As the health system shifts towards use of value-based payment, alternative payment methodologies could support implementation of Centering at FQHCs, leading to better health outcomes, higher patient satisfaction and a reduction in health disparities while also supporting FQHC financial sustainability.

Payment Models to Support Sustainability of CenteringPregnancy in Federally Qualified Health Centers

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Introduction

CenteringPregnancy (Centering) is a unique model of group prenatal care that provides enhanced support to pregnant women and should be more widely available as an option to women who get their prenatal care from Federally Qualified Health Centers (FQHCs). There are 1,385 FQHCs with approximately 14,000 sites that serve nearly 30 million people.[1] Their patients are disproportionately women (58.67%), low-income (91%), uninsured (23%) or publicly-insured (58%), and racial and ethnic minority Americans (62.99%), the same populations most likely to be harmed by racial disparities in birth outcomes and broader socioeconomic and health inequities that drive them.[2] Centering is one of the approaches that hold promise to reduce these disparities, and is associated with high satisfaction with prenatal care. Research suggests that Centering holds promise especially for supporting improved birth outcomes for specific populations at highest risk for preterm birth, infant mortality and other adverse health outcomes, in particular for reducing the risk of preterm birth for African American women and their babies.[3,4,5]

Key Points:

- The CenteringPregnancy group prenatal care model can improve outcomes and reduce disparities in birth outcomes, especially for women who are more likely to be served by FQHCs.
- FQHCs are paid a per-visit rate which does not have any flexibility for additional payments that might help to offset the cost of the enhanced services provided in Centering.
- FQHCs can use more creative enhanced payment routes and alternative payment models to support enhanced care models such as Centering.

In the Centering model, facilitators lead a cohort of eight to ten women of similar gestational age through a curriculum of ten 90- to 120-minute interactive group visits that cover medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress

[1] Learn more about the FQHC program at https://bphc.hrsa.gov/about/healthcenterprogram.
[2] America's Health Centers: 2020 Snapshot. National Association of Community Health Centers, September 2020. https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/americas-health-centers-2020-snapshot/ and National Health Center Data, Health Resources and Services Administration, accessed January 8, 2021. https://data.hrsa.gov/tools/data-reporting/program-data/national
[3] Ickovics JR, Kershaw TS, Westdahl C, Magriples U, Massey Z, Reynolds H, and Rising SS. (2007). Group Prenatal Care and Perinatal Outcomes. *Obstet Gynecol*, 110(2): 330-339.
[4] Ickovics JR, Earnshaw V, Lewis JB, Kershaw TS, Magriples U, Stasko E, Rising SS, Cassells A, Cunningham S, Bernstein P, and Tobin JN. (2016). Cluster Randomized Controlled Trial of Group Prenatal Care: Perinatal Outcomes Among Adolescents in New York City Health Centers. *Am J Public Health*, 106(2): 359-365.
[5] Picklesimer AH, Billings D, Hale N, Blackhurst D, and Covington-Kolb S. (2012). The effect of CenteringPregnancy group prenatal care on preterm birth in a low-income population. *Obstet Gynecol*, 206(5): 415.

management, labor and delivery, breastfeeding, and infant care. Participants share their own experiences, learn from each other, and develop meaningful and supportive relationships with one another and with the group co-facilitators. The sessions begin with short individual health assessments with the provider facilitator during which participants discuss personal questions or issues, and take their own vital signs and belly measurements, which they record in a notebook they use to track their care, questions, and notes.[6] Issues likely to be shared by several women are tackled during the groups so that all participants can benefit from the discussion. Traditional fee-for-service payment models do not typically reward the added value that Centering can achieve, nor do they always accommodate scheduling of longer group sessions, provision of enhanced health education or other services that can be woven into the group care model. Aligning emerging value-based payment models that reward providers for better outcomes with group prenatal care is an opportunity to make group prenatal care financially feasible.

As the health system shifts towards use of value-based payment, alternative payment methodologies could support implementation of Centering at FQHCs, leading to better health outcomes and higher patient satisfaction while also supporting FQHC financial sustainability. In Medicaid, the largest payer for maternity care, states have an opportunity to offer this model to more women as part of their emerging payment and delivery system reforms.

Value of Centering

A growing body of evidence supports the potential of Centering to improve birth outcomes and satisfaction with prenatal care, though some of the evidence is mixed and the evidence base continues to evolve. Numerous studies have examined the impact on outcomes including preterm birth, birthweight, breastfeeding, and perinatal care costs, with many identifying positive effects. Cohort studies have repeatedly suggested that Centering improves birth outcomes, including reducing preterm birth rates, low birthweight rates, and racial disparities in adverse outcomes, as well as increasing breastfeeding rates. It has also been found to reduce Medicaid costs in South Carolina while improving outcomes. However, non-randomized studies have involved self-selecting participants into Centering, which introduces risk that these women may differ in undetected ways from those who do not choose the model. Some literature reviews—one by Cochrane in 2015 that examined group prenatal care more broadly and another by Carter et al in 2017 that covered both observational and randomized studies—did not find consistent evidence that Centering improves birth outcomes, though they suggested that further research is needed.

