Promoting Equity and Value in Maternity Care

June 2020

The Health Care Transformation Task Force, with support from The Commonwealth Fund, convened a cross-sector group of maternity experts in January 2020 to identify strategies to accelerate the dissemination of effective value-based payment and delivery system models that improve maternal health outcomes, eliminate health disparities, and advance health equity, which informed the development of this report.

Value-Based Payment for Maternity Care: Challenges and Opportunities

A complex fabric of systemic issues that have led to decades-long negative trends and lasting disparities in maternal health outcomes, including through provider reimbursement which incentivizes and drives how care is delivered. Multiple sectors must come together to dismantle the barriers and systems that contribute to poor maternal health outcomes and make pregnant and birthing persons' health a priority. It is crucial to prioritize action items that get at the root cause of the most glaring issue with maternal health in this country: racial disparities. Culture change is hard to achieve because it requires commitment by leadership, and leaders across the health care industry – including policymakers – must first recognize and acknowledge the extent to which systemic racism and economic inequalities have been and remain drivers of racial disparities in maternal health outcomes in the U.S.

Value-based payment models are one promising tool to improve maternal health outcomes and promote equity, but maternity care stands out as an area where the transition to value-based payment has been very slow. The term "value-based" has become ubiquitous in the health care industry to describe payment and delivery models that move away from traditional fee-for-service medicine, yet the term "value" has different connotations to different stakeholder groups. Pregnancy is often viewed by health care payers and providers as an episode of care but for the pregnant person, pregnancy is part of their lives and longer-term health. Many women continue to lack access to affordable pregnancy care; in both rural and urban settings, hospital and obstetrics unit closures, workforce shortages, and unmet social needs have contributed to an increase in severe maternal morbidity and mortality.[1,2] There is a concern that value-based bundled payment models for maternity care – which contain total spending around a target price for all pregnancy-related services – could further disincentivize providers from taking Medicaid patients, or exacerbate underutilization of high value services for Medicaid beneficiaries relative to commercially insured plans.[3]

Health care utilization and spending is not evenly distributed throughout the perinatal period, with the majority of spending associated with the intrapartum hospital stay for women and newborns. One study showed that 81-86% of payments for maternal-newborn care in commercially insured and 70-76% in Medicaid insured birthing people was attributed to intrapartum care.[4] A more value-driven approach to provider reimbursement would shift the current allocation of resources from the intrapartum period – where procedure-intensive care and NICU utilization represent the majority of all perinatal spending – and invest in addressing significant unmet social

needs during the prenatal and postpartum phases of care, as well as lifelong primary and behavioral health care.[5,6]

Integrating an Equity Framework to Value-Based System Reform

While payment reform is an important improvement lever, current incremental approaches to value-based payment in maternity care are ill-equipped to facilitate needed systemic changes to promote equity and value in maternity care by themselves. Payment reform alone cannot address the impact of institutional racism and implicit bias on maternal health outcomes. Further, the window for perinatal care is a relatively short period of time to fully address chronic conditions or unmet social needs driven by systemic inequities and manifested in health disparities for low-income women and women of color.
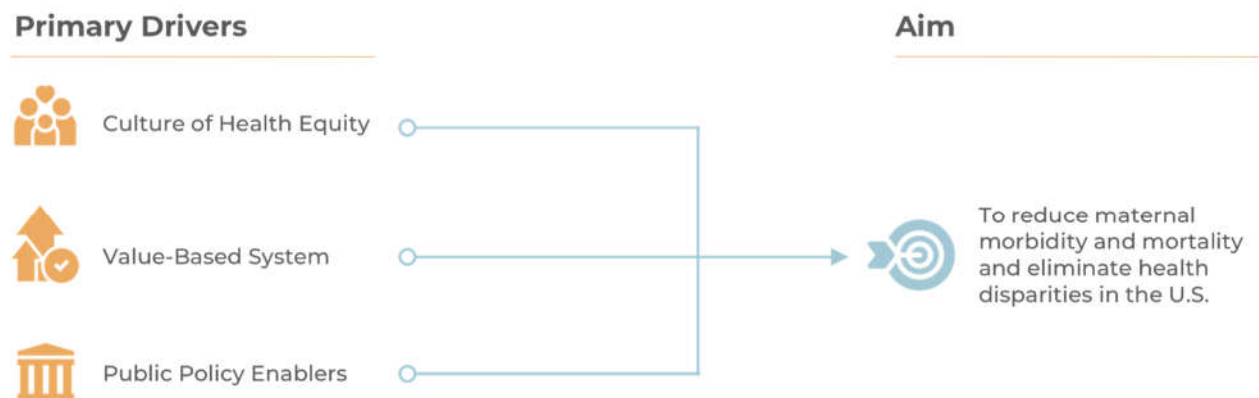
Health system leaders and policymakers must be committed to integrating a framework of health equity to be able to deliver on the aim of reducing maternal morbidity and mortality and eliminating health disparities in the US.

