically including a comprehensive prenatal panel, genetic testing based on risks and preferences, third trimester blood work, and infection screening. Birth centers have a limited point-of-care lab and send most specimens to third party labs. Routine and indicated imaging, typically including 1 comprehensive and 1-3 limited ultrasound scans in a low-risk pregnancy. Birth centers may perform ultrasounds in-house, or refer out. <strong>Comprehensive pregnancy, childbirth, and postpartum/parenting education classes or programs.</strong> May be offered in-house or referred to community educators, but generally required for birth center birth. 24/7 access to a midwife and consulting physician including assessment and management at the birth center for limited urgent care needs.</td>
<td>Telephone triage and early labor encounter(s) for maternal and fetal assessment. Use of a spacious birthing suite designed for mobility and comfort. <strong>Continuous midwifery care</strong> in active labor, birth, and early postpartum/newborn period. Presence of an additional skilled provider (RN, additional midwife, or specially trained/certified birth assistant) during active labor, birth, postpartum. <strong>Hydrotherapy</strong> Nitrous oxide Administration of antibiotics and first-line medications for common complaints. Initial management, stabilization, and coordination of transport for emergencies, e.g., resuscitation, hemorrhage protocol. Risk screening throughout labor and birth and <strong>coordination of transport and transfer of care</strong> when higher level of care is needed. <strong>Short stay</strong> in the birthing suite (typically 6-12 hours, up to 24). Postpartum routine care including suturing of lacerations. Newborn exam and routine medications. <strong>Comprehensive pre-discharge education and lactation support.</strong></td>
<td>24/7 access to a midwife and consulting physician including assessment and management at the birth center or at home for limited urgent care needs for the mother or newborn. <strong>Home visit</strong> on day 1 postpartum for mother/baby assessment, newborn screening tests, and coordination of follow-up care. 1 or more additional postpartum office or home visits including family planning counseling, lactation support, and mental health screening and referral. Ongoing gynecological, family planning, lactation, and primary care after the initial 6-8 week postpartum period. Risk screening throughout postpartum/newborn period and coordination of necessary social, behavioral, mental health, and clinical services.</td>
</tr>
</tbody>
</table>
Existing payment models for birth centers

There is substantial variation across insurance contracts in how and how much birth centers are paid. There is also variation in the structure and staffing of birth centers that may affect payment. For the purposes of this paper, we will consider a birth center that employs the midwifery-led team and bills for prenatal, intrapartum, and postpartum/newborn services as well as gynecological and primary care for non-pregnant clients.

Although maternity care experts have for years advocated to align payment with high-value care, most current payment systems that are described as “value-based” contain only small payment incentives tied to routine aspects of care, such as diabetes screening, depression screening, and postpartum visit attendance. More robust and comprehensive reforms and bundled payment models have begun to emerge, but most birth centers have not had an opportunity to participate in these new models. As a result, birth centers rely on traditional fee-for-service payment and other sources of revenue, as described in Table 3.
TABLE 3: Current Forms of Insurance Reimbursement for Birth Center Care*

<table>
<thead>
<tr>
<th>ROUTINE PRENATAL/ POSTPARTUM CARE</th>
<th>AFTER-HOURS MATERNITY URGENT CARE</th>
<th>BIRTH CENTER LABOR AND BIRTH</th>
<th>BIRTH CENTER LABOR, HOSPITAL BIRTH</th>
<th>EARLY NEWBORN CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global professional fee</td>
<td>Visits and care coordination</td>
<td>Midwifery care in labor and birth</td>
<td>Midwifery care in labor and birth, coordination of transport, and ongoing hospital-based care, when applicable</td>
<td></td>
</tr>
<tr>
<td>Other fee-for-service</td>
<td>Non-stress tests, point of care ultrasound, certain labs, counseling/lactation</td>
<td>Problem visits; non-stress tests, point of care ultrasound, certain labs, counseling/lactation</td>
<td>May include hydrotherapy, nitrous oxide, nursing services</td>
<td>May include initial stabilization and routine care, newborn physical exam, medications, tests, home visit, lactation support</td>
</tr>
<tr>
<td>Facility fee(s)</td>
<td></td>
<td>Birth assistant; use and cleaning of birthing suite, supplies, and equipment; other services depending on facility contract</td>
<td>Birth assistant; Use and cleaning of birthing suite, supplies, and equipment; other services depending on facility contract</td>
<td>May include initial stabilization and routine care, newborn physical exam, medications, tests, home visit, lactation support</td>
</tr>
<tr>
<td>Billed by third parties</td>
<td>All referred services, including labs, physician consults, fetal testing</td>
<td>Referred labs</td>
<td>Referred labs (e.g., newborn/cord blood type and direct Coombs)</td>
<td>Ambulance service when applicable; hospital and hospital-based professional services</td>
</tr>
</tbody>
</table>

* Due to broad variation in contracting, individual birth centers or payers may have different approaches.
Part 2: Structural Challenges and Proposed Solutions to Enable Appropriate Birth Center Payment

Introduction

Part 1 of this report describes the birth center model of care, delineates maternal and newborn services provided in the model, and reviews current payment structures for these services. Although birth centers are a high-value, evidence-based model of care associated with high satisfaction\(^1\), utilization of the model is extremely low.\(^{13}\) Although the payment system is not the only factor influencing development and utilization of birth centers—other factors include patient preferences and knowledge, regulatory and licensing barriers, and workforce issues—the system of financing care by midwives in birth centers has been identified by many organizations and stakeholders as a key barrier to growth and integration of the model.\(^{14,22-28}\)

Part 2 will examine the structural challenges presented by the current payment system and propose solutions that can unlock high-value care and sustain and grow an evidence-based, in-demand model of care. The challenges addressed in this report are listed in Table 4, below.

