LOGISTICS

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- Phone lines are **muted** upon entry.
- To **submit comments or questions**, click the Chat icon at the bottom of your screen.
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- The **slides and a recording** of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.
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Operational Sustainability for Maternal Health Services:

Tailored Medicaid Payment and Revenue Strategies

INTEGRATED CARE DC
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PRESENTED BY:
Michele Bosworth, MD
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Felicia Sears
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Tuesday, July 14, 2026
11:30 AM–12:30 PM ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF). This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). A total of $1,527,057.67, or 57 percent, of the project is financed with federal funds, and $1,147,478.36, or 43 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS or the U.S. Government.

DHCF
Department of Health Care Finance

HMA

TODAY'S AGENDA

INTEGRATED CARE DC
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- Welcome and Session Orientation
- From Team-Based Maternal Care Concepts to Operational Models
- Breakout Sessions
  - Operationalizing Team-Based Maternal Care in Clinical Settings: Payment, Workflow, and Partnership Readiness
  - Getting Paid in Practice: Peer Exchange on Credentialing, Claims, Documentation, and Payment Navigation
- Conclusion and Next Steps

Image Source: Microsoft 365 Stock Photos

LEARNING OBJECTIVES

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Describe common models of team-based maternal care involving doulas, federally qualified health centers [FQHCs], physician groups, and other providers (including contracted, embedded, and coordinated arrangements) and identify the payment approaches that can support each model.

Distinguish between payment strategy concepts for clinical providers (e.g., perinatal episode/value-based payment approaches) and operational claims/reimbursement navigation needs for community-based providers.

Identify practical workflow, documentation, credentialing, and reimbursement issues that affect operational sustainability in maternal health team-based care.

Identify and evaluate peer-tested strategies, tools, and workarounds that help maternal health providers navigate billing, credentialing, and payment barriers, while identifying issues to address in future individual technical assistance.

Identify immediate next steps for strengthening operational sustainability within their own organization or partnership model.

PRESENTERS

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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2025–09/22/2028. Social workers completing this course receive 1 continuing education credit.
  - *To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.*
- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 05/12/2026 to 05/11/2027. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1 Online Only, Live AAFP Prescribed credit.
  - **<u>If you would like to receive CME credit, the online evaluation will need to be completed</u>.**
  - You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 12 business days of course completion.

FROM TEAM-BASED MATERNAL CARE CONCEPTS TO OPERATIONAL MODELS:

