Strengthening the Maternal Continuum of Care in New York City

Structural Conditions Shaping Access, Continuity, and Infrastructure

Town+Gown / NYC DDC Public Buildings and Doula x Design

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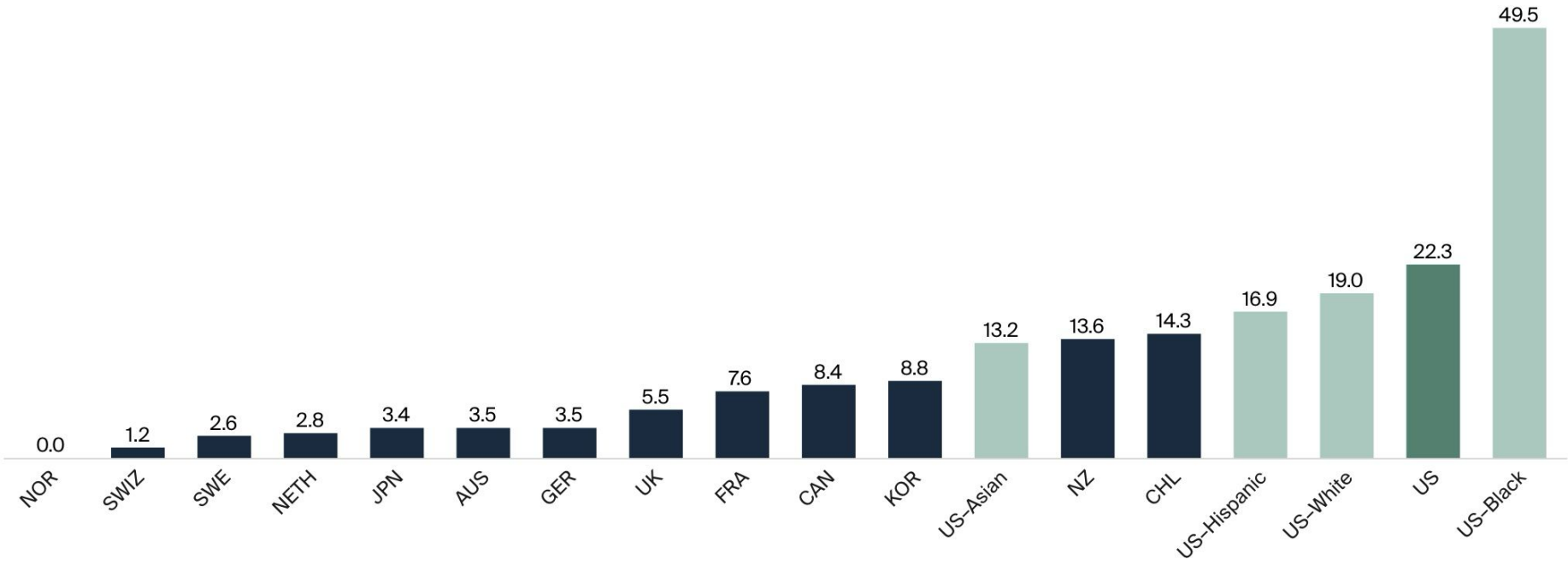
EXECUTIVE SUMMARY

NYC maternal mortality is driven by fragmented post-delivery system, not delivery-site quality

- Payment architecture concentrates revenue at delivery, structurally defunding prenatal and postpartum care — the exact phases where maternal deaths cluster
- Regulatory pathways (Article 28, CON) impose hospital-grade requirements on community providers, creating 18-24 month pre-operational debt with zero revenue
- Capital markets are inaccessible to community maternal providers: no bond ratings, no collateral, no bridge financing — locking infrastructure in hospital systems
- These three forces form a reinforcing cycle that makes community-based maternal care structurally unscalable, regardless of clinical evidence or demand

The United States continues to have the highest maternal death rate, with the rate for Black women by far the highest of any group.