> **"Health inequities are unjust and avoidable differences in health and well-being between and within groups of people. These inequities are evident in mortality and morbidity outcomes at individual and population levels. Promoting health equity is both a social justice and a practical issue that requires not only addressing the immediate health needs of individuals, communities, and populations but also tackling current and historical injustices manifested in underlying social structures, systems, and policies—the root causes of inequities."**
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> M. Ford-Gilboe, et al. (2018). How equity-oriented health care affects health: Key mechanisms and implications for primary health care practice and policy. *The Milbank Quarterly, 96(4), pp. 635-671.*

Theory of Change

What follows is a theory of change predicated on the premise that value-based delivery system reform, which includes developing and implementing processes and infrastructure to support the delivery of high-value care, must be coupled with a health equity framework and enabling public policy environment in order to achieve meaningful change.

Primary Drivers

Culture of Health Equity

Value-Based System

Public Policy Enablers

Aim

To reduce maternal morbidity and mortality and eliminate health disparities in the U.S.

The primary drivers of change – culture of equity, value-based system, and public policy enablers – are further described by secondary drivers and associated interventions that industry stakeholders can act on to drive towards the aim of reducing maternal morbidity and mortality and eliminating racial disparities in maternal outcomes in the U.S.

Driver 1: Culture of Health Equity

Fulfilling a culture of health equity requires a systemwide racial and economic justice approach to undo the status quo, with many implications beyond maternity care.

CULTURE OF HEALTH EQUITY

SUPPORTING DRIVERS	INTERVENTIONS & IMPROVEMENT STRATEGIES
Addressing structural racism	• Addressing structural and cultural competency • Patient/provider trust-building
Workforce development and training	• Reform medical education to include training on structural and cultural competency • Diversify the birthing workforce • Implicit bias training
Equity-focused quality and safety initiatives	• Measure patient experience, including respectfulness and race-based discrimination • Stratify quality and outcomes data by race and ethnicity

Addressing Structural Racism

Racial disparities in maternal health outcomes persist despite increased income and education.[7] The 2018 Listening to Mothers Survey, significant disparities exist in self-reports of unfair treatment or bias among women across race/ethnicity, language and insurance status. For

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example, eleven percent of Black women reported being treated unfairly because of their race or ethnicity during a hospital stay, compared to one percent of White women. Similarly 9 percent of women with Medi-Cal (Medicaid) coverage reported unfair treatment in the hospital because of their type of insurance compared to 1 percent of privately insured women.[8] The U.S. must also contend with a long history of coerced and involuntary female sterilization of women of color, low-income, disabled and incarcerated women, and those with mental illness; medical experimentation; and segregation.[9] This historic mistreatment of Black and Brown women has understandably created a deep-seated mistrust of the health care system.