WHAT IT LOOKS LIKE AND WHAT SUPPORTS IT FINANCIALLY

THE MATERNAL HEALTH TEAM

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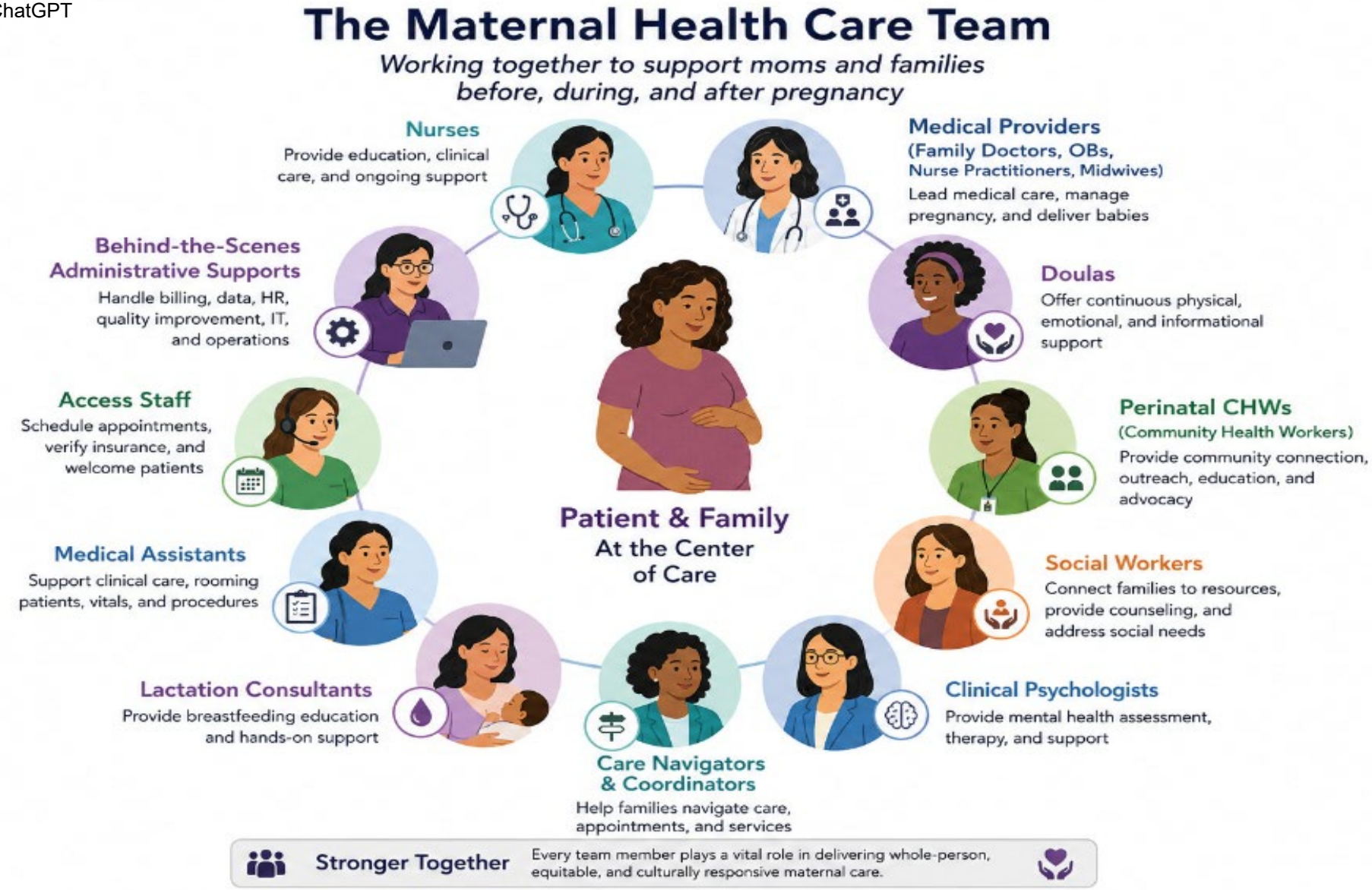
Image Source: HMA Enterprise ChatGPT



VBP FOR MATERNITY CARE: KEY DESIGN ELEMENTS

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Element	Definition
Maternal Health Episode of Care (EOC)	The defined set of maternal health care services delivered within a set timeframe (e.g., 280 days prior to delivery through 60 days postpartum) on which payments are based
Accountable Entity (AE)	Clinics or practices providing maternal health care services (e.g., OB-GYN practices, FQHCs, birth centers) that agree to be accountable for maternal health care cost and quality outcomes
Types of Payments	Monthly prospective payments (case rate): A flat monthly fee for a predetermined set of routine pregnancy-related services (paid in *advance* of the services) Retrospective shared savings/shared risk: An incentive payment based on quality performance for the entire risk-adjusted EOC (paid *after* the episode ends)
Integration of Doula Services	Costs of doula services may be included or excluded from both the prospective or the retrospective payments

EXAMPLE, USING HYPOTHETICAL DOLLAR FIGURES: PROSPECTIVE PAYMENT

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- Total estimated cost of care = **$10,000**
- Accountable Entity (AE): **OB-GYN practice**
  - Receives a fixed monthly payment (case rate) to manage and coordinate a patient's care from prenatal, labor/delivery, and postpartum.