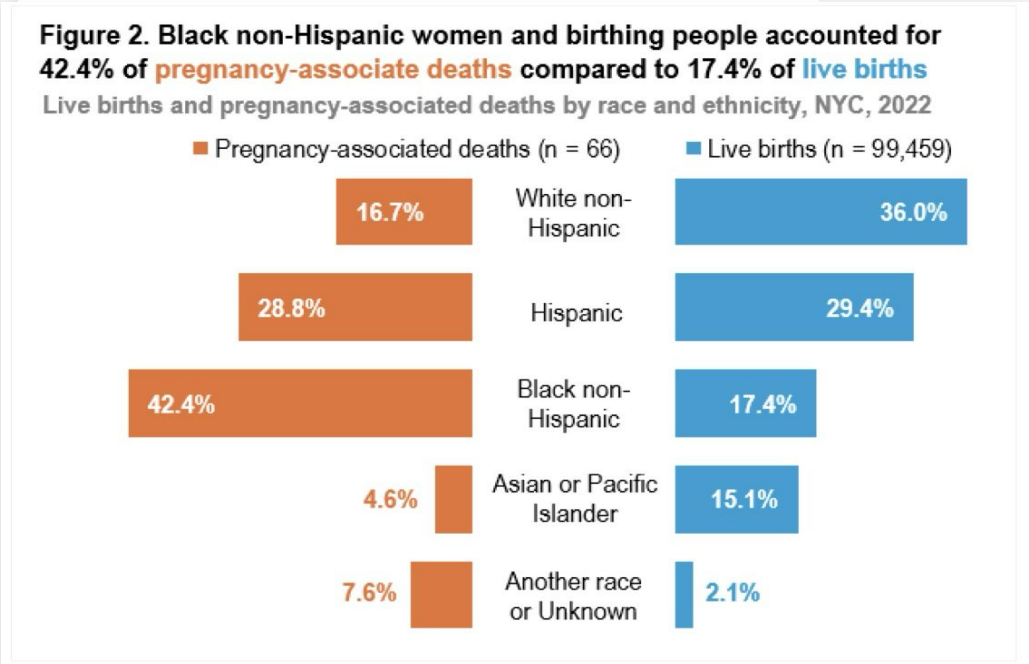
Maternal deaths per 100,000 live births



Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison (Commonwealth Fund*, June 2024). https://doi.org/10.26099/cthn-st75

THE PROBLEM

In NYC, Black birthing people: 42% of deaths, 17% of births

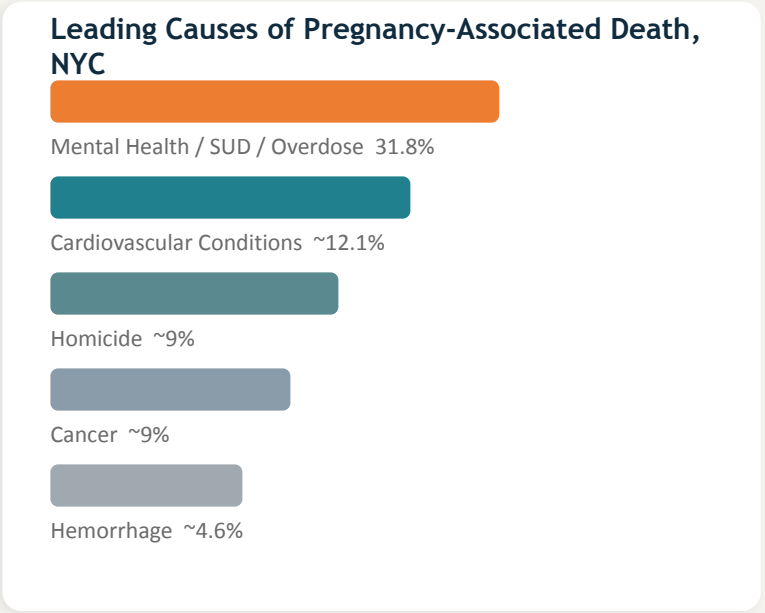


- Medicaid covers ~42% of all U.S. births and 64% of births to Black women
- Neighborhoods with highest risk — Brownsville, East Flatbush, South Bronx — overlap with highest poverty and lowest provider density
- This is not differential clinical need; it is differential system access shaped by fragmentation and barriers. (Hospital-based legacy statutory framework)