The Strong Start interventions for Medicaid beneficiaries offer a powerful example of the impact of relationship-building can have on maternal health outcomes. The goal of the Strong Start program was to improve maternal and infant outcomes for women covered by Medicaid and the Children's Health Insurance Program (CHIP) during pregnancy using three evidence-based care models: Birth Centers, Group Prenatal Care, and Maternity Care Homes. Consistent across all three models was a strong emphasis on psychosocial support through relationship-based care. Women served by

> **Introducing a trust-building visit into prenatal care practice could help overcome mistrust and fear of the health care system instilled by the historic mistreatment of women of color, as well as the ongoing bias and unfair treatment reported by women of color and low-income women.**

Strong Start reported valuing the additional attention and time the model provided including referrals to community services and greater emotional support. Program staff found that the enhanced services provided through Strong Start increased trust and engagement with the health care system, improved reported satisfaction with prenatal care and sense of well-being, led to better management of chronic conditions, and improved awareness of how to access community resources thereby improving financial, housing, and food security.[10] Additionally models of group prenatal care that specifically create community for black women and families are emerging and can serve as models for further improving outcomes.[11]

Workforce Development and Training

Physicians are not commonly trained in structural and cultural competency, but evidence and demand has grown for mandating inclusion of race-based medicine curricula and licensing requirements.[12,13] . Implicit bias is created by and reinforces inequitable systems, structures, and norms throughout the health care system, including in the administration and evaluation of payment models, that contribute to unacceptable disparities in patient care outcomes. Implicit bias training can enable greater conversations about race and gender oppression and how these factors

influence maternal health disparities. Programs such as the "Eliminating Inequities in Perinatal Health Care Project" launched by Diversity Science provide practical tools and evidence-based learning modules for perinatal providers focused on implicit bias and reproductive justice.[14] In 2019 the American Academy of Family Physicians (AAFP) launched implicit bias training as part of the organization's "EveryONE Project," a toolkit to promote diversity and address the social determinants of health and to advance health equity through family medicine.[15] The implicit bias training tool provides a curriculum for practicing family physicians as well as residents focused on how to deliver culturally proficient care with the goal of reducing health inequities.[16] Implementing this tool has helped providers recognize and combat implicit biases and has created a safe space to have difficult conversations on race and gender oppression.

This training is particularly important for providers and medical students as research suggests that training including individuation and practiced perspective-taking can help reduce the contribution of implicit bias to health disparities.[17] All health care stakeholders should commit to implicit bias training that acknowledges unconscious attitudes – as well as explicit discrimination – and provides strategies to reduce bias and counter its impact. In addition to implementing workforce training that centers health equity, health care institutions should prioritize the recruitment and development of racially and ethnically diverse health care professionals, and examine "standard" care delivery practices. For example, the structure of prenatal visits is not conducive to providers prioritizing relationship building and asking patients how they are, what they are feeling, and what is worrying them. Transforming perinatal care to allow for relationship-building requires a fundamental change in how providers are trained and practice, including addressing the role of explicit and implicit bias

Equity-Focused Quality and Safety Initiatives

Quality and safety improvement initiatives should center equity as an objective. A first step to doing this is by stratifying all quality and evaluation outcomes by race, ethnicity, and socioeconomic status. Maternal mortality and morbidity data as well as value-based payment model performance outcomes measured by payers should be stratified by race and ethnicity in order to identify variation and health disparities and target interventions to close the gap.

Implementing patient-reported outcomes measures (PROMs) and respectfulness measures can also ensure that pregnant persons' goals and values are being honored. Research indicates that beyond the retrieval of information and data, PROMs serve an important relationship building function by providing patients a space to discuss issues with providers[18]; there is further development needed to create a measure of woman-reported outcomes of maternal and newborn care that could provide a basis for both clinical dialogue and formal evaluation. The National Birth Equity Collaborative is working with the American College of Obstetricians and Gynecologists to develop a new "respectfulness measure" for patient-reported experiences related to trust in the care team during childbirth and pregnancy.[19] Additionally, CMS, provider organizations, and measure development organizations should prioritize development of maternity patient-reported outcomes measures that capture feedback on the patient's care experience, including perception of unfair treatment due to race, ethnicity, and other social factors, in order to eliminate obstetric racism.[20]

Driver 2: Value-Based System

A value-based system of health care prioritizes accountability for quality, health outcomes, and value over volume of care.