### TABLE 4: Structural Challenges Impacting Birth Center Payment and Financial Viability

<table>
<thead>
<tr>
<th>CHALLENGE</th>
<th>Page</th>
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<tbody>
<tr>
<td>There are no national standards for contracting and coding.</td>
<td>14</td>
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<tr>
<td>Contracting requirements are burdensome and costly.</td>
<td>17</td>
</tr>
<tr>
<td>Facility payments are often tied to state licensure, but not all states license birth centers, and many that do have complex regulations resulting in birth centers operating legally without separate facility licensure.</td>
<td>18</td>
</tr>
<tr>
<td>Payments are inequitable and often inadequate to cover costs of midwifery care and facility services.</td>
<td>20</td>
</tr>
<tr>
<td>Timing of payments is mismatched with the costs of delivering care.</td>
<td>27</td>
</tr>
<tr>
<td>Families face high out-of-pocket costs.</td>
<td>28</td>
</tr>
</tbody>
</table>
Challenge: There are no national standards for contracting and coding.

For the 98% of births that occur in hospitals, there are existing systems and structures for calculating and paying facility costs, which include room and board, nursing care, and supplies. These systems are highly complex but standardized, and have resulted in approximately 60 cents of every dollar spent on maternity care paying for hospital facility services.29 For instance, many hospitals will receive payments based on Diagnosis Related Groups (DRGs), a set of codes that correspond to services and supplies provided by the facility for each type of hospitalization that results in a 50% increase in payments for cesarean versus vaginal birth, as well as higher payments for births that involve complications or where the infant uses the neonatal intensive care unit.30

Sixty cents of every dollar spent on maternity care pays for hospital facility services.29

The Affordable Care Act clarified that payment for birth center facility services is distinct from and additional to payment for labor and birth professional services. However, DRGs and other hospital coding systems are specifically not applicable to outpatient facilities such as birth centers, and although there are some revenue and facility codes designated for birth centers, no national standards exist for how those codes are used and they do not cover the full range of services offered in birth centers.

In the absence of a standard set, birth centers have been left to independently select codes that work for them or use what each health plan will accept. Sometimes this varies with each payer, meaning one birth center could be forced to use different codes for the same service depending upon the payer, if they wish to be contracted and paid. This results in widespread variation (see Table 5) and complex administration of birth center billing. Workflows to support such complex billing are not well supported by outpatient practice management software and often require birth centers to hire specialists to handle claims.

There is also marked variation in how charges are submitted and paid when a birth center admission results in a transfer and hospital birth. These births often consume significant birth center resources, as the majority of intrapartum transfers relate to prolonged labor, maternal exhaustion, or need for additional pain management.21 Some birth centers have negotiated a single facility fee for all labors, regardless of where the birth actually occurs. Other contracts prorate fees based on time spent in the birth center, and many birth centers report receiving no facility payment at all when transfer to the hospital occurs, despite the fact that the birth center incurred costs prior to transfer.

In part because of this complexity, many birth centers opt not to contract with insurers for facility and/or professional reimbursement at all, offering self-pay bundled prices and various payment plans directly to consumers instead. Although some families may submit qualified expenses for out-of-network reimbursement and/or use tax-advantaged savings funds to pay for care, this drives up the average out-of-pocket cost for birth center care and makes it inaccessible to low-income individuals.
### TABLE 5: Variations in Birth Center Contracting and Recommended Best Practices

<table>
<thead>
<tr>
<th>TYPE OF CONTRACTING VARIATION</th>
<th>BEST PRACTICE*</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“All in” vs. “all separate” facility codes. Some birth centers bill fewer codes and include more services in each code (“all in”) while others bill more codes and include fewer items in each code (“all separate”).</td>
<td>AABC recommends birth centers shift to “all in” billing if adequate rates can be established for Core Birth Center Codes. See example “all in” contracting scenario, using the recommended Core Birth Center Codes in Table 6.</td>
<td>Birth centers have developed separate codes generally as a response to inadequate rates for the overall facility cost. This increases complexity of coding and billing, driving up inefficiencies and in many cases out-of-pocket costs.</td>
</tr>
<tr>
<td>Newborn facility fees included in maternal payment vs. billed separately.</td>
<td>Newborn facility fees should be separate from maternal facility fees.</td>
<td>The newborn is a second patient who is utilizing the birth center facility. Newborns may be insured on a different plan; separate charges allow each plan to pay for facility services for their insured. Combining maternal and newborn facility rates falsely inflates birth center costs when compared to hospital rates because hospitals generally do not combine nursery charges with maternal room and board.</td>
</tr>
<tr>
<td>Coverage for labor care not resulting in a birth (intrapartum transfer or discharged home not in active labor).</td>
<td>Utilize S4005 code and set rate equivalent to facility rate for births occurring in the center.</td>
<td>Births and intrapartum transfers require similar facility resources, including staffing and use and sanitation of birthing suite, equipment, and supplies. Contract structures that disincentivize clinically appropriate transfers should be avoided.</td>
</tr>
</tbody>
</table>