NYC Department of Health, MMRC, September 2025, https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2025.pdf

THE PROBLEM

Most maternal deaths occur postpartum — driven by mental health and substance use, not obstetric complications



- 75.6% of mental health-related deaths involved overdose; >75% of those involved opioids
- Most deaths occur weeks to months after delivery, when patients have lost contact with the care system

86.4% of pregnancy-associate deaths are PREVENTABLE

Source: NYC DOHMH MMRC 2025, NYS OMH 2025

THE PROBLEM

Perinatal behavioral health infrastructure is nearly nonexistent relative to demand

15-20K

Births/yr needing perinatal mental health support

1

Specialized perinatal psych inpatient unit (NYC area)

2

Specialized perinatal IOPs in the NYC area

0

Of 3,999 psychiatric beds, none are formally designated for the perinatal population

-506

Psychiatric beds lost 2014-2023 (-11.2%)

-20%

Black and Hispanic zip codes in Brooklyn have 20%+ fewer maternal health professionals/capita than the borough average

Sources: Postpartum Support International Intensive Treatment Registry (accessed 2026); Northwell Health / Zucker Hillside Hospital; The Motherhood Center of New York; Child Center of NY; NYS Office of the State Comptroller, March 2024; ACOG Committee Opinion No. 757 (2018); Capstone stakeholder research (2026)

Source: PSI Registry, NYS Comptroller 2024

DIAGNOSIS | PAYMENT

Medicaid global codes create a "revenue cliff" — the delivering provider captures all episode value

How Global OB Codes Work

- CPT 59400/59510: Entire episode bundled to delivering provider
- CPT 59425/59426: Prenatal-only codes — one unit per pregnancy, billed retrospectively
- CPT 59430: Single postpartum visit code
- **Result: Zero incremental cash flow during prenatal care for non-delivering providers**

- A prenatal provider who manages a full pregnancy but does not attend delivery receives a single, late, modest payment
- The system rewards retention of the birth — not coordination or appropriate referral
- Referring a complex patient to a specialist is financially penalized under the current architecture
- Community midwives and FQHCs bear this penalty disproportionately

Source: eMedNY Fee Schedule 2025

DIAGNOSIS | PAYMENT

The same clinical event generates radically different revenue depending on care setting

Revenue Component	Hospital (Art. 28)	Birth Center (CABC)	FQHC
Professional fee	Global code	Global or antepartum-only	PPS rate/visit
Facility fee	**~$10,000-$12,000 (APR-DRG)**	**None (std FFS)**	Included in PPS
Same-day BH billing	Yes	Yes	No (1-visit/day rule)

- A routine vaginal delivery generates ~$10-12K more in a hospital than a birth center — same patient, same outcome
- FQHCs are reimbursed ~70% of true cost (Urban Institute); PPS rate ceilings exceeded by 44%
- One-third of FQHC Medicaid payments are delayed through reconciliation

Source: eMedNY 2015/2025, Urban Institute 2023

DIAGNOSIS | REGULATION

Article 28, CON processes, transfer requirements and liability rules impose hospital-grade requirements on community-scale providers, raising the cost and risk before a site can even serve patients

- **CON applications** require $200K+ in legal, architectural, and consulting fees before approval certainty
- **Physical plant standards** (door widths, medical gas, ambulance egress) drive costs independent of clinical acuity
- **Part 795** requires transfer agreements but hospitals have no legal obligation to sign them.
- **18-24 month** timelines from application to first patient, with zero revenue

- **Article 28 + CON** front load time, design requirements, and legal/architectural costs before approval is certain.
- **Transfer Agreements** are often required but hospital cooperation is voluntary, safety requirements become a relationship dependent feasibility gate.
- **Malpractice and liability exposure** increase financing risk and can eliminate margins for community based providers.
- **Community maternal models fail before opening,** because regulatory pathways are too costly, uncertain, hard to finance and regulation creates pre-operational debt.