Second trimester through 60 days postpartum (8 months)

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
$1250	$1250	$1250	$1250	$1250	$1250	$1250	$1250

8 Monthly Payments x $1,250 = **$10,000 total paid to AE**

Paid prospectively regardless of actual services used

- Considerations for doulas
  - If doula services are **included**, there is an **add-on to case rate** (e.g., $100 add-on payment, for a total monthly payment of $1350), which the AE distributes to doula
  - If doula services are **excluded**, doulas are **reimbursed separately** by Managed Care Plans or Fee-for-Service (i.e., the same way they are paid today)

EXAMPLE, USING HYPOTHETICAL DOLLAR FIGURES: RETROSPECTIVE SHARED SAVINGS

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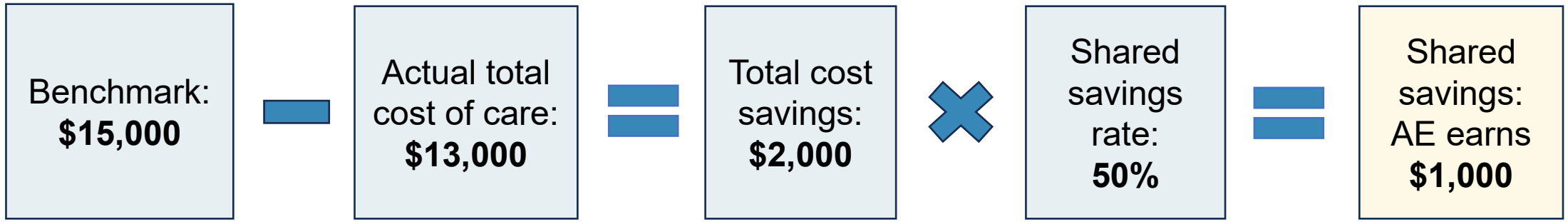
- Total estimated cost of care (benchmark) = **$15,000**
- Accountable Entity (AE): **OB-GYN practice**
- After the episode ends, actual costs are compared to the benchmark and quality performance is assessed to determine shared savings:



- Considerations for doulas:
  - If doula services are **included** in total cost of care: AE may distribute shared savings to doula
  - If doula services are **excluded** in total cost of care: AEs will be incentive to refer to doulas and may distribute shared savings with them

TMAH MODEL COMPARED TO CONNECTICUT AND NEW JERSEY

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	CONNECTICUT	NEW JERSEY	TMaH
Overall Approach	Maternal Health Episode of Care (280 days prior to delivery through….		
	90 days postpartum	60 days postpartum	60 days postpartum
Accountable Providers	Physicians, nurse practitioners, and Nurse-Midwives (***excludes FQHCs***)	OB-GYNs and midwives (FQHCs ***can partner,*** but not be an accountable provider)	OB-GYNs, **FQHCs, birth centers** *Note: CMS considering requiring the accountable provider organization to provider prenatal, postpartum, and labor/delivery services
Doula Considerations	• Increased case rate payment to account for doula services • Cost of doula services not included in TCOC	Encourages doulas' services to improve overall quality of care and cost; but payments do not embed their services	• Encourages doulas' services to improve overall quality of care and cost • Cost of doula services not included in TCOC
Payment	Monthly Case Rate Payment + Shared Savings Incentive Payment	• Fee for service (FFS) continues • Three Payment Opportunities: Shared Savings, Substance Use Disorder (SUD) Incentive, High Performance Bonus	• Monthly Case Rate Payment + Shared Savings/Shared Risk Incentive Payment • **CMS-directed Infrastructure Payments**

FOUR OPERATIONAL PRACTICES THAT POSITION YOU FOR THE TMAH PAYMENT MODEL

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Regardless of what DC's final model looks like, these four practices are foundational for every provider type.

1 Enrollment and Network Participation

- Enroll with all three DC Medicaid managed care plans (MCPs): AmeriHealth Caritas DC, MedStar Family Choice DC, HSCSN
- Doulas: Verify enrollment status with each MCP. Billing eligibility is not automatic upon Medicaid enrollment
- FQHCs: Confirm you're on each MCP's provider panel before referring doulas or PCHWs

2 Clean Claims and Coding Accuracy

- DC doulas bill using CPT codes with the HD modifier. Not HCPCS S9445 used in other states
- Use correct place of service, National Provider Identifier (NPI), and taxonomy codes on every claim
- Document services to meet medical necessity standards; link to covered prenatal/postpartum episodes

3 Eligibility Verification, Every Visit

- Verify Medicaid eligibility at every encounter. DC members can change MCPs monthly
- A patient enrolled with AmeriHealth this month may be with MedStar Family Choice DC next month
- Build a verification step into your intake workflow; do not assume prior eligibility holds

