

# Partnering with Providers to Improve Maternal Health

May 2023



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## Key Takeaways

- Maternal health disparities are worsening in the U.S., prompting stakeholders to employ strategies to improve maternal health outcomes, especially within Medicaid where women are at greater risk for morbidity and mortality.
- Provider enablement and quality improvement programs, like the Obstetrics Practice Consultant (OBPC) program and Obstetric Quality Incentive Program (OBQIP) can improve maternal and infant outcomes, access to care, and costs.
- Providers participating in both OBPC and OBQIP programs showed the greatest improvements in measures like cesarean section (C-section) rates, adequate prenatal care, and post-partum visits, but providers participating in just one program also demonstrated improvements on multiple measures.

# Overview

**The Medicaid program plays an important role in maternal health in the United States (U.S.) as the program finances over 40 percent of births, with a greater share of births among younger women, those with lower levels of educational attainment, those living in rural areas, and non-white women.<sup>1,2</sup>**

Medicaid programs, providers, and managed care plans are actively strategizing how to improve maternal outcomes, including enhancing provider communication, developing innovative programs, and focusing on quality improvement.

This paper describes the landscape of maternal health in Medicaid, opportunities to improve the quality of maternal care, and how Elevance Health's affiliated Medicaid plans are collaborating with providers through their Obstetrics Practice Consultant (OBPC) Program and Obstetric Quality Improvement Program (OBQIP). It concludes with findings from an evaluation of these initiatives, demonstrating transformations in care delivery and resultant improvements in maternal health among Medicaid members.

Disparities in maternal mortality and morbidity are increasing in the U.S.

## Maternal Health in Medicaid

**Between 2018 and 2021, the number of maternal deaths in the U.S. has almost doubled and the rate of maternal deaths (per 100,000 live births) has increased by 80 percent, with disparities among Black and Hispanic women sharply increasing.<sup>3</sup>**

Compared to privately insured people, individuals who are pregnant and covered by Medicaid are more likely to experience certain pregnancy risk factors, such as obesity, and have higher rates of severe maternal morbidity and mortality.<sup>4</sup>

These statistics underscore that improving maternal health, and the existing disparities especially among people enrolled in Medicaid, should be a priority in the U.S. Indeed, multiple stakeholders across the health-care ecosystem have recommended action.<sup>5</sup> Several strategies exist to improve the ongoing maternal health crisis such as addressing workforce challenges, assisting with health-related social needs (HRSNs), and improving the quality of care.

# Improving Quality in Maternal Care

**In states that deliver Medicaid through contracting with managed care plans, Medicaid requires that plans pay providers, at a minimum, the reimbursement fee set by the Medicaid agency for each Medicaid service the plan is responsible for covering.**

Historically providers received payment for rendered services via fee-for-service (FFS), without consideration for quality of care or member outcomes. As a result, Medicaid agencies and managed care plans are evolving how they pay for services by moving towards reimbursing providers based on outcomes through value-based care (VBC) programs.

VBC models can reduce costs and improve member experience and quality.

Although several different types of VBC models exist, their primary goal has been to reduce costs while improving member experience and quality. More recently, VBC models have become population health focused by prioritizing the advancement of health equity and reducing disparities.<sup>6</sup> The cornerstone of VBC is the use of evidence-based quality performance goals and financial incentives and/or penalties.

Many VBC programs exist to improve quality in the delivery of maternal care, however, stakeholders and experts have noted previous challenges including:

- Inadequate data infrastructure to allow for continuous feedback loops to providers.
- Lack of communication between providers and the member's health plan during the pregnancy and postpartum period.
- Not focusing on both maternal and infant outcomes.
- Unable to address implicit bias among providers.
- Putting too much financial risk on providers.
- Inability to address workforce shortages.
- Unable to effectively implement meaningful health equity performance measures.<sup>7</sup>

Through a provider enablement initiative combined with a VBC program, Elevance Health has developed interventions to reduce or mitigate many of the challenges that other providers and payors have experienced in improving maternal health outcomes and quality.