*AABC recommends these best practices based on input from the Expert Advisory Panel and other stakeholders. However, these experts acknowledge that many birth center contracts are priced inadequately for the recommended Core Birth Center Codes, and the cost of care is covered via reimbursement for additional codes, including but not limited to incremental nursing care (023x series); medical/surgical supplies and devices (027x series); and room and board (012x series). Payers should continue to reimburse these codes until such time that a global case rate is negotiated for an adequate amount using the Core Birth Center Codes.*
**SOLUTION:** Establish standard facility codes for birth center birth, intrapartum transfer, and newborn care ("Core Birth Center Codes") and move toward global rates that cover all related facility costs under these codes.

Reducing the complexity and variation in birth center coding and moving toward a standard set of Core Birth Center Codes has many potential benefits. These benefits include:

- **Easier contracting process for birth center and payer.** Once claims systems are set up to process standard birth center codes, payers will not need to operationalize each unique birth center contract into their claims systems.
- Less need for birth centers to use specialized systems and consultants for coding and billing
- Fewer claims denials and resubmissions
- Increased transparency and simplicity for clients, enabling them to predict their out-of-pocket costs
- More stable payment for birth centers, ability to predict revenue based on volumes
- Ability to reliably identify birth center admissions and births in administrative data

AABC recommends a transition to the highlighted revenue and CPT/HCPCS codes when billing facility charges for births and intrapartum transfers, ensuring that no existing birth centers are forced to quickly change their billing processes.

### TABLE 6: Core Birth Center Codes

<table>
<thead>
<tr>
<th>REVENUE CODE</th>
<th>PROCEDURE CODE (CPT/HCPCS)</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0724</td>
<td>59409</td>
<td>Birth Center Revenue Code for vaginal birth. Use this code to indicate use of the facility for labor, delivery, and postpartum (maternal) care.</td>
</tr>
<tr>
<td>0724</td>
<td>S4005</td>
<td>Interim Labor Facility Global – labor occurring but not resulting in birth. Use this code to indicate someone used the facility but did not birth during the admission, e.g., intrapartum transfer or discharged home not in labor.</td>
</tr>
<tr>
<td>0724*</td>
<td>99463**</td>
<td>Birth center facility code for newborn use of facility. Use this code for a baby born in the birth center facility.</td>
</tr>
</tbody>
</table>

* Some contracts use 0170 or 0179, which are inpatient codes for "nursery" services, and some health plans may prefer these codes. Birth centers are prohibited from having a separate nursery in their facility, so code 0724 more appropriately reflects the revenue code of the facility. ** 99463 is appropriate if the newborn is born and discharged on the same day; 99460 should be used if born and discharged on different days.

Challenge: Contracting requirements are burdensome and costly.

Birth center facility contracts frequently include documentation or reporting requirements that pose significant barriers, especially for new birth centers that are in the development phase. These start-up centers may need contracts in place to finance development of the birth center and to invest in compliance and quality management systems. In addition, the requirements often exceed those imposed by birth center accreditation or state licensure, creating burdensome and costly compliance barriers and giving hospitals and physicians undue control over the birth center model, which is midwifery-led and encompasses care that is within the independent scope of midwives.27

Examples of contracting rules that can be problematic for birth centers include requirements for signed transfer agreements with hospitals and transport teams, and signed collaboration or supervision agreements with physicians. It is an AABC National Standard for birth centers to have written plans for consultation, collaboration, transfer, and referral, and to maintain robust continuous quality improvement efforts focused on transfer and emergency transport.31 However, there are myriad reasons why it can be difficult to obtain signed contracts, especially for new or independently owned birth centers. Physicians, hospitals, and emergency transport providers may have concerns about liability, want to negotiate payment, or lack bandwidth to engage in collaboration and joint quality management.

In addition, requiring signed agreements gives de facto control of birth centers to hospitals and physicians, who have potent financial incentive to maximize hospital births and physician care. Such requirements thus serve as an anti-competitive barrier to entry, restricting choice for consumers and reducing access to an evidence-based model of care.

SOLUTION: Align contracting requirements with national AABC Standards for Birth Centers and remove unnecessary or burdensome contracting rules.