4 Denial Management and Appeals

- Track every denial by MCP, denial reason code, and service type
- Common denial reasons: non-covered service, missing authorization, incorrect modifier, credentialing gap
- File appeals within MCP timelines. Most require appeal within 60–180 days of denial date

DC'S PATH FORWARD: WHERE WE ARE AND WHAT YOU CAN DO RIGHT NOW

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2025–2026 DHCF Incentive Program	2027 CMS Infrastructure Payments	2028–2031 DHCF QI Program Begins	2029 (shared savings)–2031 (prospective payments (tentative; subject to change) TMaH Payment Model Begins

WHAT'S STILL TBD (CMS is deciding)

- Final payment structure (prospective case rate versus FFS + shared savings)
- Whether doula costs will be excluded from shared savings calculations (CMS has indicated this verbally, final decision pending [potential good news for doulas])
- Quality measure set and specific performance thresholds
- Minimum volume requirements and eligible provider types
- MCP contracting requirements specific to the VBP model

WHAT YOU CAN DO RIGHT NOW

- Get enrolled: Not just Medicaid, but each managed care plan specifically. Verify your status with all three DC Medicaid MCPs.
- Review your billing codes. Confirm the use of the HD modifier on all doula claims.
- Build an eligibility check into every patient encounter.
- Start tracking denials by MCP and reason code. You will need this data when DC launches the VBP model, and you need to demonstrate your track record.
- Participate in this Learning Collaborative. It builds the relationships that DC will need in 2028.

QUICK POLL: How many DC Medicaid MCPs are you currently enrolled and actively billing with? [0] [1] [2] [3] [4 — all of them]

BREAKOUT SESSIONS

BREAKOUT ROOM LOGISTICS

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Breakout Group Composition

- Participants will be placed into the following provider groups with a facilitator:
  - Physician groups and FQHCs
  - Doulas and perinatal community health workers (PCHWs)

Breakout Group Activities

- Introduce yourself; join on video and come off mute!
- Select one participant to report back key themes

Breakout Discussion

- **Physician groups and FQHCs**: What does it take to operationalize and finance collaborative maternal care in clinic/practice settings?
- **Doulas/PCHWs**: What does it take to navigate the real mechanics of credentialing, billing, documentation, claims, and getting paid?

BREAKOUT A: FQHCs and Physician Groups

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Topic: Operationalizing Team-Based Maternal Care in Clinical Settings: Payment, Workflow, and Partnership Readiness

Q1

Team-Based Care in DC

Let's discuss the different ways that Doulas and PCHWs are associated with FQHCs and physician groups; tell us about the way it works in your practice.

Q2

Payment Model

What did you think when you heard about the New Jersey or Connecticut models? What do you think it will take for models like those to happen in DC?

Q3

Next Steps

What changes need to occur in your practices to move the care model towards one similar to New Jersey or Connecticut?

BREAKOUT A: WHAT WE'RE HEARING LIVE NOTES

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Operational Features of Current/Future State Partnerships with Doulas/PCHWs

Current:

- GW doesn't directly employee doulas but encourages patients to bring their doulas – GW does refer to patients to doulas when requested but no formal system to make referrals.
- Mary's Center – formal system no longer exists but Healthy Start program supports perinatal care. Interested in reengaging/hiring doulas in the future
- Sibley – partnership with sister hospital to support patients through medical school program – supports doula but there is a policy in place that prevents formal referrals as it may be seen as an endorsement.
- Unity Care – seeking more information and resources to refer Medicaid patients to doulas – partners with Mamatoto Village, BirthingKind has offered to partner with them,
- Children's – patients come with their doulas, no formal referral system. Children's employees CHWs

Future:

- Doulas need support with MCP contracting

Payment Model

- GW: financing model drives – the model would need not to be an integrated model to incentivize implementation but rather a separate model. For example, contraceptive model (e.g., traditional FFS model) - maximizing hospital is interested in maximizing revenue.
- Unity Care – slight concern with prospective payment and case rate. However, shared savings could used to leverage doulas services through partnerships and not necessarily need to employee doulas

Next Steps

BREAKOUT B: DOULAS AND PCHWS: GETTING PAID IN PRACTICE

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Topic: Peer Exchange on Credentialing, Claims, Documentation, and Payment Navigation

Q1

Enrollment and Credentialing

Where are you in the enrollment process with each of the DC Medicaid MCPs? What barriers have you hit and what worked?