# Obstetrics Practice Consultant Initiative

Elevance Health identified an opportunity in 2015 to improve communication between its Medicaid health plans and their obstetric (OB) providers.

The goals for these improvements were to:

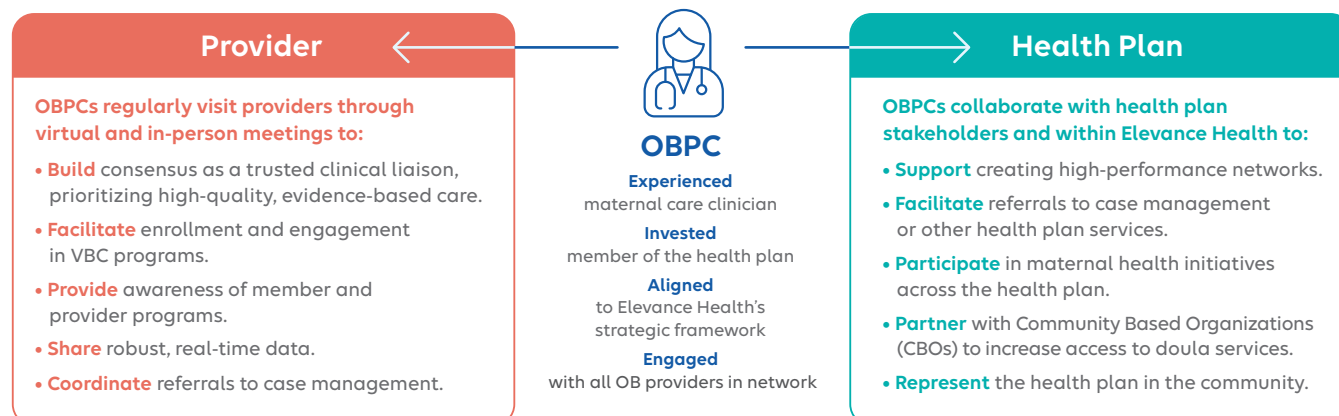
- Enable OB providers to deliver timely and person-centered interventions to members to address clinical and nonclinical factors.
- Improve the experience for both providers and members.
- Improve affordability.

Although the health plans have dedicated points of contact for all network providers, their focus is on operations and contracting. They do not have the clinical expertise or bandwidth to provide consultation on high-quality, evidence-based care; therefore, the improvement of maternal health outcomes was not the primary focus of engagement between OB providers and their health plan contacts.

Based on these observations, Elevance Health created a specialty provider enablement program to engage and collaborate with providers using data, best practices, and evidence-based guidelines. Elevance Health hired OB Practice Consultants (OBPCs) to specifically partner with OB providers. OBPCs are clinicians with obstetric specialty practice expertise who collaborate with providers through in-person and virtual touchpoints. They work to support the quality improvement of health outcomes, serve as clinical liaisons, and provide timely and relevant data to providers to inform decision making.

These provider partnerships, defined by bi-directional conversations between the OBPC clinicians and providers, have consistently demonstrated meaningful results, leading to exponential growth of the OBPC initiative. Today OBPCs serve over 2,400 providers across 21 Medicaid states. Figure 1 describes the OBPC's role within the health plan and how they coordinate with providers.

**Figure 1**  
**OBPC Role with Providers and Health Plans**



# Obstetric Quality Incentive Program

**Elevance Health developed an Obstetric Quality Incentive Program (OBQIP) that offers incentives to OB providers for increasing access and improving the quality of care and outcomes for Medicaid members during the pregnancy and postpartum period.**

OBQIP is an incentive-only VBC program in which OB providers can receive a bonus payment if they meet a pre-determined set of performance measures. Therefore, OB providers do not assume risk if they do not meet the performance measures.