Payers should eliminate contracting requirements or waive them for birth centers that achieve and maintain accreditation from the Commission for Accreditation of Birth Centers (CABC), including centers that are in the pre-accreditation process. CABC provides support, education, and accreditation to developing and established freestanding birth centers. Although independent from AABC, CABC has developed and maintains performance indicators for all of the national Standards for Birth Centers established by AABC. These standards are comprehensive and are widely recognized by health insurance companies and Medicaid programs, a growing number of state licensure bodies, liability insurance underwriters, and by maternity care professional organizations, including the American College of Obstetricians and Gynecologists, the Society for Maternal Medicine, and the American Hospital Association.32

Although independent from AABC, CABC has developed and maintains performance indicators for all of the national Standards for Birth Centers established by AABC.
Challenge: Facility payments are often tied to state licensure, but not all states license birth centers, and many that do have complex regulations resulting in birth centers operating legally without separate facility licensure.

Each state has a different approach to birth center licensing, including 10 states that do not license birth centers at all and many states that have complex and burdensome birth center regulations that result in few or no licensed birth centers. In some of these states, however, birth centers may operate without a facility license. Licensing requirements may be waived for small birth centers, as is the case in Utah. Regulations may also allow midwives or physicians to operate birth centers under their professional licenses, as in California or, under recently established midwifery birth center regulations, New York. Birth centers also exist in states that don’t license them, such as Michigan, North Carolina, and Idaho.

Although there are legal mechanisms for these unlicensed birth centers to exist, health plans often require facility licensure to approve facility payments. Unlicensed birth centers thus cannot access payment to cover the fixed costs of offering and maintaining a facility equipped and staffed for low-risk birth and first-line management of obstetric and neonatal emergencies.

This structural challenge has resulted in a flourishing of birth centers in communities that can sustain a cash-pay model, where clients opt out of using their insurance altogether or must pay for the full cost of care up front and have their claim submitted after the birth. This creates obvious inequities in access to the birth center model of care, and places financial risk on families rather than health plans or birth centers.

In addition, lack of licensure means there is no state oversight of facility safety or compliance with birth center standards.

SOLUTION: Accept CABC Accreditation in Lieu of Licensure.

Many commercial health plans and two state Medicaid programs (North Carolina and Louisiana) formally recognize CABC accreditation for the purposes of facility payment where there is no state mechanism for birth center licensure. This enables birth centers to demonstrate to payers their compliance with AABC National Standards and appropriate governance and administration of the facility.

Where birth centers exist and are not licensed as facilities, or where they operate on a physician or midwife’s license, CABC-accredited centers should be eligible for separate facility payment and/or enhanced professional payment sufficient to cover the cost of the facility.

As discussed above, CABC has developed and maintains performance indicators for AABC National Standards for Birth Centers, and is the accreditation standard most broadly recognized by policy makers, payers, and professional organizations. Table 7 details the benefits of CABC accreditation versus licensure for establishing and maintaining quality and providing more equitable access.
### TABLE 7: Comparison of Birth Center Accreditation and Licensure for Facility Recognition in Payment Contracts

<table>
<thead>
<tr>
<th>CABC ACCREDITATION</th>
<th>STATE LICENSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently applied in all states</td>
<td>Different in every state, including 10 states with no licensing mechanism.</td>
</tr>
<tr>
<td>Aligned with AABC National Standards&lt;sup&gt;31&lt;/sup&gt;</td>
<td>May or may not be aligned with AABC National Standards or best practices.</td>
</tr>
<tr>
<td>Continuously updated based on multi-disciplinary review of new evidence</td>
<td>Not frequently updated. Many states' regulations are decades old.</td>
</tr>
<tr>
<td>Birth center-specific</td>
<td>May include requirements intended for more complex facilities or for hospitals, including highly restrictive Certificate of Need requirements.</td>
</tr>
<tr>
<td>Comprehensive, addressing:</td>
<td>May focus narrowly on the physical plant, infection control, and personnel practices with insufficient attention to emergency preparedness, quality of care, or compliance with clinical standards.</td>
</tr>
<tr>
<td>● philosophy and scope of service</td>
<td></td>
</tr>
<tr>
<td>● planning, governance, and administration</td>
<td></td>
</tr>
<tr>
<td>● human resources</td>
<td></td>
</tr>
<tr>
<td>● facility, equipment, and supplies</td>
<td></td>
</tr>
<tr>
<td>● the health record</td>
<td></td>
</tr>
<tr>
<td>● research</td>
<td></td>
</tr>
<tr>
<td>● quality evaluation and improvement</td>
<td></td>
</tr>
</tbody>
</table>

**SOLUTION:** Adopt AABC Model Licensing Regulations.

States that have restrictive or outdated regulations or that do not yet license birth centers should utilize AABC's Toolkit for Best Practices in Birth Center Regulations to introduce state licensing that aligns with evidence and birth center best practices.<sup>15</sup> The toolkit includes draft regulations that were developed with multi-stakeholder input, along with educational materials to understand controversies and best practices in designing effective regulations. The toolkit can be accessed on the AABC website at [BirthCenters.org/regstoolkit](http://BirthCenters.org/regstoolkit).
**Challenge: Payments are inequitable and often inadequate to cover costs of midwifery care and facility services.**

Although midwives and birth centers provide many of the same services as physicians and hospitals, and although research shows paying for midwives and birth centers reduces overall care and saves the system money, physicians and hospitals are paid at higher rates.