[6] CenteringPregnancy is one of a variety of group prenatal care models (others include Expect with Me and Supportive Pregnancy Care), but it is defined by the process framework, the number, structure, and content of sessions and certification of facilitators by the Centering Healthcare Institute. The Centering model has also been expanded to parenting and chronic disease care, but CenteringPregnancy was the first of the Centering models and has the most developed evidence base. For more information on the CenteringPregnancy model see https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

Research conducted so far suggests that Centering holds promise especially for supporting improved birth outcomes for specific populations at highest risk for preterm birth, infant mortality and other adverse health outcomes. In particular, Pickelsimer (2012) and Ickovics (2007) found that it reduced the risk of preterm birth for African American women and their babies, supporting the value of the model as an option for this population. Ickovics et al (2016) also found positive effects of the model on birth outcomes for adolescents. As Medicaid programs seek to reduce health disparities and improve birth outcomes across the country, these results suggest that states, health plans, and providers that serve Medicaid populations should consider the model as a critical component of maternity care delivery. The ongoing Centering and Racial Disparities (CRADLE) study is a randomized controlled trial that is likely to provide more definitive evidence on Centering's potential to reduce disparities.[7] In addition to the positive birth outcomes shown in many studies, women consistently express high satisfaction with the care model, supporting its broader availability as an option.

While the availability of Centering in FQHCs is increasing[8], the need for start-up funding and ongoing staff resources can be a barrier to its wider implementation. Given that FQHCs disproportionately serve populations that could be interested in and benefit from Centering, stakeholders should take steps to support its expansion. Key performance metrics that FQHCs must report include the percentage of pregnant women with their first prenatal visit in first trimester as well as the percentage of newborns with low and very low birth weight, making Centering's potential impact highly relevant to their efforts to measure their impact.

Brief Context on FQHC Fee-for-Service Payment and Resulting Challenges for Centering

Under the FQHC Prospective Payment System (PPS), states are required to pay FQHCs a per-visit rate. Their payment methodology varies depending on the age of the FQHC and other factors. The rates are determined based on a historical formula that is not automatically updated to align with community needs, goals, or value-based payment. Each FQHC has a unique PPS rate based on its allowable costs. In some states, that is a uniform rate for all services. In other states, there are separate rates for medical, behavioral health, and dental services.

The PPS rate is trended forward annually by an inflation index, the Medicare Economic Index (MEI). MEI has not kept up with general inflation, let alone medical cost inflation, which is often in the 1-3% range annually. The PPS rate must also be adjusted as needed to reflect changes in the scope of service furnished by the center, but each state sets their own threshold for which new services trigger a rate increase. That threshold exceeds the incremental cost of adding Centering. The PPS rate is an all-inclusive "encounter rate," which includes a face-to-face visit with a billable provider and any services provided incidental to that visit (e.g., laboratory services). Non-provider visits (e.g., nurse-only, case management only) and enabling services are not billable, but costs were included in the initial PPS rate calculation to the extent that they were in place at the time the initial PPS was calculated. Providers other than FQHCs are generally paid more for longer and more complex visits or when more services are

[7] See Chen L, Crockett AH, Covington-Kolb S, Heberlein E, Zhang L, Sun X, (2017). Centering and Racial Disparities (CRADLE study): rationale and design of a randomized controlled trial of centeringpregnancy and birth outcomes. BMC Pregnancy Childbirth 17(1):118.

[8] 58% of all Centering sites are currently FQHCs, an increase from 48% in 2017.

rendered during the same visit, whereas FQHC PPS rates are always the same regardless of the length, intensity, or number of services rendered. Some states have add-on billing codes that can be used to enhance reimbursement for group care or codes for health education that help to support Centering, but these are not available to FQHCs.

This fee-for-service PPS payment approach limits the provision of more resource-intensive visits such as Centering. Centering visits are typically 90 to 120 minutes long and involve a larger care team.

Financial Support for FQHCs to Add Centering Programs

FQHCs in some states are using alternative payment models (APMs) to enhance access to care and patient outcomes. Some APMs provide more flexible funding of support services that are not eligible for additional payment under PPS. A variety of FQHC-specific and broader alternative payment methodologies could support Centering. FQHCs can develop APMs for their direct services through their state primary care associations. They must then receive state Medicaid Agency approval followed by approval from the Centers for Medicare and Medicaid Services.

Enhanced Payments that Could Support Centering

The following table summarizes potential revenue streams that could be used in an FQHC setting to support Centering. Some represent strategies under the current PPS methodology while others modify current PPS rules or offer opportunity for incentive payments for improved patient outcomes that result from Centering. Rebasing of the prospective payment rate holds promise to compensate FQHCs more accurately for the services and value provided by Centering.