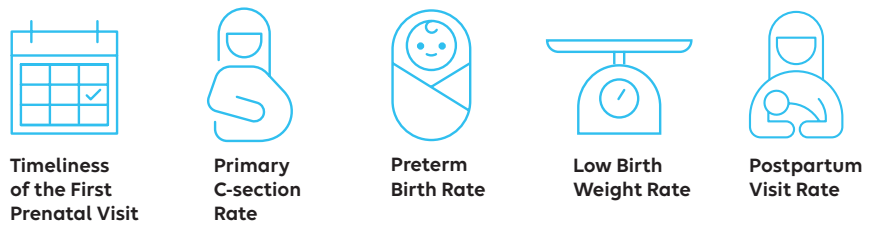
Where Elevance Health's affiliated Medicaid plans offer OBQIP, all OB provider groups within the health plan's network may enroll in OBQIP if they meet the following criteria:

- Remain in good standing under the contract with their health plan throughout the performance measurement period.
- Have at least 25 members who completed all prenatal and delivery care with the provider group during the performance measurement period.
- Meet at least quarterly with an OBPC to review their performance and discuss additional member-level programs.
- Complete yearly implicit bias training for each staff member.

## Performance Measures

OBQIP performance measures may be based on HEDIS® standards or standards established by the health plan related to the appropriateness of utilization of medical or other services. There is a core set of performance measures that the program evaluates all OBQIP providers on (See Figure 2).

**Figure 2**  
**OBQIP Core**  
**Performance Measures**



Although OBQIP has the same goals and objectives across all states (see Figure 3), health plans have had flexibility in:

- **Selecting additional performance measures.**

These “variable measures” may include indicators such as tobacco use or cervical cancer screenings.

- **How they weigh measures toward a total earned points score.**

The weight of all measures (both core and variable) selected by the health plan must equal 100. Therefore, health plans can evenly distribute the points across measures or could give more weight to a specific measure, so long as the total earned points amongst all measures equal 100.

- **The maximum incentive percentages providers can earn.**

The OBQIP incentive payment is based on the total earned points and the OB provider’s total reimbursements during the performance year. In 2020, the incentive payment percentages ranged from 2.5 to 7.5 percent across states, and by 2022, many health plans increased their percentage to 10 percent.

Allowing flexibility at the plan level allows for OBQIP to be tailored to individual states’ maternal health priorities while still ensuring consistency across OBQIP goals and objectives.

**Figure 3**  
**OBQIP Goals & Objectives**



### **Program Improvement**

Health plan leadership and experts in maternal child health and payment innovation within Elevance Health review the program annually to discuss opportunities for improvement, providers’ feedback, and potential revisions to improve outcomes and performance. For example, in 2023, OBQIP introduced a new health equity measure focusing on hypertension in Black mothers and will monitor the measure to determine its continuation in 2024. As a result, in 2024 health plans will also no longer have the option to select additional variable measures as the program continues to refine and add health equity measures.

### Intersection of OBPC and OBQIP

- Both the OBPC and OBQIP initiatives track the same core OBQIP performance measures.
- OBQIP providers must meet with their OBPC quarterly to discuss their OBQIP progress but may also access other resources OBPCs offer.
- When providers participate in OBQIP, they automatically have access to OBPCs.
- Providers in OBQIP have specialized health plan support and resources through the OBPC initiative with OBPCs supporting more than 180 OBQIP providers in 2022.

## Evaluation of OBPC and OBQIP

**Elevance Health conducted an analysis of maternity outcomes and costs of delivery associated with OBPC, OBQIP, and when OBQIP and OBPC are combined.**

### Methods

The evaluation period for the results below includes Medicaid deliveries occurring from January 2019 to June 2020 with a mom-baby linkage (i.e., able to identify both in claims). The evaluation excluded deliveries in the bottom five percent and the top one percent of all delivery costs for mothers and infants. Birth costs are costs incurred from the time of the mother’s admission to the time of the mother’s and infant’s discharge, and include delivery, well-baby, and Neonatal Intensive Care Unit (NICU) costs.

There were three study groups with the evaluation comparing each to a different control group. Table 1 displays the three study groups and their control groups.