VALUE-BASED SYSTEM

SUPPORTING DRIVERS	INTERVENTIONS & IMPROVEMENT STRATEGIES
High-value care	• Shared/collaborative decision-making • Patient education and engagement • Integrated medical, behavioral, social needs
Full complement of birth workers	• Payment parity for midwives & birth centers • Reimbursement for doulas/community health workers and maternity care coordinators • Coordination with and funding for community-based organizations
Value-based payment	• Pay-for-performance • Alternative payment models
Data sharing and rapid-cycle program evaluation	• Develop better quality improvement measures • Develop better accountability measures • Multi-payer alignment on measures

High-Value Care

High-value maternity care is equitable, patient-centered, culturally competent, and respectful, and requires a focus on improved clinical quality in addition to shared and collaborative decision-making with the birthing person.

Value-based payment model isn't a necessary precondition to pay for and drive greater uptake of high-value care. Women's interest in less intervention-focused models for perinatal care – including midwife-led care and freestanding birth centers – far outweighs its uptake, in part due to limited availability and access to these types of providers and facilities as they are not covered by Medicaid or other insurance.[21] Less intervention-focused care models are not only highly effective but also reduce costs for the health care system.[22] Pregnant persons should be able to make an informed choice regarding their care plan, provider, and birth setting which requires the educational resources and support tools (e.g., portal/app communication) necessary to make these decisions.

As the Listening to Mothers survey indicates, there is clear evidence that most maternity care decision-making remains uninformed and that caregiver attitudes, preferences, and incentives strongly impact use of interventions. Recent research indicates that use of shared decision aids in pregnancy care resulted in increased knowledge and significant reductions in decisional conflict.[23] Health care providers should implement decision aids that are designed to facilitate shared, informed choices that are more consistent with the pregnant persons' values about labor and delivery. An important component of shared decision-making is providers' understanding of the structural determinants of health that may influence their patients' health. Maternity care providers should implement standardized screening, documentation, and referral for social risk factors, unmet social needs, and behavioral health issues and maximize referrals and integration with social services and behavioral health providers to meet pregnant persons' needs. Other stakeholders, such as payers, can help support providers by reimbursing for other birth workers such as maternity care coordinators, doulas, and community health workers to assist in connecting patients to community resources and social services.

Multi-modal decision aids and expanded perinatal care teams should help with both patient education as well as a provider's understanding of the pregnant person's values and desires about their care. As noted in the recent National Academies of Medicine report on birth settings, having these tools available to women prior to the onset of pregnancy through employers, health plan intranets, or respected maternity websites, women and providers might be more knowledgeable about choices for their care.[24]

Full Complement of Birth Workers

Community-based organizations and perinatal health workers have been shown to improve maternal health outcomes and reduce health disparities by providing services like peer support programs, community doulas, and postpartum support groups.[25] Community Health Workers (CHWs) – like doulas – often have shared lived experiences with the people they serve and are trained to bridge the community and the health system, to provide health education and promote healthy behaviors, and also serve as patient advocates.[26] Research indicates that CHWs play a key role in helping individuals access health care, including coordinating primary care and preventive services, managing chronic conditions, and empowering and activating patients to get needed clinical and non-clinical services and care.[27] Yet the wraparound services provided by these organizations and perinatal health workers like doulas are not universally reimbursed by insurers.

State Medicaid and commercial payers should modify fee schedules to reimburse for perinatal support services. Minnesota[28], Oregon[29], Indiana[30], and New Jersey[31] – cover doula services through Medicaid, and New York State Medicaid launched a 3-year pilot program in 2019 covering doula services. A number of states have also introduced legislation relating to Medicaid coverage of doula services.[32] However, these pilots and expanded coverage programs are only successful if they incorporate adequate reimbursement and do not create barriers to licensure that community-based doulas often have difficulty overcoming. Additional efforts should address pay equity for doulas and investments in a culturally diverse workforce.

