OB Task Force: Financing & Sustainability Workgroup — Meeting 1 Summary

Meeting date: November 10, 2026
Duration: 1 hour
Workgroup leads/facilitators: Michael Costa and Rachel Garfield
Next meeting: November 23, 2026

1-Minute Summary: Key Takeaways

The first Financing & Sustainability Workgroup meeting focused on defining the financial challenges facing obstetric care in Vermont, especially in rural and low-volume settings. Participants agreed that **low reimbursement, particularly Medicaid reimbursement, is a major issue**, but also emphasized that **higher rates alone will not solve the problem**.

The group identified the need for a **multi-faceted approach** that addresses payment models, capacity funding, staffing costs, shared workforce strategies, and reimbursement for the full continuum of women's, maternal, newborn, and family-centered care.

Top priorities included:

- Paying for **capacity in low-volume birthing settings**, not only per delivery.
- Establishing an **analytic baseline** for OB costs, reimbursement, and losses.
- Understanding upcoming **maternity billing/coding changes**.
- Exploring **alternative payment models**, such as capacity payments, global budgets, or broader women's health payment models.
- Considering how Vermont can **share staff, training, and clinical competencies** across institutions.
- Recognizing that OB services include prenatal, delivery, postpartum, newborn, lactation, mental health, social work, and community supports.

The next step is to review notes, define needed homework, and return with data and potential solution areas for discussion.

Attendees

Name	Affiliation
Rachel Garfield, Workgroup Chair	Vermont Child Health Improvement Program, UVM

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Michael Costa, Workgroup Chair	Gifford Health Care
Rick Hildebrant, Taskforce Chair	Vermont Department of Health
Ilisa Stalberg, Organizer	Vermont Department of Health
Katy Leffel, Organizer	Vermont Department of Health
Shayla Livingston	Vermont Department of Health
Julie Parker	Blueprint for Health
Chelsea Oclatis	Maitri Healthcare
Lou McLaren	Blue Cross Blue Shield of Vermont
Elizabeth A. Kyhill	Rutland Regional Medical Center
Devon Green	Vermont Association for Hospitals and Health Systems
Terri Lynn Graham	Central Vermont Medical Center
Tracey L. Paul	North Country Hospital
Stephanie Winters	Vermont Medical Society
Jonathan Billings	Northwestern Medical Center
Jessa Barnard	Vermont Medical Society
Mindy Dame	Southeastern Vermont Medical Center
Alicia Cooper	Department of Vermont Health Access
Marc Kosak	Central Vermont Medical Center
Deirdre M. O'Reilly	UVM Medical Center
Sara Forward	Vermont Child Health Improvement Program, UVM
Scott Comeau	Porter Medical Center
Katie Garland	Mathematica
Carrell, Katelyn	Vermont Agency of Human Services
Kimberley Sampson	Southeastern Vermont Medical Center
Debra S. Beauchesne	North Country Hospital
Kristen Bigelow	BiState Primary Care Association
Jacquelyn Ethier	Brattleboro Memorial Hospital
Tom Weigel	Blue Cross Blue Shield of Vermont
Maddison McGuiness	Maitri Healthcare
Marj Meyer	UVM Medical Center, VCHIP
Jun Chon MD	Porter Medical Center / CVMC
Erinn Mandeville	Green Mountain Birth Center
Craig Jones	Vermont Agency of Human Services
Sarah E. Decker	Rutland Regional Medical Center
Corina Tennant	Brattleboro Memorial Hospital
Amy Coonradt	Agency of Human Services

Purpose of the Meeting

Michael Costa opened by emphasizing that the workgroup should be **action-oriented** and focused on concrete steps to sustain access to OB care in Vermont.

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He framed the work as a three-meeting process:

1. **Meeting 1:** Understand the problem.
2. **Meeting 2:** Identify options and move toward recommendations.
3. **Meeting 3:** Name concrete actions for the state, providers, patients, and partners.

The purpose of this first meeting was to review pre-meeting survey results, discuss whether the identified priorities reflected participant concerns, identify gaps, and begin narrowing the group's focus.

Need, Priorities, and Charge

Need

Participants described a growing challenge in sustaining OB services in Vermont, especially in rural and low-volume settings. Key pressures include:

- Declining birth volume, including an approximately **10% reduction in births over the last decade**.
- High fixed costs required to maintain 24/7 OB readiness.
- Financial instability from low or declining volume.
- Workforce challenges, including recruitment, retention, locums reliance, and maintaining competency.
- Risk of creating or worsening **obstetric deserts** if services close.

Participants stressed that the analysis should include the **cost of losing OB access**, not only the cost of keeping services open.

