MED Policy Brief
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MEDICAID EVIDENCE-BASED DECISIONS PROJECT

Enhancing Global Billing Practices for Medicaid Pregnancy Services

As pregnancy care grows increasingly complex in the United States, the widespread use of global obstetric billing in Medicaid programs faces mounting scrutiny.[1] While this bundled payment model, currently employed by 37 state Medicaid programs, streamlines reimbursement for prenatal, delivery, and postpartum services, clinicians argue it fails to account for the rising challenges in maternal care.[1]

BACKGROUND

Concerns around the global billing model for pregnancy services have intensified due to significant demographic shifts and health trends.[1,2] The rising proportion of births to women over 35, combined with the higher prevalence of risk factors among Medicaid beneficiaries—including chronic health conditions and socioeconomic barriers to care—creates a more complex care environment.[3]

According to the Centers for Disease Control and Prevention (CDC), in 2020, about 15% of births were to women aged 35 and over, up from approximately 11% in 2000.[4] Advanced maternal age is strongly associated with higher risks of gestational diabetes, preeclampsia, cesarean delivery, and pregnancy-related morbidity for mothers. It also associated with increased chance of miscarriage, stillbirth, chromosomal abnormalities, preterm birth, and low birth weight for infants.[3] These trends toward increasing complexity in pregnancy care are particularly concerning for the Medicaid population, where additional risk factors are often present.

Given these rising complexities, clinicians are concerned that global billing does not adequately compensate for the increased care needs among patients with Medicaid.[2] Socioeconomic challenges are in this population are strongly associated with inadequate access to healthy foods and higher rates of smoking or substance use disorders, contributing to conditions like gestational diabetes and hypertension.[5] Additionally, a higher prevalence of chronic health conditions such as obesity, diabetes, and hypertension further complicate pregnancies for patients with Medicaid coverage.[5]

This brief synthesizes findings from the MED report *Global billing for pregnancy: advantages, disadvantages, and mitigation strategies*,[6] which reviewed current literature around the use of global billing for obstetric services and included interviews with key stakeholders, including Medicaid officials from several states, experts from the Centers for Medicare & Medicaid Services (CMS), representatives from the American College of Obstetricians and Gynecologists (ACOG), and managed care organizations (MCOs).

This policy brief aims to inform policymakers about strategies to address challenges with global billing and consider the need for more nuanced payment adjustments. These include integrating supplementary coding mechanisms—such as current procedural terminology (CPT) Category II codes—for better tracking and measuring care delivery timing and performance. Additionally, it explores alternative payment models (APMs) to global billing that incorporate risk adjustment for clinical and social health determinants.

Context and Significance

Global obstetric billing emerged in the 1980s as a streamlined approach to maternity care reimbursement, using specific CPT codes (59400-59618) to cover various combinations of prenatal, delivery, and postpartum services.[7] The payment approach aimed to reduce administrative burden and provide predictable payments for clinicians.[7] However, the landscape of maternal healthcare has transformed dramatically since the model's inception, with increasing care complexity, rising maternal mortality rates, and persistent health disparities leading Medicaid programs to reevaluate the use of global billing for pregnancy services.[1]

Impact of Extended Postpartum Coverage on Billing Practices

Adjustments in Billing Practices to Support Comprehensive Care

The American Rescue Plan Act's provision allowing state officials to extend Medicaid coverage to 12 months postpartum necessitates adjustments in billing practices.[8,9] Traditionally, global obstetric billing covers services up to six weeks postpartum.[8,9] With extended coverage, state Medicaid programs are providing guidance on billing for additional postpartum services using appropriate evaluation and management (E/M) codes (99211–99215).[6] This ensures clinicians are compensated for extended care, supporting continuity and addressing postpartum health needs that may arise beyond the initial period.[6]

Structural Challenges with Global Billing for Pregnancy Services

The current global billing framework presents several fundamental challenges that affect care delivery and outcomes, including data transparency, risk adjustment, and care fragmentation.[1,10] The primary tension exists between administrative efficiency and data transparency.[1,10] While the bundled payment approach simplifies billing processes, it obscures crucial information about specific services provided during the maternity care episode.[1,10] This lack of granularity complicates quality monitoring and makes it difficult for state Medicaid programs to track compliance with CMS's Prenatal and Postpartum Care HEDIS measures.[1,10]