Value-Based Payment

Changing the way that providers are paid can be an effective tool for incentivizing better care delivery. Previous work by the HCTTF outlined three predominant payment strategies in the transition away from fee-for-service care: 1) perinatal fee schedule changes, or paying differently for high-value vs. low-value care, 2) value-based maternity payments which link reimbursement to maternal outcomes and total cost, and 3) comprehensive payments for mother and newborn which link reimbursement for both maternal and infant quality outcomes and total cost.[33]

Pay-for-performance and FFS reimbursement can incentivize best practices, with ready examples of payment changes reducing unwarranted variation in utilization and or noncompliance with clinical guidelines. Payers can utilize fee schedule changes to pay for high-value care when contracting with providers not ready to take on risk or enter into an episode of care or other risk-based model due to lack of infrastructure and resources in their practice or communities. For example, several state Medicaid programs have unbundled payments for postpartum long-acting reversable contraception (LARC) procedures from the maternity global fee to improve access to this service for women that want to voluntarily space pregnancies.

Fee schedule changes can also take the form of reduced or non-payments for services that are not evidence-based. As an example, decades-long guidance from the American College of Obstetricians and Gynecologists (ACOG) discouraged elective deliveries (e.g., scheduled C-Sections or medical inductions) prior to 39 weeks gestation without a medical reason.[34] Many payers have stop paying for early elective deliveries prior to 39 weeks as an effective strategy to reduce this low-value and potentially harmful service.[35] Texas introduced a nonpayment policy for early elective deliveries and saw the rate of such deliveries decrease by 10 – 14 percent among the Medicaid population[36]; other states adopting similar policies have experienced comparable reductions.

Alternative payments models (APMs) link provider reimbursement to maternal outcomes and cost. Given the shared accountability between providers and payers, it is important for local-level stakeholders to collaborate in the design of APM models to establish shared objectives and metrics of success. For example, in designing an episode of care model with QualComm, the Pacific Business Group on Health convened local stakeholders to identify what two key metrics the episode of care model will focus on. The stakeholders identified two leading goals: 1) increasing use of nurse-midwives, and 2) greater behavioral health screenings. Thus, the models' performance will be evaluated by the percentage of births attended by nurse-midwives and the new National Committee for Quality Assurance (NCQA) postpartum depression screening performance measure.

Data Sharing and Rapid-Cycle Program Evaluation

There is a dearth of perinatal clinical quality measurement and inconsistent approaches to data collection and sharing that limits the capability to effectively identify care gaps and quality anomalies, stratify outcomes data by race and ethnicity, and guide QI work. For example, ACOG has noted inconsistency in the way providers measure postpartum hemorrhage, despite this being the cause of approximately eleven percent of maternal deaths in the U.S; of the deaths due to hemorrhage, 54-93 percent may be preventable.[37] Additionally, stakeholders should transparently share information about failures as well as successes and best practices, learning about what does not work is critical given the imperative of acting and innovating quickly to protect pregnant persons and babies.

Commonly used "adequacy" measures for prenatal and postpartum care (*e.g.*, when or how many prenatal visits were attended) are not seen as a sufficient means to assess the quality of care received. And basic utilization information – such as the proportion of midwifery-attended visits and births – isn't regularly captured and reported. Federal funding is one potential catalyst to advance more meaningful quality metric development, especially measures used for

"accountability," e.g., in a pay-for-performance, public reporting, recognition or alternative payment model, which must meet a higher bar in terms of validating and benchmarking.

There is room for greater cross-stakeholder alignment across various measure sets. Insurers, clinicians, hospitals, and patients are also looking at different sets of information, often on different systems. Better interoperability among electronic health record systems and better clinical data exchange among providers, hospitals, birth centers, and patients is needed for timely program evaluation and as well as patient care coordination. The general lack of women's health data elements in the United States Core Data for Interoperability (USCDI) is problematic, particularly the lack of pregnancy status.[38] Current metric development processes do not support standard measure definitions and consensus on these definitions, but private payers could use an aligned set of metrics in contracts regardless of type of provider or line of business.