Enhanced Payment Example: Prospective Payment Rate Carve-outs

- More than a dozen states have made changes to exclude or "carve out" the cost of long-acting reversible contraceptives (LARCs) from their FQHC PPS rates so that the high cost of the devices is not a barrier to FQHCs offering them as part of a comprehensive set of contraceptive options.
- For example, Illinois has taken a number of steps, including a PPS carve-out for FQHCs and rural health centers, and an additional $35 incentive payment for 340B providers that use LARCs.
- Like other effective contraceptive methods, LARCs are highly cost-effective, and increasing access to enable FQHCs to meet existing demand can lead to savings to Medicaid programs on the order of $5 for every $1 spent.

ENHANCED PAYMENTS	POTENTIAL FOR USE AS A REVENUE SOURCE FOR CENTERING	EXPLANATION	PROCESS
Prospective Payment System	Medium	Centering increases show rates for prenatal visits, post-partum visit and infant well-child visits. Centering can be part of a strategy to attract new patients or to retain existing patients who would otherwise seek prenatal care elsewhere.	Implementation by the FQHC; no state policy changes needed Develop a marketing campaign to promote Centering.
Cost-based reimbursement	High	Any additional cost of the Centering Program is included in a reconciliation payment; may only capture incremental cost directly proportional to percent of all patients covered by Medicaid.	Medicaid agency approval followed by CMS approval through a State Plan Amendment Example: Missouri
One time or periodic rebasing of the Encounter Rate using a new cost report	High	Any additional cost of the Centering Program is included in future year's encounter rate; may only capture incremental cost directly proportional to percent of all patients covered by Medicaid.	Medicaid agency approval followed by CMS approval through a State Plan Amendment Example: Delaware
Care Coordination and Care Management Fees including Health Homes	Medium	To the extent that patients in the Centering Program quality and enroll in the CC/CM program	Medicaid agency approval followed by CMS approval through a State Plan Amendment for Health Home care management; Medicaid MCO approval for a care coordination fee. Example: several states have FQHCs participating as health homes but pregnancy is not a qualifying condition so the

			patient must otherwise qualify. North Carolina has mandated that health plans must delegate care management to qualified FQHCs.
Add-on payment for specific high-cost services	Moderate	Payment above the PPS rate	Medicaid agency approval followed by CMS approval through a State Plan Amendment Example: certain dental procedures in Michigan; long acting reversible contraceptives in numerous states

Alternative Payment Models That Could Support Centering

Several other, broader approaches also hold promise for supporting Centering, including potential inclusion of Centering in a shared savings and/or risk, or global capitation payment for maternity care. Alternative Payment Models are a type of enhanced payment that can reward improvements in birth outcomes that may result from Centering while addressing the challenge of getting adequate payment for enhanced services.[9]

ALTERNATIVE PAYMENT MODELS	POTENTIAL FOR USE AS A REVENUE SOURCE FOR CENTERING	EXPLANATION	PROCESS
Pay-for-Quality[8]	Medium	To the extent that there are pregnancy, post-partum, or infant-related metrics	Approval by a Medicaid MCO or State Medicaid agency in non-managed care states Example: several states including Connecticut's PCMH+ program

[9] These issues and models are explored further in the following paper: Diana Rodin and Margaret Kirkegaard, Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Care Model: Strategies to Sustain a Successful Model of Prenatal Care. Centering Healthcare Institute, April 9, 2019. https://www.globenewswire.com/news-release/2019/04/09/1799853/0/en/CenteringPregnancy-Aligns-with-Value-Based-Payment-Models.html

Pay-for-Efficiency	Medium	To the extent that pregnant women are part of the included population for total ED visits, potentially avoidable ED visits, potentially avoidable hospitalizations or 30-day readmissions	Approval by a Medicaid MCO or State Medicaid agency in non-managed care states Example: several states including Tennessee
Primary Care Capitation	Medium	To the extent that the Centering approach allows substitution of less costly care team members for "billable" providers and/or care is provided more efficiently with fewer complications.	Medicaid agency approval followed by CMS approval through a State Plan Amendment Example: Oregon
Bundled Payment for Pregnancy	Medium	To the extent that the Centering approach allows substitution of less costly care team members for "billable" providers and/or care is provided more efficiently with fewer complications.	Medicaid agency approval followed by CMS approval through a State Plan Amendment Example: Michigan
Shared Savings/Risk or Global Capitation	Medium to high	To the extent that the Centering approach reduces ED utilization, hospitalizations, or readmissions for complications of pregnancy or other co-morbidities, C-section rates, neonatal ICU stays or unplanned repeat pregnancies.	Approval by a Medicaid MCO or State Medicaid agency in non-managed care states Example: Illinois

Recommended Next Steps

States can support FQHCs to implement Centering by incorporating APMS that are best suited to the prevailing payment models and future plans for payment reform and innovative care models such as Centering. These steps help expand availability of a group prenatal care model that holds promise to improve birth outcomes and women's satisfaction with their prenatal care, and to reduce health disparities while supporting the financial sustainability of a key element of the health care safety net.

FQHCs and their primary care associations may be unaware of this menu of payment options and the experience of their colleagues in other states. Some still lack a thorough understanding of the Centering model of care. The Centering Healthcare Institute can enhance awareness through its staff or by sponsoring educational presentations to promote adoption of Centering and payment strategies to underwrite its cost.