Source: NYS PHL Art. 28, Stakeholder Interviews 2026 10 NYCRR Part 795, Stakeholder Interviews

DIAGNOSIS | CAPITAL

Community maternal providers are structurally excluded from every major capital pathway

$582/ft²

NYC healthcare construction cost (2025)

$10M+

Est. minimum cost: compliant birth center

18%

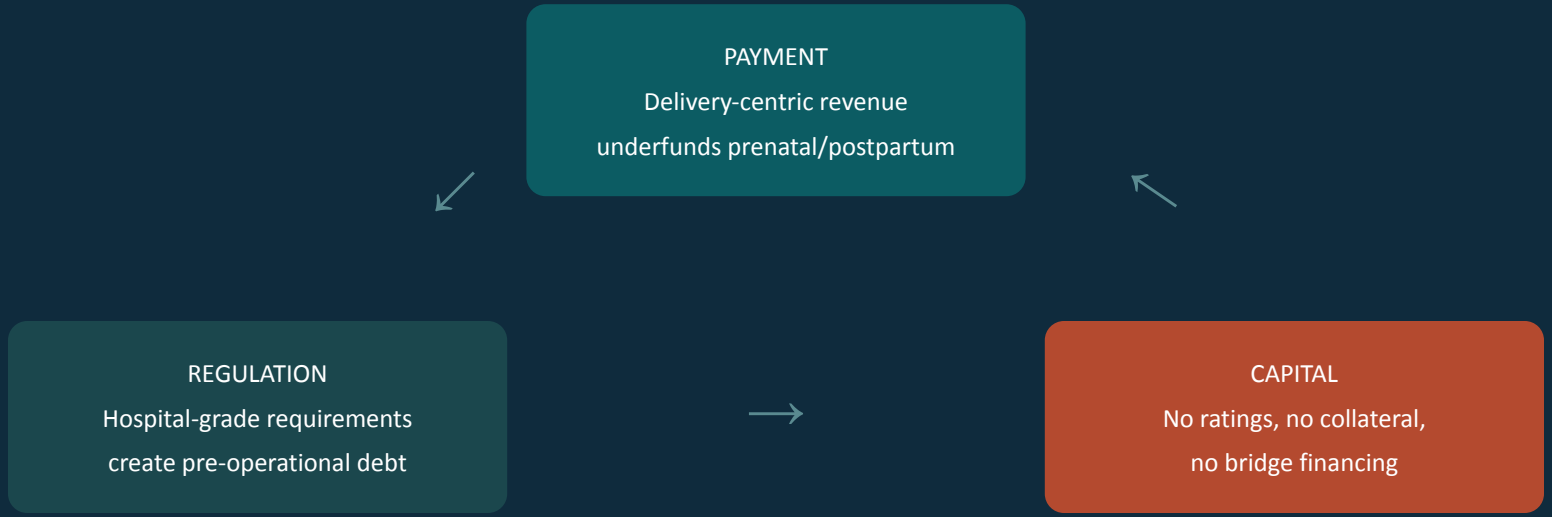
Construction cost increase since 2020

- DASNY one-step bond approval requires "A" rating — community providers have no bond ratings at all
- State capital grants require spend-first/reimburse-later — organizations without credit lines cannot bridge the gap
- The $5M Birthing Place Foundation grant covers ~50% of costs; org must carry negative cash balance throughout development
- NYCHH, as a City-supported covered organization, has access to City capital support, bond-financed infrastructure, and supplemental Medicaid payments — a different capital universe; voluntary safety-net hospitals rely more on their own revenues plus supplemental Medicaid support

Source: Gordian RSMeans 2025, DASNY

DIAGNOSIS | SYNTHESIS

Payment, regulation, and capital form a self-reinforcing cycle that locks community care out



Each domain amplifies the others: regulatory uncertainty raises financial risk, financial instability blocks capital, capital constraints prevent infrastructure, and without infrastructure there is nothing to bill through.