Driver 3: Public Policy Enablers

Policy change is also a critical lever to be able to address the complex and interconnected public health and social service shortcomings that often contribute to pregnant persons' poor outcomes and widening disparities.

	SUPPORTING DRIVERS	INTERVENTIONS & IMPROVEMENT STRATEGIES
PUBLIC POLICY ENABLERS	Comprehensive health coverage across the life course	• Medicaid expansion • Extended postpartum Medicaid coverage
	Supporting the maternity care workforce	• Scope of practice changes • Improved Medicaid reimbursement rates • Reimbursing for social services
	Federal/state partnership	• Federal/state legislation • Technical assistance and guidance • Demonstration projects and program evaluation

Comprehensive Health Coverage Across the Life Course

Many of the adverse outcomes during the perinatal episode emanate from deficiencies in primary health care, mental health, behavioral health, and oral health care. An analysis by Premier found that excess costs in labor and delivery are in part due to potentially preventable complications and pre-existing chronic conditions, and that care coordination and management of pre-existing conditions could help hospitals lower their labor and delivery costs for complicated childbirths by 20 percent.[39] Yet the maternity window is a short period of time during which a lifetime of inequities and deficiencies cannot be fully addressed.

In order to improve maternal health outcomes our system needs to be redesigned to ensure comprehensive access to affordable and comprehensive health care coverage throughout pregnancy, postpartum up to one year after delivery, and throughout the entire lifespan. Longitudinal access to affordable health care is both a policy driver and a health equity driver given that health insurance coverage is marked by significant racial and ethnic disparities in the United States.[40]

Pregnancy-eligible Medicaid beneficiaries are subject to time-limited coverage of 60 days postpartum in both Medicaid expansion states and non-expansion states. There are 14 states that have not yet expanded Medicaid; states that have expanded Medicaid have a significantly lower maternal mortality ratio relative to non-expansion states.[41] Approximately 50 percent of women in non-expansion states and approximately one in three women in expansion states had an insurance disruption during the preconception through postpartum period.[42] This disruption and 60-day cutoff are particularly concerning given that one-third of maternal deaths occur one week to one year postpartum.[43] In addition to supporting comprehensive coverage across the lifespan by expanding Medicaid, States can take action now to extend postpartum Medicaid coverage to a full year. California, Illinois, Missouri and New Jersey all took legislative and regulatory action in 2019 to extend postpartum coverage.[44]

Expanding the Medicaid coverage for low-income pregnant women from 60 days to a full year postpartum will ensure coverage during a critical window for new moms and babies as roughly one-third of all pregnancy-related deaths occur one week to one year after a pregnancy ends according to the CDC. This action can be taken by states individually through waivers or financing extended Medicaid coverage on their own, or Congress could change federal statute. The bicameral Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services (MOMMIES) Act re-introduced in the 116th Congress would expand categorical Medicaid eligibility for low-income pregnant women from two months to a full year postpartum and ensure that all pregnant and postpartum women have full Medicaid coverage, rather than coverage that can be

limited to pregnancy-related services.[45] The Helping Medicaid Offer Maternity Services (MOMs) Act[46] and the Mothers and Offspring Mortality and Morbidity Awareness Act (MOMMA's) Act[47] also have similar aims.