**Table 1**  
**Evaluation Study and Control Groups**

Study Group	No. of Births	Control Group
OBQIP only	5,211	No OBQIP, model controls for OBPC
OBPC only	12,173	No OBPC, model controls for OBQIP
OBQIP + OBPC	11,881	No OBQIP, no OBPC

The evaluation used inverse probability weighting to control for a host of risk factors to ensure that study and control groups were balanced on baseline risk. This includes maternal health factors, risk of C-section and NICU admission, previous pregnancy outcomes, HRSNs, participation in member-level programs, and health plan differences. In addition, to address selection bias in provider programs, the evaluation controlled for providers’ historical performance.

Finally, generalized linear regression models were used to test for significance, with a p-value less than or equal to 0.05 signifying statistical difference between each study group and its respective control group.



## Measures

The evaluation focused on clinical outcomes, process, and cost measures throughout the entire birthing process. Table 2 provides the list of measures and their descriptions.

**Table 2**  
**Evaluation Measures**

Measure	Description
<b>NICU Admission Rate</b>	Percentage of births that resulted in a NICU admission before the initial discharge to home
<b>NICU Length of Stay</b>	Average length of NICU stay among infants admitted to the NICU before initial discharge to home
<b>Preterm Birth Rate*</b>	Percentage of all deliveries occurring with less than 37 weeks gestation
<b>Low Birth Weight Rate*</b>	Percentage of deliveries resulting in birth weight less than 2,500 grams
<b>C-section Rate</b>	Percentage of all deliveries that were C-section deliveries
<b>Primary C-section Rate*</b>	Percentage of all deliveries that were first-time C-section deliveries
<b>Vaginal Birth After C-section (VBAC)</b>	Successful vaginal delivery after C-section among singletons
<b>Timeliness of Prenatal Care*</b>	Percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 42 days of enrollment in the health plan
<b>Adequacy of Prenatal Care (Kotelchuck Index)</b>	Uses prenatal care initiation and total number of visits to classify prenatal care as adequate
<b>Postpartum Visit Rate*</b>	Percentage of members with postpartum visits 21 to 56 days after delivery
<b>Birth Cost</b>	Total cost of delivery from the duration of the initial admission, including costs for both mothers and infants
<b>NICU Cost</b>	Total average NICU cost
<b>First Year Maternal Cost</b>	Total cost of maternal claims in the first year after delivery
<b>First Year Infant Cost</b>	Total cost of infant claims in the first year after delivery

\*Denotes an OBQIP Core Performance Measure. OBQIP rates only include "attributed members" who are female members who have completed obstetrical care, including delivery, during the performance period and who are attributed to the OB Provider based on claims data for OBQIP measures.

# Evaluation Results

The evaluation analyzed all measures within each study population and its respective control group and then calculated the relative differences between each study and control group to compare the programs' impact. Therefore, all results are displayed in percentages and reflect the relative differences between the study groups and their control groups.

**To interpret the figures below:** The measures are displayed by row, each in its own color, while the program comparisons (i.e., study groups) are noted across the top of each column. Each study group is compared to its respective control group. Favorable results are presented in color, while unfavorable results are shown in gray. Among both favorable and unfavorable results, those with statistical significance are shown with an asterisk.

## Delivery Outcomes

Delivery outcomes include overall C-section rates, primary C-section rates (i.e., first time), and VBAC rates. Figure 4 displays the delivery outcomes for each study group as compared to its respective control group.

**Figure 4**  
**Delivery Outcomes**

	OBQIP	OBPC	OBQIP + OBPC
<b>C-section</b>	↓ 4%*	↑ 4%	↓ <1%
<b>Primary C-section</b>	↓ 6%*	↓ 3%	↓ 9%*
<b>VBAC</b>	↓ 6%	↑ 30%*	↑ 22%*

\*Statistically significant difference from control group (p=.05).

- C-section rates were significantly lower in the OBQIP group compared to its control group.
- Primary C-sections were significantly lower in the OBQIP and OBQIP+OBPC groups.
- VBACs were significantly higher in the OBPC and OBQIP+OBPC study groups.