While Medicare rules have established since 2011 that certified nurse midwives (CNMs) should be paid at the same rate as physicians for the same services, many commercial plans and Medicaid programs have not adopted payment parity and still reduce CNM fees by a percentage of the physician fee schedule. Similar or sometimes larger reductions are applied to other types of licensed midwives, including Certified Professional Midwives (CPMs) and Certified Midwives.

For the facility, birth center payment tends to be low overall and, because different plans use different methods to calculate facility rates, payments vary considerably. For example, an analysis of pricing methods in state Medicaid programs detected 3.5-fold pricing variation across a sample of just three states with known Medicaid facility fees that responded to the survey. As with professional services, there is a considerable payment disparity between Medicaid and private plans, with Medicaid reimbursement to birth centers less than half that paid by private insurers.

Low facility reimbursement rates and wide variability are artifacts of the lack of a DRG-like process for establishing prices and corresponding services. As a result, there are no clear industry standards for how much a birth center birth should cost, or which fee schedules to reference when determining prices. Some health plans have even indexed birth center facility prices using physician professional fee schedules for vaginal birth. This is like equating the cost for a physician to enter a room and deliver a baby with the cost of building, equipping, and maintaining that room and providing the nurse and support staff. Not surprisingly, this method results in woefully inadequate prices for birth center services.

Nonpayment is also a serious challenge. Traditionally, birth centers have used revenue from birth-related facility fees or other service lines to pay for uncompensated but fundamental aspects of the birth center model in all phases of care. Table 8 lists some of the high-value, integrated components of the birth center model that are frequently uncompensated, or that are presumed to be included in the facility fee but not accounted for when setting facility rates. Professional and facility fees recouped from each enrolled client are often inadequate to cover these additional services. Costs are frequently passed along to clients, who pay out of pocket for non-covered services.
TABLE 8: Fundamental and High-Value Components of the Birth Center Model That Are Frequently Uncompensated*

<table>
<thead>
<tr>
<th>PRENATAL</th>
<th>LABOR AND BIRTH</th>
<th>POSTPARTUM AND NEWBORN</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Extended visit length (30-60 min or 90-120 min group visit option vs. 10-15 min in typical practices)</td>
<td>- Continuous labor support from a midwife and/or birth assistant</td>
<td>- Newborn screening tests</td>
</tr>
<tr>
<td>- Comprehensive education and wellness programs</td>
<td>- Doula support for those who need or desire it</td>
<td>- Comprehensive education, lactation, and wellness programs</td>
</tr>
<tr>
<td>- After-hours urgent care visits</td>
<td>- Use of the birthing suite prior to transfer for hospital birth</td>
<td>- Home visit(s)</td>
</tr>
<tr>
<td>- Point-of-care ultrasound</td>
<td>- Birth center accreditation and quality management programs</td>
<td>- After-hours urgent care visits</td>
</tr>
<tr>
<td>- Services by non-providers (nurses, doulas, peer support)</td>
<td>- Point-of-care ultrasound</td>
<td>- Point-of-care ultrasound</td>
</tr>
<tr>
<td>- Additional clinic or home visits for those who need them</td>
<td>- Use of nitrous oxide</td>
<td>- Services by non-providers (nurses, doulas, peer support)</td>
</tr>
<tr>
<td>- Phone calls, secure messaging, or telehealth encounters</td>
<td>- Use and sanitation of hydrotherapy tub</td>
<td>- Additional clinic or home visits for those who need them</td>
</tr>
<tr>
<td></td>
<td>- Immediate newborn care during birth center stay</td>
<td>- Phone calls, secure messaging, or telehealth encounters</td>
</tr>
</tbody>
</table>

* Note that some birth centers or midwifery practices have successfully negotiated contracts that allow for reimbursement of some of the listed services. However, these services remain uncompensated or undercompensated for many birth centers.

Although inadequate reimbursement rates and nonpayment problems exist in the private market as well, these issues are particularly acute with Medicaid. Medicaid professional reimbursement for maternity care is low across all providers, and is typically subsidized at the group level by substantially higher commercial reimbursements and other billable or cash-pay services. At this time, Medicaid facility rates in most states are generally inadequate, and birth centers often lose money when they serve Medicaid-insured people.23, 26 Although the Strong Start study demonstrates clear benefits of the birth center model for Medicaid beneficiaries, payment disparities, along with complex Medicaid contracting rules, discourage centers from accepting Medicaid, or lead to centers capping their Medicaid caseload. These inequities also prevent development of new birth centers in communities with high rates of Medicaid insurance, such as rural areas and low-income neighborhoods, disproportionately impacting Black, Indigenous, Latinx and other people of color.19, 26, 33
SOLUTION: Set prices based on the value of the model and ensure they cover costs.