Supporting the Maternity Workforce

Low Medicaid reimbursement rates further disincentivize providers from caring for this vulnerable population. States should bring Medicaid reimbursement rates to parity with Medicare, similar to how some states are working to bring primary care and specialty care rates to parity. Additionally, within Medicaid, greater payment parity is needed for midwives.[48] Greater payment parity for birth centers is also essential to ensure that high-value providers and birth settings are available. States can also improve access to midwife-led births by changing scope of practice laws to support the maternity care workforce, including:

- *Supporting the full practice authority for Certified Nurse Midwives (CNMs), Certified Midwives (CMs) and Certified Professional Midwives (CPMs) to the full extent of their training and licensure*
- *Licensing Certified Professional Midwives and Certified Midwives to bill and practice in all states*
- *Licensing Nurse Practitioners to practice without supervision and bill on their own*
- *Offering state-to-state reciprocity across the multiple types of accrediting and credentialing bodies for midwives*

States should also drive greater integration of medical, behavioral, and social needs care through policy changes. As one best practice example, the California Assembly passed legislation (AB 2193) that requires obstetric providers to screen pregnant persons for perinatal mood and anxiety disorders in the perinatal period.[49] This legislation went into effect on July 1st 2019, making California the 5th state to require screening for perinatal mood and anxiety disorders along with New Jersey, Illinois, Massachusetts, and West Virginia.[50] West Virginia also requires that every maternity care provider in the state complete and submit a Pregnancy Risk Scoring Instrument, which identifies medical, behavioral, and social risk factors.[51]

However, social needs and risk factor screening is ultimately inadequate if appropriate social safety net funding and community resources are unavailable to adequately address the needs identified during screening. Ensuring robust social services requires a strengthening of social safety net programs so that they are accessible and able to adequately meet the needs of pregnant persons and their children throughout the course of their lifetime. State legislation and policies are also needed to address local market issues that contribute to access and quality issues, and advance interventions and policy that will truly improve health outcomes and support all people to achieve their highest possible level of health and well-being. States governments are well-positioned to

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advance robust multi-sector partnership between health care, public health, social services, and community-based organizations (CBOs) to advance this objective.[52]

Federal/State Partnership

The 116th Congress recently introduced a number of bills aimed at improving maternal health outcomes under the Black Maternal Health Momnibus Act of 2020, including legislation to extend 12-month postpartum coverage for Medicaid beneficiaries, invest in rural maternal health, promote midwifery, and implement implicit bias trainings for maternity care providers.[53] The Birth Access Benefitting Improved Essential Facility Services (BABIES) Act would address the lack of a federally mandated birth center facility fee by establishing prospective payment systems under Medicaid and providing greater reimbursement parity through a variety of payments including a partial facility payment.[54]

The CMS Center for Medicaid and CHIP Services has a role to play in providing States with technical assistance and guidance to understand which benefits, services, and alternative payment models can be covered through existing authorities. Likewise, States could drive greater uptake of value-based payment models for maternity care by requiring the state purchasing agency to meet a threshold of births covered under a value-based maternity model, with appropriate protections in place for high-risk pregnancies.

The Momnibus bill includes the Innovative Maternal Payment and Coverage to Save Moms (IMPACT) Act, calls on CMS to implement a perinatal APM demonstration project and specifies that the Secretary must conduct an evaluation of the project that stratifies maternal health outcomes by race, ethnicity, socioeconomic indicators, and other factors at their discretion.[55] Current and future APMs, whether in Medicaid or the commercial market, should follow suit and stratify outcomes to ensure equity is a criterion for model evaluation and expansion.

Conclusion

The strategies outlined above are foundational and intended to provide greater transparency about the needs and experiences of pregnant persons, while addressing coverage gaps to ensure that all women have access to culturally-competent, integrated, and affordable care in their communities and within the health care system.

In support of taking multi-sector action, the Health Care Transformation Task Force has launched the **Maternal Health Hub**, a public learning community open to all health care stakeholders including payers, providers, policymakers, researchers, patients, community-based organizations, and others to share best practices and develop common action plans to move towards a more equitable system of maternal health care. For more information and to join the forum, visit www.maternalhealthhub.org.

The Health Care Transformation Task Force is a unique collaboration of patients, payers, providers and purchasers working to lead a sweeping transformation of the health care system. By transitioning to value-based models that support the Triple Aim of better health, better care and lower costs the Task Force is committed to accelerating the transformation to value in health care.

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