## Infant Outcomes

Infant outcomes include NICU admission rates, NICU length of stay, preterm birth, and low birth weight. Figure 5 displays the infant outcomes for each study group as compared to its respective control group.

**Figure 5**  
Infant Outcomes

	OBQIP	OBPC	OBQIP + OBPC
NICU Admission Rate	↑ 1%	↑ 16%*	↑ 17%*
NICU Length of Stay	↑ 6%	↓ 17%*	↓ 14%*
Preterm Birth	↓ 2%	↑ 11%*	↑ 9%*
Low Birth Weight	↓ 3%	↓ 5%	↓ 7%

\*Statistically significant difference from control group (p=.05).

- NICU admission rates were significantly higher in the OBPC and OBQIP+OBPC groups.
- Yet, the length of NICU stays were significantly lower in the OBPC and OBQIP+OBPC study groups.
- Preterm birth was significantly higher in the OBPC and OBQIP+OBPC groups, though the rate of low birth weight was lower—but not statistically significant—across all study groups.

## Access Outcomes

Access outcomes include timely prenatal care, adequate prenatal care, and postpartum visits. Figure 6 displays the access outcomes for each study group as compared to its respective control group.

**Figure 6**  
Access Outcomes

	OBQIP	OBPC	OBQIP + OBPC
Timely Prenatal Care	↑ 12%*	↓ 6%*	↑ 5%*
Adequacy of Prenatal Care	↑ 1%	↑ 14%*	↑ 15%*
Postpartum Visit	↑ 28%	↑ 50%*	↑ 91%*

\*Statistically significant difference from control group (p=.05).

- Except for timely prenatal care in the OBPC study group, all three study groups outperformed their control groups in all other measures.
- OBQIP and OBQIP+OBPC had significantly better timely prenatal care outcomes.
- The combination of OBQIP+OBPC, as well as OBPC alone, resulted in significantly better adequacy of prenatal care and much higher postpartum visit rates.

## Cost Outcomes

Cost outcomes include overall birth costs, NICU costs, and costs associated with the mothers and infants in the first year after birth. Figure 7 displays the cost outcomes for each study group as compared to its respective control group.

**Figure 7**  
**Cost Outcomes**

	OBQIP	OBPC	OBQIP + OBPC
Overall Birth Costs	↓ 4%*	↓ 1%	↓ 5%*
NICU Costs	↓ 9%	↑ 4%	↓ 5%
Mother's 1st Year After Birth	↓ 2%*	↓ 3%*	↓ 5%*
Infant's 1st Year After Birth	↓ 5%	↑ <1%	↓ 5%

\*Statistically significant difference from control group (p=.05).

- Most costs were lower across the three study groups in comparison to their control groups.
- All three study groups had significantly lower costs within the mother's first year after birth than their comparison groups.
- The OBQIP and OBQIP+OBPC had significantly lower overall birth costs.

Overall, the OBPC and OBQIP programs individually demonstrated a positive return on investment with each program independently achieving over \$5 million in savings.

## Limitations

There are three limitations to note. First, the methodology assumes that members in each program are similar to members not in the program in order to attribute differences in groups to the program. Second, although the evaluation accounts for many differences in risk profiles, it can only adjust for observable differences (e.g., claims history, age, known conditions, location). Therefore, the ability to adjust for differences between groups is limited by the amount of data available. Third, OBQIP tends to enroll the highest performing providers, while OBPCs tend to target lower-performing providers, which may influence the results in ways that could not be controlled for.

# Discussion

**These evaluation findings demonstrate that provider enablement and quality improvement incentives can have favorable impacts across prenatal care and delivery, infant outcomes, access to care, and costs.**

Providers participating in one or both programs demonstrated improvements on multiple measures.