Multiple studies have demonstrated that midwife-led care and a birth center option for low-risk birth are associated with lower overall cost of care compared with physician-directed care and universal hospitalization for birth.\(^1\)\(^,\)\(^2\)\(^6\)\(^,\)\(^34\)-\(^36\) The lower costs are driven primarily by better outcomes and decreased length of stay. For example, regardless of whether the birth occurred in the birth center or hospital, participants in the federal Strong Start study who enrolled in the birth center program had fewer cesareans, preterm births, and infant hospitalizations than similar Medicaid-insured individuals in typical care.\(^1\) Also, the birth center model includes home-based postpartum dyad (mother/baby) care after the initial 6-12 hours, whereas hospital postpartum stay is generally 24-48 hours for a vaginal birth and about twice that for a cesarean birth.

Regardless of whether the birth occurred in the birth center or hospital, participants in the federal Strong Start study who enrolled in the birth center program had **fewer cesareans, preterm births, and infant hospitalizations** than similar Medicaid-insured individuals in typical care.\(^1\)

The midwife-led birth center model also involves lower utilization of tests, procedures, and medications that can drive up the cost of care. Midwives tend to prioritize shared decision making, thus recommendations for tests and treatments are individualized rather than routine. In addition, midwives tend to recommend self-care and non-pharmacologic strategies as the first line for common complaints before recommending medical management. In labor and birth, the approach to care supports physiologic labor progress and non-pharmacologic pain management. As a result, midwifery-led care and birth center birth may result in specific savings such as reductions in:

- out-of-network or specialty lab studies, including unnecessary genetic testing
- non-medically necessary ultrasound
- non-medically indicated progesterone treatments
- medical treatment for nausea and vomiting
- labor induction and augmentation
- analgesia, anesthesia, and other labor and birth medications

**Payments that are equivalent to or even higher than physician and hospital rates can be justified based on these savings, which are driven by improved outcomes and personalized care and attention.** Health plans that continue to pay lower fees to midwives should follow the lead of Medicare and the majority of state Medicaid agencies and ensure payment parity between midwives and physicians who bill for the same services.

Some argue that hospitals should be paid a premium due to their high fixed costs. Although birth centers do not have some of the fixed costs that hospitals have, such as maintaining operating rooms,
anesthesia, and specialist services, the birth center model of care is time- and resource-intensive and the focus on maternity and limited primary care means fixed costs cannot be spread across multiple patient populations and service lines the way they can in a hospital.

An adequate payment for birth center services will depend on factors including birth center volume/community size, local rents and salaries, and payer mix, as well as the specific services that are intended to be covered by each code or bundle. Table 9 presents sample expenses to show costs of operating a hypothetical birth center at different volume levels. As the table demonstrates, most of the costs are fixed, so per-birth expenses will be high in lower volume centers. For a center to remain viable, these costs must be covered through maternity reimbursement, recouped through other billable and cash-pay service lines, or supported by public or private grants or start-up investors.

Photo credit: Monet Nicole
TABLE 9: Sample Annual Expenses for a Freestanding Birth Center*

<table>
<thead>
<tr>
<th>Expense</th>
<th>Sample Amount at 100 births/year</th>
<th>Sample amount at 300 births/year</th>
<th>Includes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel - Midwives</td>
<td>$450,000</td>
<td>$700,000</td>
<td>Team of midwives to cover the 24/7 call schedule; provide associated prenatal, postpartum, and primary care; and participate in practice management, community engagement, and quality improvement initiatives</td>
</tr>
<tr>
<td>Personnel - Other Clinical</td>
<td>$150,000</td>
<td>$500,000</td>
<td>Birth assistants (Registered Nurse or specially trained/certified community birth assistant); office-based medical assistants and/or nurses</td>
</tr>
<tr>
<td>Personnel - Non-Clinical</td>
<td>$200,000</td>
<td>$500,000</td>
<td>Administrative director and support team, education and care coordination personnel</td>
</tr>
<tr>
<td>Business Activities and Contracted Services</td>
<td>$200,000</td>
<td>$300,000</td>
<td>Malpractice insurance, compliance programs, IT services, billing service and other management fees, answering service, janitorial and waste disposal services, Medical Director, staff training, and other costs of delivering care and complying with birth center standards</td>
</tr>
<tr>
<td>Facility Rent and Utilities</td>
<td>$100,000</td>
<td>$125,000</td>
<td>Facility that can accommodate 2-4 birth suites, exam rooms, classroom(s), a laboratory, supply areas, restrooms, and staff areas; must meet relevant state and local guidelines related to size and clearances, security, fire and hazardous waste safety, ventilation, plumbing, and electrical</td>
</tr>
<tr>
<td>Furniture, fixtures, and equipment</td>
<td>$20,000</td>
<td>$25,000</td>
<td>Amortized cost of medical devices and clinical equipment as well as non-clinical furniture and fixtures</td>
</tr>
<tr>
<td>Technology</td>
<td>$10,000</td>
<td>$20,000</td>
<td>Computers, printer/fax/scanning, software including charting system, and wireless network</td>
</tr>
<tr>
<td>Office and Clinical Supplies</td>
<td>$25,000</td>
<td>$75,000</td>
<td>Medications, consumable supplies for births, test kits and other laboratory supplies, patient education materials, and general office supplies</td>
</tr>
<tr>
<td>Licenses and Accreditation</td>
<td>$5,000</td>
<td>$5,000</td>
<td>State licensure and CABC accreditation fees</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$1,160,000</strong></td>
<td><strong>$2,250,000</strong></td>
<td><strong>= $11,600/birth</strong>   <strong>= $7,500/birth</strong></td>
</tr>
</tbody>
</table>