Q2

Billing, Claims, and Denials

What are your top one or two denial reasons? What tools or processes do you use to submit and track claims and what do you wish you had?

Q3

Contracting Provider Arrangements

How are you positioning yourself as a preferred referral partner with clinical teams, and what quality or performance incentives have come up in those conversations?

Q3

What's Working

What workarounds, tips, or resources have helped you get paid? What is something you wish someone had told you earlier in this process?

Our goal today: Share what you know, learn from each other, and identify what you want to tackle next in your 1:1 TA.

BREAKOUT B: WHAT WE'RE HEARING LIVE NOTES

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Capture key themes as they emerge during the Breakout B discussion.

ENROLLMENT BARRIERS

What credentialing or MCP enrollment issues came up?

- Bills not submitted due to not being a provider (Paperwork complete ~3 years prior)
- Communication barriers with the MCPs.
- I'm enrolled with HSCSN, but haven't received any clients. Just got info to learn about enrolling with AmeriHealth.
- I have only successfully enrolled with WellPoint but now they're going away, I guess? It's been a 1.5-year process with AmeriHealth and is still not active even though I've signed the contract a few weeks ago finally; Still in process with MedStar after several months
- **Delayed responses from the MCPs, unsure if paperwork has been received.**
- We are still in the beginning stages of credentialing and enrolling as Medicaid doulas
- Unsure who to contact for credentialling at the MCP (will help with communications.
- For credentialing we still need support on how to enroll as a group
- In process with HSCSN and Amerigroup
- I'm credentialed with Wellpoint. I've submitted my credentialing for Medstar and haven't got that yet. I've received the letter saying I'm credentialing for AmeriHealth but haven't received the 2nd letter or Pin.
- Have hit multiple barriers - them losing my paperwork the first time, long timeframes of 120 days to do initial credentialing, staff leaving at the MCPs and then all the communication going dead…
- I'm not enrolled, trying to find out what the process looks like; we hear from other doulas and the challenges around payment processing, so trying to assess if this process is worth it. But I am bilingual (English/Spanish) and know a high volume of my potential clients are in DC
- Similar to Kortny, began credentialing years ago. Completed enrollment with HSCSN and Wellpoint but they are transitioning out now. I will begin credentialing with Amerihealth but that takes 120 days, I reached out to see if there is an opportunity for expedited credentialing due to the circumstances but seems as not right now.

BILLING AND DENIAL PATTERNS

What claim submission or denial issues were shared?

- Haven't had a chance to take a DC Medicaid client or bill so haven't experienced this.
- **Place of service:** Upon submitting the claim early on, there is a location for place in multiple areas (creating discrepancies and payment issues).
- **Underbilled submitted claims**: The included quantity didn't multiply correctly (paid for two services rather than eight), which has still not been addressed (with Wellpoint, which is transitioning).
    - Claims are in collections for both over- and underpayments.
    - Lack of continuation on the claims journey to ensure payment (disconnects with the MCPs).
- Billing with MCPs
    - Mamatoto bills for our PCHWs/Community Birth Workers through a contract. They don't bill as individual providers

WHAT'S WORKING CONTRACTING ARRANGEMENTS

What contracting or preferred provider arrangement questions arose?

- Referral partner contract with AH, but have not started on the performance incentive path.
- Not applicable for me at the moment, don't have a formal arrangement with an MCO
- Just starting!
- I have no formal agreements/arrangements, as of yet.
- Arrangements with the health system (Unity), but not the MCPs.
- Concerns about delayed payments may prevent contracting.