Risk adjustment limitations present another significant structural challenge.[6] Current global billing models primarily differentiate reimbursement based on delivery method (vaginal versus cesarean), failing to account for the full spectrum of clinical complexities that may arise during pregnancy.[6] This simplified approach to risk adjustment inadequately compensates clinicians managing high-risk pregnancies, potentially creating access barriers as clinicians may be hesitant to take on complex cases that require significantly more resources and time.[6]

Care fragmentation has emerged as a critical concern as healthcare delivery patterns evolve.[1] The global billing model assumes continuity of care with a single clinician throughout the pregnancy episode, an assumption increasingly at odds with modern healthcare delivery patterns.[1] Geographic mobility, physician availability, the widespread use of obstetric hospitalists, and changes in managed care enrollment often result in pregnant individuals receiving care from multiple clinicians across different settings.[1] This fragmentation particularly affects rural areas, where there is a scarcity of clinicians, and travel distances complicate care coordination.[6]

Data Transparency Solution

Implementation Challenges of CPT Category II Codes (F Codes)

To address data transparency issues, Medicaid programs in Colorado and North Carolina have mandated the use of CPT Category II codes (F codes), specifically 0500F for initial prenatal visits and 0503F for postpartum care visits, alongside global billing codes.[11,12] These codes capture detailed information on the timing of visits without providing additional reimbursement, aiding in HEDIS measure reporting.[11,12] However, clinicians have reported challenges with EHR systems not accommodating these codes, necessitating system upgrades and clinician training.[11,12] The lack of immediate financial incentives for using F codes may also hinder widespread adoption.[11,12]

EFFORTS TO IMPROVE ACCESS AND OUTCOMES IN MEDICAID PROGRAMS WITH GLOBAL BILLING

Adjustments in Reimbursement Rates

Recent state initiatives to increase Medicaid maternity care payment rates reveal both the importance and complexity of such increases.[2] North Carolina Medicaid's 2023 increase to 71% of Medicare rates marked their first obstetric payment adjustment in a decade, reflecting an effort to improve provider participation and access to care.[13] However, research suggests that rate increases alone may not fully address disparities in care access and outcomes.[14] A 2015 study examining the effects of increased Medicaid reimbursement rates found that while higher payments modestly improved access to prenatal care overall, the benefits were not equally distributed across demographic groups.[14] White patients saw greater improvements than patients of color, indicating that simply increasing reimbursement rates may not suffice to reduce health disparities.[14] This suggests that while increasing Medicare payment is an important policy goal, it should be pursued as part of a comprehensive strategy that includes other interventions to address systemic barriers to care access and quality.[14] State Medicaid programs considering rate increases must also carefully evaluate budget implications and develop implementation strategies that ensure enhanced payments translate into meaningful improvements in care delivery and health outcomes.[15]

Use of Maternity Kick Payments

Several state Medicaid programs--including Colorado, New York, and North Carolina—make fixed supplemental payments, known as kick payments, to managed care plans when pregnant enrollees enroll late in their pregnancies, to help offset the higher costs of short-term enrollment and the intensive care needs often associated with late-term pregnancies.[15] Maternity kick payments are one-time payments made by states to MCOs when a delivery occurs, designed to supplement regular capitated rates and help offset the higher costs associated with pregnancy and delivery. The distribution of these payments varies by state policy, with MCOs typically retaining the funds to cover delivery costs, though some may pass portions to clinicians depending on state requirements and individual MCO practices.[15] This approach helps to stabilize the financial landscape for MCOs and encourages them to maintain comprehensive coverage for pregnant enrollees, thereby enhancing access to critical maternity care services.[15]

Specific rates for maternity kick payments vary widely across Medicaid programs, ranging from $2,838 in New Hampshire to $14,493 in Maryland, highlighting the diverse financial strategies in place.[15] These payments are typically triggered by a delivery and are made in addition to the MCO capitated rate.[15] While Colorado, New York, and North Carolina Medicaid primarily use these payments for delivery-related services, North Carolina extends its maternity event payments to cover prenatal and postpartum care as well.[15] This comprehensive approach aims to mirror the global billing payments received by clinicians, ensuring a more holistic financial support system for MCOs.[15]

ALTERNATIVES TO GLOBAL BILLING

Per-Service Billing and Supplemental Codes

Some state Medicaid programs have considered or implemented per-service billing using CPT codes 59409–59622 and 99211–99215 to enhance data capture for specific services, facilitating quality reporting and more precise reimbursement alignment.[6] While this approach improves transparency, it increases administrative workload for clinicians, who must submit claims for each service rendered.[6] Additionally, per-service billing may reduce incentives for continuity of care, as clinicians are reimbursed per encounter rather than for overseeing the entire episode of care.[6]