ROOT CAUSES

Every layer of the system — from facility standards to capital markets — is calibrated to hospitals

Regulation	Article 28 standards were written for inpatient facilities. Physical plant requirements (medical gas, ambulance egress) apply equally to a 4-bed birth center and a 400-bed hospital.
Capital	DASNY bonds require institutional credit ratings. State grants require spend-first reimbursement. Hospital capital budgets run through City appropriations. Community providers have no parallel pathway.
Governance	Multiple agencies (DOH, DOHMH, OHIP, H+H, MCOs) each control a piece of the pathway. No single entity is accountable for approval-to-operation. Fragmented authority creates implementation paralysis.

Source: NYS PHL Art. 28, DASNY

DIAGNOSIS | MODEL COMPARISON

Every community care model faces structural barriers — they differ only in which barrier binds first

Dimension	Birth Center	Hospital Midwifery	Community Doula
Capital need	$10M+ (highest)	Hospital-funded	Minimal
Regulatory burden	Full CON + Art. 28	Within hospital license	None
Binding constraint	Capital + regulation	Institutional politics	Payment adequacy
C-section rate	5-8.6% (AABC data)	~20-25% (low-risk)	N/A
Clinical autonomy	High	Constrained	High (within scope)

- Birth centers have the best outcomes (5-8.6% C-section vs. 26.6% national) but face the highest structural barriers
- Hospital midwifery is financially secure but clinically constrained by institutional governance
- Doulas require minimal capital but face payment delays of 2 weeks to 12 months

Source: AABC Strong Start, eMedNY 2025

ROOT CAUSES

Managed care administrative burden compounds structural payment inadequacy

12.5%
Medicaid MCO prior auth denial rate (national)

2.2x
Higher than Medicare Advantage denial rate (5.7%)

2wk-12mo
Doula payment timelines reported

- Each denied or delayed claim is deferred cash — community providers without billing departments absorb this as operational risk
- Doula MCO billing transition (April 2025) adds administrative complexity to already unstable payment streams
- FQHC supplemental payments are reconciled retroactively — one-third of payments systematically delayed
- No formal Medicaid guidance exists for split-episode payment when patient transfers between providers

Source: HHS OIG 2023, Ancient Song Interview

ROOT CAUSES

FQHCs — the backbone of community health — are reimbursed 70 cents on the dollar

PPS Structural Constraints

- One-visit-per-day limit: Cannot bill prenatal + behavioral health on same day
- Off-site rate penalty: Reduced reimbursement for care outside the health center
- Doulas not recognized: Not a billable provider type within PPS
- **PPS rate ceilings exceeded by 44% for most visits**

- FQHCs serve the highest-need Medicaid populations but cannot financially sustain integrated maternal care
- The one-visit-per-day rule directly prevents the integrated prenatal + behavioral health model that MMRC data demands
- 1115 Waiver requires rates reach 80% of Medicare — a meaningful but insufficient step toward cost-coverage

Source: Urban Institute 2023, NYS 1115 Waiver

RECOMMENDATIONS | PAYMENT REFORM

Align Medicaid payment with care continuity — starting with CPT 2027 implementation

R1: Adequate Per-Visit Rates for CPT 2027

Set per-visit prenatal/postpartum rates that cover cost of delivery in community settings — not just hospital-derived averages

Community midwives and FQHCs become financially viable for the first time

R2: Site-of-Care Parity Analysis

Commission formal DOH comparison of total payment per clinical event across hospital, birth center, and FQHC settings

Data foundation for equitable rate adjustment

R3: Split-Episode Payment Guidance

Formal DOH rules for payment when prenatal and delivery providers differ

Providers can coordinate care without financial penalty

Source: AMA CPT Panel 2025, eMedNY 2025

RECOMMENDATIONS | CAPITAL & INFRASTRUCTURE

Build a capital pathway that community maternal providers can actually access

C1: Dedicated Maternal Health Capital Track

Establish DASNY program with simplified underwriting for projects <$15M; include CABC-accredited centers

Community birth centers and perinatal BH facilities gain access to tax-exempt financing for the first time