SHARING FROM THE BREAKOUTS

BREAKOUT A: KEY TAKEAWAYS FOR THE FULL GROUP

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1

One key takeaway about team-based maternal care:

- **Models/Relationships with doulas vary across sites and referral partnerships vary in formality. Relationship building is key to "growing" these networks/partnerships."**

2

Planning for a new payment model:

- **At least one prefers separating the hospital payment and the doula payment.**
- **More understanding around the differences between the physician group model vs the FQHC model is needed to understand operational realities and opportunities with a new payment model.**

3

Changes to be planned for in preparation for new payment model:

- **Doulas need support on how to enroll with Medicaid managed care plans.**

Need to go deeper? 1:1 Technical Assistance is available; connect with your coach after today's session.

BREAKOUT B: KEY TAKEAWAYS FOR THE FULL GROUP

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1

One key takeaway about team-based maternal care or payment structure:

- **Communication is a huge issue. There is a need to know who to contact regarding credentialing, billing, and denials. It is impossible for a small business to undergo this.**

2

One operational barrier or payment challenge that surfaced repeatedly:

- **Credentialing, delays, "quantity," "place of service."**
- **Bills do not always get paid the first time because they are not showing up in the system, or credentialing approval is still in process.**
- **Doulas' claims are in collections due to the MCPs claiming duplicate billing that must be paid back.**

3

One issue to move into future technical assistance or the August follow-up webinar:

- **How information on how individual providers/small businesses can take on credentialing, contracting, billing, denials without the infrastructure, experience, and tools.**
- **More details on value-based payment.**

Need to go deeper? 1:1 Technical Assistance is available—connect with your coach after today's session.

REMINDERS AND NEXT STEPS

TIMELINE FOR 2026

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May
Cross-Provider Journey Mapping (5/12/26)
1:1 TA

June
Improving Coordination Across Screening and Referral Workflows (6/9/26)
1:1 TA

July
Operational Sustainability for Maternal Health Services (7/14/26)
1:1 TA

We are here!

August
Group Learning (8/11/26)
1:1 TA

September
Group Learning (9/8/26)
1:1 TA

October
In-Person Workshop (10/20/26)
1:1 TA

November
Group Learning (11/10/26)
1:1 TA

December
Group Learning (12/8/26)
1:1 TA

MILESTONE 7 ACTIVITIES DUE DATE

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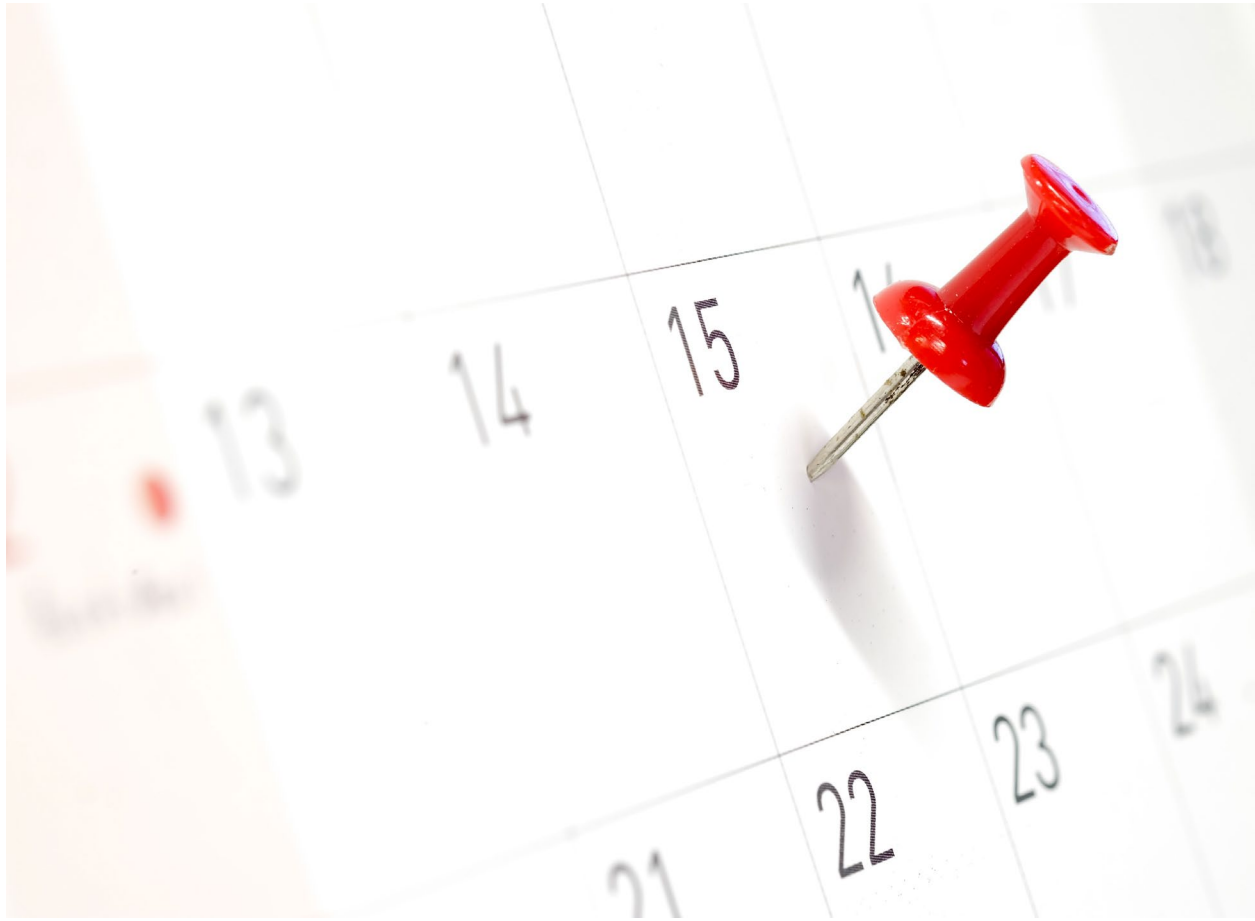
All Milestone 7 activities (Learning Collaborative participation) and required documentation must be completed and uploaded in D-TIPs by **December 15, 2026**, to receive the incentive payment of $15,000.