*Note that these are hypothetical costs and may not reflect actual costs. Pricing should, whenever possible, reflect actual costs and be adjusted for market differences.
**SOLUTION:** Pay for newborn services that may occur in the birth center or at home.

Hospitals generally receive facility or nursery fees for newborns that are separate from maternal room and board. However, birth centers often face challenges negotiating separate birth center facility payments for newborns. Although some payers incorporate newborn costs in negotiated facility rates for the maternal birth center stay, this falsely inflates birth center costs when compared to hospital rates. Newborns also may be insured on a different plan than the birthing parent. Separate charges allow each plan to pay for facility services for their insured. The recommended coding for newborn facility services can be found in Table 6.

Birth center providers also face challenges getting paid for newborn professional services occurring in the birth center or at home. Midwives may need supplementary credentialing to bill for newborn services. Postpartum dyad home visits are often performed by nurses, and include newborn assessment, lactation counseling, and newborn screening tests. While the screening tests themselves are generally reimbursed, the cost of performing the test may not be, especially when performed by a nurse and/or at home. Facilitating payment for these necessary and fundamental services is needed in order to enable appropriate integration and coordination of newborn care in the birth center model.

**SOLUTION:** Offer enhanced professional payments to midwives providing the Birth Center Model of Care, regardless of location of birth.

Studies have demonstrated the benefits of the birth center model throughout pregnancy, even for those who give birth in the hospital, either by choice or clinical circumstance. As discussed above, these benefits are robust and both clinically and economically important: They include reductions in preterm birth, cesarean birth, and infant hospitalizations and emergency department visits.1, 36

Enhanced payments for professional services can enable longer visits and lower volume, which supports relationship-based care, care coordination and quality improvement activities, continuous midwifery care in labor, and integrated mother-baby care in the postpartum/newborn period, among other high-value aspects of the birth center care model. (See Table 8.)

**SOLUTION:** Pay for services provided by educators, birth assistants, doulas, lactation consultants, behavioral health counselors, and care coordinators.

While birth center services are typically midwife-led, care is often provided by a team that includes other professionals who are trained and/or certified to provide perinatal support services but cannot directly bill for care. This includes perinatal educators who teach childbirth, lactation, and parenting classes; a nurse or other birth assistant who attends the birth and is certified in neonatal resuscitation and other birth emergencies; lactation peer counselors or International Board Certified Lactation Consultants, mental or behavioral health counselors, and care coordinators. These professionals’ services, which are integral to the birth center model, should be paid for so the costs are not borne by families and do not become a financial disadvantage of choosing a birth center for care. The method could be through direct payments, enhanced professional payments, or payment bundles.
**SOLUTION**: Pay for additional and after-hours visits for those who need them.

Birth centers are staffed with midwives and other skilled professionals 24/7 and have the ability to conduct first-line assessment and management for urgent care concerns including first trimester bleeding, nausea and dehydration, urinary and genital tract infections, decreased fetal movement, mental health screening and first aid, and assessment and management of lactation problems, among other services. Assessment and management in the birth center setting has the potential to avoid emergency department visits, improve continuity and experience of care, and reduce costs. Birth centers may be able to bill for procedures such as non-stress tests or intravenous hydration, but often have professional or facility claims denied for care that would be reimbursed at a higher rate if it were to occur in a hospital setting. Health plans should negotiate adequate payments for outpatient management of these urgent care concerns, whether through enhanced professional payments or facility payments.

**SOLUTION**: Include facility, clinical, and non-clinical services in comprehensive bundles for each phase of care.

Ultimately, payment for maternity care should be agnostic to type of provider and location of care, as long as necessary and evidence-based services are provided. Bundled payments are a method of providing a single payment for an episode of care that covers facility, professional, and other costs associated with that episode. For birth centers and other primary maternity care models, bundles should be constructed, priced, and administered for each phase of care: antepartum/prenatal; labor, birth, and immediate postpartum; postpartum; and newborn. This structure would enable provision of the birth center model of prenatal and postpartum care to families who deliver in the hospital. It also would benefit community-based outpatient maternity care providers and facilities.

Photo credit: Kallyn Boemer
Challenge: Timing of payments is mismatched with the costs of delivering care.

The birth center model of care involves a coordinated program of time-intensive, relationship-based care throughout pregnancy. However, neither the midwives nor the birth center receive payment for these services until after the birth, when claims for the global professional fee and the facility are submitted. This delay in payment poses particular challenges for owners of new birth centers, who must develop the facility and program of care and deliver many months of services before they can generate revenue to cover their start-up and operating costs. This payment structure thus disincentivizes the development of new birth centers, especially in communities where payment is expected to be low and/or where regulatory barriers are also high. The structure also disincentivizes postpartum care, which occurs after submission of claims for the global episode.