Priorities

The pre-meeting survey identified four major priorities:

1. **Paying for capacity in low-volume settings**
   OB units must maintain readiness regardless of birth volume.
2. **Staffing costs and salary needs**
   Includes OBs, CNMs, per diem staff, locums, and cross-trained providers.
3. **Low reimbursement rates per case**
   Medicaid reimbursement was repeatedly raised as inadequate.

4. **Limited reimbursement for related services**
   Includes services around pregnancy, postpartum, newborn care, transport, lactation, mental health, social work, and family supports.

Charge of the Workgroup

The workgroup's charge is to develop **concrete, actionable recommendations** related to financing and sustainability that can inform state partners and potentially support policy or legislative action.

The group is expected to:

- Clarify the financing and sustainability problems facing Vermont OB care.
- Identify priority areas for action.
- Explore feasible payment and sustainability strategies.
- Consider roles for the state, payers, hospitals, providers, and community partners.
- Move from discussion toward actionable recommendations.

Survey Themes Reviewed

Rachel Garfield summarized approximately 15 survey responses, which generated about 24 distinct items. The themes were grouped into four major areas:

1. Paying for Capacity in Low-Volume Settings

This was the most common theme. Participants noted that current payment structures generally pay by case or service, but do not adequately support the fixed cost of maintaining 24/7 OB capacity in low-volume settings.

2. Staffing Costs and Salary Needs

Sustaining OB care requires enough clinicians and staff to provide safe coverage. Issues included competitive salaries, reliance on locums and per diem staff, recruitment challenges, cross-training needs, and skill maintenance in low-volume settings.

3. Low Reimbursement Rates

Participants raised concerns that reimbursement, especially Medicaid reimbursement, does not cover the cost of OB care and creates barriers to sustaining hospital and private practice models.

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4. Limited Reimbursement for Related Services

Participants emphasized that OB care extends beyond delivery. Under-reimbursed or unreimbursed services include transport, home visiting, lactation, mental health, social work, newborn care, telehealth, and community supports.

Major Themes from Discussion

1. Reimbursement Matters, but It Is Not the Whole Solution

Participants strongly affirmed that reimbursement is a major problem. Medicaid rates were specifically highlighted as inadequate for OB care.

At the same time, participants cautioned that increasing rates alone will not solve the issue. Sustainability also depends on volume, staffing, readiness, related services, and payment structure.

Potential focus areas:

- Medicaid rate adequacy.
- Commercial payer participation.
- OB reimbursement compared with other service lines.
- Payment structures beyond fee-for-service.

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2. Capacity Payments or Global Budgets May Be Needed

A recurring idea was that Vermont may need to pay for **availability and readiness**, not just births or visits.

Participants discussed:

- Capacity payments for keeping birthing units open.
- Global budgets for OB service lines.
- Readiness payments for rural or low-volume settings.
- Payment models that reduce volatility from fluctuating birth volume.

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3. The Group Needs a Clear Analytic Baseline

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There was broad agreement that recommendations should be informed by stronger data.

Key questions include:

- What does OB care cost today?
- What do hospitals and practices lose?
- What is reimbursed by payer type?
- What services are not covered?
- How do fixed costs compare to variable costs?
- How will upcoming billing and coding changes affect revenue?

This was identified as a priority homework area.

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4. OB Care Is Broader Than Delivery

Participants emphasized that financial analysis should not focus only on births. OB and women's health care also include:

- Prenatal and postpartum care.
- First-trimester and reproductive health care.
- Lactation support.
- Mental health care.
- Social work.
- Care coordination and patient communication.
- Newborn and nursery care.

The group noted that counting only deliveries risks missing significant under-reimbursed work.

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5. Workforce and Financing Are Intertwined

Although workforce has its own subgroup, participants noted that workforce and financing cannot be fully separated.

Key issues included:

- High locums and per diem costs.
- Providers leaving employed roles for higher-paid or more flexible work.
- Recruitment challenges in rural settings.
- Professional isolation and burnout.
- Need for skill maintenance in low-volume sites.

Potential approaches:

- Shared staffing models.
- Regional pools of OBs, CNMs, or other clinicians.
- Cross-training providers.
- Rotations through higher-volume sites.
- Payment support for competency maintenance.

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6. Billing and Coding Changes Are a Major Unknown

Participants discussed upcoming changes to maternity care billing, including the move away from the global OB package toward standard E&M billing and separated maternity codes.

Payer representatives noted that the impact is uncertain because CMS had not yet released key reimbursement information. The changes are expected to be budget-neutral in concept, but the real-world effect in Vermont is unknown.

Follow-up needed:

- Monitor CPT maternity care code changes.
- Understand payer implementation.
- Support practices in billing accurately.
- Assess whether changes improve or worsen sustainability.