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LOOKING AHEAD: NEXT STEPS

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Homework

- Consider where you're at and what steps you may need to take given what you've heard about potential changes coming from CMS for the TMaH Payment model.
- Identify one or two *best practices* or *ideas for change* discussed today that you would like to consider advancing in your practice for your individual coaching sessions.

Collaboration and Support

- **Individual Coaching**: All participants should have individual coaching sessions scheduled with their assigned coaches!
- **Goal**: Complete all sessions before **December 15, 2026**.

Coming Next!

- **Session 4**: Tuesday, August 11, 2026, 11:30 AM–12:30 PM
- **In-Person Workshop**: Tuesday, October 20, 2026 (***SAVE THE DATE!)***

WRAP UP AND NEXT STEPS

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- Please complete the online **evaluation by <u>July 24</u>!**
  - **<u>If you would like to receive CME and CE credit, the evaluation will need to be completed</u>.** You may use the link in the chat box or scan the QR code to access the evaluation.

- The slides and a recording of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.

- For more information about Integrated Care DC, please visit: www.integratedcare.dc.gov

CONTACT US

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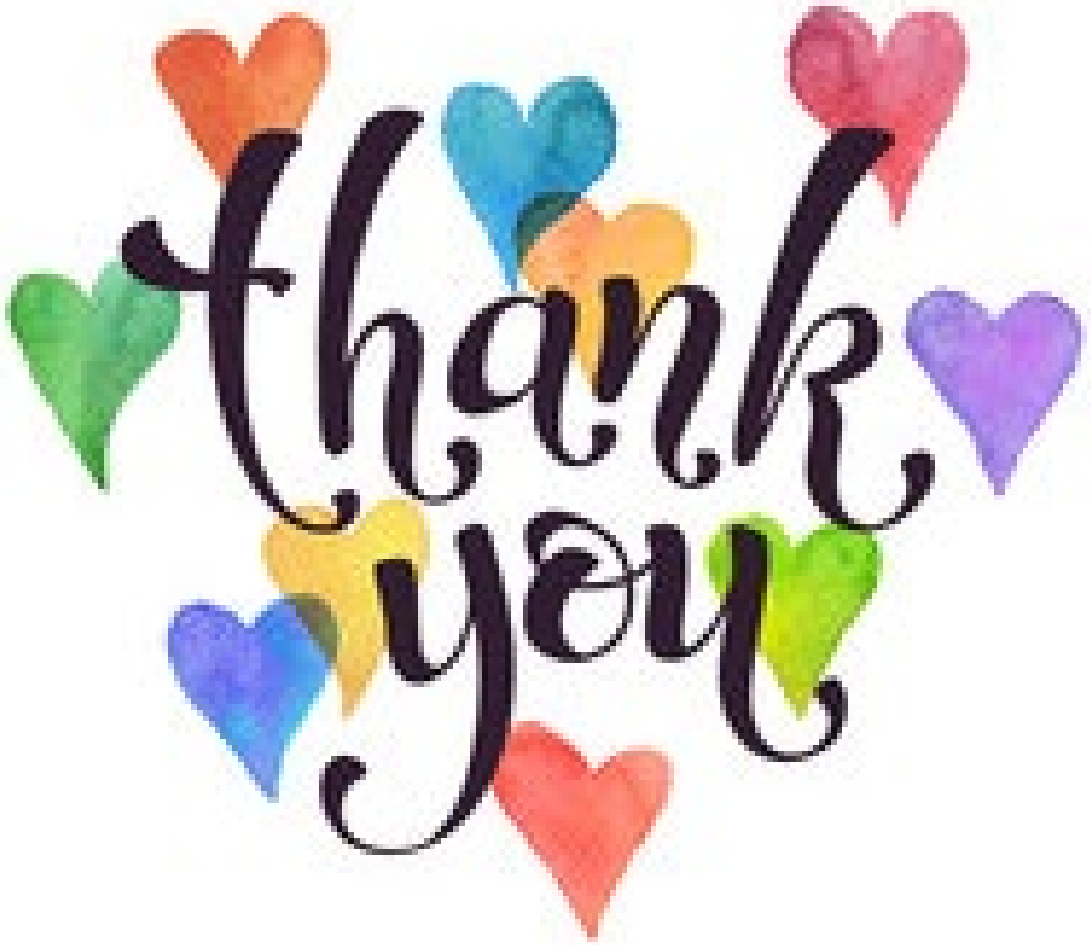

For the Amazing Work You Do!

APPENDIX

REFERENCES

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CT MEDICAID: EPISODE OF CARE APPROACH COMPLETELY OVERHAULS MATERNITY PAYMENTS

INTEGRATED CARE DC
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Program Start Date: January 1, 2025