SOLUTION: Unbundle prenatal and postpartum care from the global professional fee and redefine comprehensive bundles of services for each phase of care.

The current global professional fee, which covers all prenatal visits, attendance during labor and birth, and postpartum care and follow-up, is not optimal for birth centers, which invest significant resources “upstream” in the prenatal period, as described in Table 2. Fee-for-service payments for prenatal care and/or per-member-per-month (PMPM) payments over the course of care are two approaches to structuring payment to coincide with when costs are incurred in the model.

Unbundling the global professional fee also affords the opportunity to re-create bundles that are better aligned with the goals of the overall system and that provide mobility and coordinated care for people who experience changes in their risk status, preferences, or team composition over the course of their pregnancies. Birth centers can provide bundles of services for each phase of care as described in Table 2. These bundles should be priced based on the value and inputs in each phase of care, as described throughout this report.

Photo credit: Monet Nicole
Challenge: Families face high out-of-pocket costs.

Although the cost of birth center birth is substantially lower than that of hospital vaginal birth, most people face higher out-of-pocket costs when they choose a birth center. As discussed earlier in this report, this is often the result of the birth center being out-of-network or adopting a cash-up-front policy, and efforts to improve payment rates and simplify contracting requirements, discussed earlier in this report, will serve to address this challenge. However, birth center fees can be higher for families even when the birth center is in-network with the plan, as a result of tiered pricing and preferred provider contracts. In addition, high-deductible plans distort the cost differences, because families will pay a large sum regardless of their chosen birth setting, and savings accrue to the health plan, with little or any of the savings passed on to the family.

Uncertainty about out-of-pocket expenses can also deter people from enrolling in birth centers. Unexpected costs may arise for families if they receive care in the birth center during labor but have to be transferred to a hospital to give birth, or if out-of-network providers become involved in care after transport. The potential for surprise or out-of-network bills can make birth center care appear to be the more expensive option.

SOLUTION: Include birth centers in preferred provider networks.

Ensuring that birth centers are included in each network tier and that out-of-pocket costs are low would give people the ability to choose the best birth location and likely lead to higher utilization of birth centers, reducing costs to health plans.

SOLUTION: Designate all evidence-based maternity and newborn care as preventive care and not subject to deductible, copayments, or coinsurance.

The Affordable Care Act designates a set of preventive care services that are not subject to deductibles, copayments, or coinsurance. This is based on the value-based insurance design principle, where financial incentives should align with adopting care that prevents development or exacerbation of disease. There is broad variation in how basic prenatal, intrapartum, and postpartum services are treated with respect to designation as preventive care. While all maternity care is preventive in nature, birth centers and midwifery represent evidence-based, preventive care that, under these principles, should not be subject to cost sharing.
Conclusion: The Role of Birth Centers in Emerging Value-Based Payment Models

There is widespread acknowledgement by leaders and stakeholders that alternative payment models are needed to drive value-based care and improve maternal and infant health outcomes.\textsuperscript{22-26, 30, 37} However, progress has been slow in implementing substantive payment reforms. More comprehensive value-based payment models are beginning to emerge, with health systems adopting episode-based bundles and accountable care frameworks.

Some of these emerging payment models hold promise for birth centers and other high value care models, but participation in payment innovations will require infrastructure such as administrative systems for coding and billing, quality measurement and reporting capabilities, and standard definitions and value metrics. The complex and inadequate fee-for-service payment system for birth centers impedes their ability to engage in or lead efforts to reorient payment around high-value care and equitable access.

Payment challenges faced by birth centers are emblematic of broader challenges in allocating payments across providers, facilities, and phases of care. Many of the same forces that result in underinvestment in birth centers also impact other cost-effective care models and essential services, including rural hospitals and clinics, family practice models, home birth and home visitation programs, doulas and community health workers, and hospital-based midwife-physician collaborative models, among others. Thus, the structural challenges described in this report must be addressed for broader payment reforms efforts to be successful.

Midwifery care, birth centers, and related services must be “seen” in order to be measured and valued, and they are currently invisible in data systems that rely on coding systems designed for hospital and physician services. Although emerging payment models will likely be agnostic to facility and provider type for determining the price of care, the current systems for coding, billing, and accounting will remain the primary means of identifying costs and allocating payments to different “inputs.” Thus, more mature systems are needed to value and pay for collaborative models that span outpatient and inpatient care settings, a multidisciplinary team of care providers and support personnel, two (or more) patients, and multiple distinct phases within the overall clinical episode.

To optimize access to and utilization of birth centers and other community-based, prevention-oriented care models, system stakeholders should holistically define the essential care and services needed in each phase of care and at each level of care. Design of the overall system should focus investment in primary maternity care including community-based access to essential preventive and supportive care and health management, with linkages to higher levels of care as needed.
REFERENCES