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7. Alternative Models of Care and Patient Experience Matter

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Participants noted that some Vermont families seek care out of state for freestanding birth centers or specific midwifery models. Patient experience, quality, and trust were raised as important parts of sustainability.

Potential areas of focus include:

- Freestanding birth centers.
- Midwifery-led care.
- Home birth where safe and appropriate.
- Hospital/non-hospital partnerships.
- Patient-centered models that may keep families in Vermont.

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8. Malpractice and Liability May Be a Barrier

Malpractice was not a survey theme but was raised in discussion. It may affect home birth providers, some midwifery models, and provider recruitment or retention.

Potential follow-up areas include:

- Malpractice cost by provider type.
- Midwifery and home birth network participation.
- FTCA coverage opportunities for FQHCs.
- Liability concerns affecting OB practice.

Participant-Communicated Priorities

Across the survey, discussion, and chat, participants prioritized:

- Developing a financial baseline for Vermont OB care.
- Assessing Medicaid reimbursement adequacy.
- Exploring capacity payments or global budgets.
- Understanding upcoming billing changes.
- Avoiding OB deserts.
- Supporting shared staffing and training models.

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- Paying for the full continuum of women's, maternal, newborn, and family care.
- Covering transport, competency maintenance, and community-based supports.
- Ensuring quality and patient experience remain central.

Ideas or Areas of Potential Focus

The group did not finalize solutions, but several directions emerged:

Payment and Financing

- Capacity payments.
- Global budgets.
- Readiness payments.
- Supplemental payments for low-volume rural settings.
- Broader women's health payment models.

Data and Analysis

- Cost of OB care by setting.
- Reimbursement and losses by payer type.
- Fixed versus variable costs.
- Impact of declining birth volume.
- Impact of CPT/payment changes.
- Societal cost of OB deserts.

Shared Workforce and Training

- Shared OB/CNM staffing across hospitals.
- Cross-site rotations.
- Cross-training family medicine physicians or other clinicians.
- Regional clinical support.
- Skill maintenance in low-volume settings.

Alternative Care Models

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- Freestanding birth centers.
- Midwifery-led care.
- Home birth where appropriate.
- Hospital/non-hospital partnerships.
- Patient-centered models that retain families in Vermont.

Key Takeaways for Decision-Makers

- The core issue is not only reimbursement; it is sustainability amid low and declining birth volume.
- OB care requires capacity, readiness, and skilled staff regardless of delivery volume.
- Fee-for-service payment may not work well for low-volume rural OB care.
- Participants want data before recommendations.
- Medicaid reimbursement is a central concern, but solutions must also address payment structure, workforce, quality, and access.
- The cost of losing services, including OB deserts, should be included in the analysis.
- Maternal, newborn, women's health, and family supports should be considered together.

Task-Outs and Follow-Up Items

1. Review Meeting Notes and Identify Homework

Assigned to: Michael Costa, Rachel Garfield, VDH team/note-takers

The facilitation team will review meeting notes and determine what homework is needed before the next session.

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2. Develop or Scope an Analytic Baseline

Assigned to: Workgroup leads/VDH team, with likely input from hospitals, payers, and finance leaders

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Questions to address:

- What does OB care cost today?
- What do hospitals and providers lose?
- What reimbursement is received by payer type?
- What services are not covered?
- How will January/2027 coding changes affect revenue and losses?

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3. Examine Alternative Reimbursement Models

Assigned to: Workgroup leads, payers, Medicaid/DVHA representatives, hospital finance participants

Models to examine include:

- Capacity payments.
- Global budgets.
- Readiness payments.
- Broader women's health payment models.
- Payment for related services such as lactation, mental health, transport, social work, and newborn care.

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4. Track Maternity Billing/Coding Changes

Assigned to: Payers, Medicaid/DVHA, providers, and finance teams

Follow-up questions include:

- When will CMS release reimbursement information?
- How will payers respond?
- How should practices prepare?
- Will changes be budget-neutral in Vermont?
- Could changes improve reimbursement for currently uncompensated work?

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5. Coordinate with Workforce Workgroup

Assigned to: Workgroup leads and OB Task Force subgroup leads

Coordinate on shared staffing, regional pools, cross-training, competency maintenance, and support for rural clinicians.

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6. Bring Solution Areas to Next Meeting

Assigned to: Workgroup leads and participants

The next meeting will focus more directly on possible solutions, including participant ideas and models from other states.

Next meeting date: November 23, 2026

Bottom Line

The first meeting established that Vermont's OB financing challenge is complex and urgent. Participants agreed that sustainability will require more than higher reimbursement rates. The next phase should build a clearer financial baseline, assess upcoming billing changes, and explore payment models that support capacity, readiness, workforce stability, and the full continuum of maternal and newborn care.

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