Alternative Payment Models (APMs) and Their Efficacy

Alternative payment models, such as Connecticut Medicaid's HUSKY Maternity Bundle Payment Program, offer a potential solution by replacing global billing with prospective case rates that are adjusted for risk.[16-18] This model starts payments in the second trimester and includes retrospective reconciliation against a target price that incorporates clinical and social risk factors.[16-18] While this approach aims to promote comprehensive, coordinated care, previous attempts at its implementation

by Medicaid programs in Arkansas, Colorado, and New York have faced challenges.[6] These include clinician hesitancy to opt-in due to concerns over financial impact and quality metrics, as well as limited observed improvements in cost savings or quality outcomes.[6]

STATE CONSIDERATIONS FOR GLOBAL OBSTETRIC BILLING POLICY BRIEF

State Medicaid programs can improve maternal health outcomes, enhance equity, and increase efficiency by addressing limitations in global billing for maternity care. The following recommendations are based on evidence and insights from this MED report's key informants and our literature review:

1. **Adjust Reimbursement Rates and Payment Strategies**
    - » Increase Reimbursement Rates: Align Medicaid reimbursement for global obstetric codes more closely with Medicare rates to cover the full costs of care, especially for high-risk pregnancies.
    - » Implement Maternity Kick Payments: Consider supplemental payments for managed care organizations to offset the financial risks of high-cost pregnancies, ensuring adequate resources for maternity care.

2. **Enhance Coding, Billing Practices, and Data Transparency**
    - » Adopt Specific Tracking Codes: Use codes like 0500F for initial prenatal visits and 0503F for postpartum care, or tools like pregnancy notification forms, to improve data transparency, monitor care more precisely, and collect granular data for quality tracking and improvement.
    - » Extend Postpartum Billing: Issue guidance that allows clinicians to bill beyond the standard global code period, enabling comprehensive reimbursement through individual evaluation and management codes.
    - » Support High-Risk Pregnancy Care: Introduce complexity modifiers or permit separate billing for supportive services to better account for the additional resources required.

3. **Explore Alternative Payment Models and Innovations**
    - » Evaluate Prospective Case Rate Models: Consider models like Connecticut's HUSKY Maternity Bundle Payment Program to cover a broader range of services and encourage comprehensive, high-quality care.
    - » Promote Equity-Focused Initiatives: Incorporate culturally responsive care strategies, such as doula services and lactation support, to address disparities and improve outcomes for diverse populations.

4. **Leverage Quality Metrics**

    » Align Payment with Quality Measures: Use metrics like CMS's Prenatal and Postpartum Care measure, which assess the timeliness of prenatal care in the first trimester and postpartum visits between 7 and 84 days after delivery,to improve health outcomes while maintaining accountability.

5. **Address High-Risk Populations**

    » Incorporate Risk Adjustment: Explore payment models that account for clinical and social risk factors to provide equitable compensation for clinicians serving high-risk populations.

    » Focus on Behavioral Health and Substance Use: Implement screening and treatment efforts for behavioral health conditions during pregnancy to mitigate contributors to maternal mortality and morbidity.

CONCLUSION

Global obstetric billing in Medicaid programs stands at a critical juncture, with mounting concern about its limitations driving the need for reform. While the model's administrative efficiency remains valuable, its inadequacies in addressing care complexity, ensuring data transparency, and promoting health equity require policy attention. State Medicaid programs have multiple options for addressing these challenges, from incremental modifications to comprehensive payment reform initiatives.

Success in improving maternity care payment systems will require careful balancing of competing priorities: maintaining administrative efficiency while enhancing data collection and quality of care monitoring, ensuring adequate provider compensation while controlling costs, and promoting care coordination while accommodating delivery system fragmentation. State Medicaid programs must also consider their unique geographical, demographic, and health system characteristics when designing solutions.

The path forward likely involves a combination of short-term improvements to existing global billing systems and longer-term transitions toward more sophisticated payment models. State Medicaid programs may approach these changes systematically, with careful attention to implementation requirements and stakeholder impacts. By learning from early adopters and maintaining focus on maternal health outcomes, Medicaid programs can work toward payment systems that better serve their Medicaid populations while maintaining operational efficiency.

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