Eligible Providers: 30+ deliveries/ year. Excludes FQHCs.

HUSKY HEALTH CONNECTICUT

Episode:	**Pregnancy (280 days prior to delivery)→ Labor and Delivery (L&D)→ Postpartum (90 days postpartum)**			
Maternity Episode Services	• Prenatal visits • Routine ultrasound • Labs • Genetic testing • Doulas • Lactation Consultants	• Care Navigators • Group education • Birth education • Screenings • Care coordination activities	• Vaginal Delivery • C-Section • OB/licensed midwife professional services	• Breastfeeding Support • Depression Screening • Contraception planning • Ensure link from L&D to primary and pediatric care

- Bundled “Case Rate” payments adjusted based on:
  - Quality; Social and Clinical factor risk adjustment
  - Add-on payment of $21/month to fund doula and lactation services

NJ MEDICAID: EPISODE OF CARE APPROACH INCREMENTALLY CHANGES MATERNITY PAYMENTS

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Program Start: 2022 (pilot)

Eligible Providers: Voluntary participation, 15+ deliveries. FQHCs can participate but not as the accountable providers

Episode:	Pregnancy (280 days prior to delivery)→ L&D→ Postpartum (60 days postpartum)
Maternity Episode Services	• Includes physician services, inpatient and outpatient hospital (including emergency department visits), imaging, labs, and prescription drugs. • Includes services delivered by the episode participant and services delivered by other providers

3 Payment Opportunities:

- Shared Savings based on cost of care during the episode and performance in quality
- High Performer Bonus: episode cost of care and quality
- SUD Incentive: caring for a high % of patients with substance use disorder (SUD)