In this evaluation, the combination of OBQIP+OBPC exhibits the most favorable impact on primary C-sections, NICU length of stay, adequacy of prenatal care, postpartum visit rates, overall birth costs, and costs within the mother's first year after birth. However, the results also show that even one intervention on its own can have positive impacts on maternal and infant health. In a separate analysis, health plans with higher incentive percentages (i.e., higher bonus payment opportunities) appeared to outperform those with lower incentive percentages, perhaps signifying that when providers have a potential for higher incentive reimbursement, it may influence their behavior to meet or exceed the measures.<sup>8</sup>

NICU admission rates and preterm births were worse in the OBPC and OBQIP+OBPC study groups. Yet related measures of NICU length of stay and low birth weight were more favorable in these groups. This may be due to the unique needs of the population that providers are serving in addition to the lack of available data on infants to risk adjust appropriately. Future evaluations could consider new risk adjustment techniques to better understand infant outcomes and help explain NICU measures.

## Lessons Learned

With several years of both OBPC and OBQIP operating, Elevance Health has learned important lessons that other stakeholders and policymakers may consider. These include:

- **Rigorously evaluate each program** and have a continual improvement process that includes providers, health plans, program staff, and other internal subject matter experts.
- **Stay informed on evidence-based practices** in maternal and neonatal care and apply those to relevant programs to achieve high quality care.
- **Equip providers with access to digital tools** that support easy bidirectional communication between provider staff and the health plans.
- **Advance health equity and improvements in health care disparities** through partnerships with providers, such as supporting enhanced care delivery and implementing incentive measures that address health equity.
- **Benchmark outcomes and share scorecards** with providers showing actionable data, cross comparison between other providers within their market, and continued focus on improving outcomes.

# Conclusion

**Medicaid managed care plans are an important partner that can offer specialty resources to support OB providers in improving maternal and infant morbidity and mortality outcomes.**

These provider partnerships combined with provider incentives can drive meaningful engagement leading to improved health outcomes and quality of care delivery while at the same time reducing costs. Other health plans, providers, and Medicaid agencies interested in improving maternity care may look to implement similar VBC models that incorporate provider enablement alongside quality incentives. Further, there may be opportunities to apply these findings and lessons learned in Medicaid to support commercially based VBC payment models.

## Endnotes

<sup>1</sup> Kaiser Family Foundation. (n.d.). Births Financed by Medicaid, 2020. Retrieved September 16, 2022, from <https://www.kff.org/8140f64/>.

<sup>2</sup> Medicaid and CHIP Access Commission. (2022, June). Medicaid's Role in Maternal Health. Retrieved March 28, 2023, from <https://www.macpac.gov/publication/chapter-5-medicoids-role-in-maternal-health/>.

<sup>3</sup> The Centers for Disease Control and Prevention. (2023, March 16). Maternal Mortality Rates in the United States, 2021. Retrieved March 28, 2023, from <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>.

<sup>4</sup> Medicaid and CHIP Access Commission. (2022, June).

<sup>5</sup> Health Care Transformation Task Force's Maternal Health Hub. (2023, February 21). Lessons Learned from a Multi-Stakeholder Roundtable on Medicaid Maternity Strategies. Retrieved March 28, 2023, from <https://maternalhealthhub.org/resource/lessons-learned-from-a-multi-stakeholder-roundtable-on-medicoid-maternity-strategies/>.

<sup>6</sup> Nundy, S., Cooper, L.A., & Mate, K.S. (2022, February 8). The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. *JAMA*, 327(6), 521–522. Retrieved March 31, 2023, from <https://doi.org/10.1001/jama.2021.25181>.

<sup>7</sup> Health Care Transformation Task Force's Maternal Health Hub. (2023, February 21).

<sup>8</sup> Internal Elevance Health OBQIP analysis.

# About Us

## **Elevance Health Public Policy Institute**

The Public Policy Institute (PPI) was established to share data and insights that inform public policy and shape the healthcare programs of the future. PPI strives to be an objective and credible contributor to healthcare transformation through the publication of policy-relevant data analysis, timely research, and insights from Elevance Health's innovative programs.

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