C2: Bridge Financing for Pre-Operational Costs

Revolving bridge loan fund, milestone-disbursed, interest-free pre-op period, covering architectural/legal/first 90 days of operating capital

Eliminates the spend-first/reimburse-later trap that makes state grants unusable for orgs without credit lines

C3: Mandatory Technical Assistance

Funded TA program (DASNY apps, CON, MCO contracting, CPT 2027 transition) — required for all capital program applicants

Levels the playing field; prevents $200K+ in wasted pre-development costs from failed applications

Source: DASNY, PCDC Interview

RECOMMENDATIONS | REGULATORY REFORM

Recalibrate regulation to match clinical risk — not hospital legacy standards

Publish Clear Licensure Guidance	Plain-language pathway distinguishing legal operation vs. state licensure vs. Medicaid scaling. Clarify what triggers building-driven review vs. clinical quality oversight.
Standardize Transfer Agreement Expectations	Create templates and expectations. Address the fundamental asymmetry: birth centers must have agreements but hospitals have no obligation to cooperate.
Review Proportionality of Requirements	Distinguish safety-essential requirements from hospital-inherited assumptions. Enable community expansion without unnecessary hospital-grade burdens (e.g., OB/GYN medical director for low-risk settings).
Perinatal Behavioral Health Licensure Pathway	Create unified regulatory pathway for integrated perinatal BH and stabilization models. Current system requires combining Article 28 + OMH + OASAS — multiplying timelines and costs.

Source: NYS PHL Art. 28, 10 NYCRR Part 795

RECOMMENDATIONS | FLAGSHIP INITIATIVE

Build perinatal behavioral health infrastructure in the neighborhoods where deaths cluster

RECOMMENDATION 4: Develop perinatal behavioral health and respite centers

Coordinated strategy across payment (day-rate models), regulation (unified licensure pathway), and capital (dedicated financing + TA) for integrated perinatal medical and behavioral health services, geographically targeted using MMRC data.

- DOH convenes interagency working group (OMH, OASAS, DASNY, and DOHMH with DDC) to define standardized model
- OHIP pilots Medicaid day rates for integrated perinatal behavioral health, geographically targeted via MMRC mortality data
- DOH issues interim guidance on combining Article 28 + OMH + OASAS licensure pathways
- For future architectural design projects within Town+Gown, DOHMH with DDC could identify suitable study site or sites from areas previously identified in this research (Brownsville, South Bronx, East Flatbush or Central Harlem)

The Town+Gown research program can move from this research project with future academic architecture studio projects, to identify study sites and consider designs and design standards for primary care facility model-based continuum of care programs.

Source: NYC DOHMH MMRC 2023, NYC Mayor's Office 2024

IMPLEMENTATION

Implementation will require coordinated interagency planning and future Town+Gown supported research

Recommendation	Primary Actor	Timeline
R4: Perinatal BH Infrastructure	DOH, DASNY State DOH task force/DOHMH with DDC/future design partners	12-36 months
C1: Maternal capital track	DASNY, DOH, Town+Gown/future policy research partners	12-24 months
C2: Bridge financing	DOH, CDFI, NYCEDC, Town+Gown/future finance research partners	12-18 months
R-B: Regulatory streamlining	DOH/OHSM/future legal policy partners	12-24 months
R1: CPT 2027 rates	DOH/OHIP	By Q3 2026
R2-R3: Payment guidance	DOH/OHIP	6-12 months

- Tier 1 (future Town+Gown-supported research): Perinatal BH infrastructure, maternal capital pathways, and bridge financing.
- Tier 2 (convening/agenda-setting): Regulatory streamlining, pilot coordination architecture studio work, system cost-benefit analysis, legal-policy pathway research.
- Tier 3 (Systemic-level reform/advocacy): Payment reform, rate adequacy, 1115 waiver alignment.

Source: Capstone Analysis 2026

IMPLEMENTATION

Measure structural change — not just clinical outcomes

Payment Indicators

- Per-visit prenatal rates adopted at community-viable levels by Q1 2027
- Split-episode payment guidance published by DOH
- Site-of-care parity analysis completed and published
- Doula payment timelines reduced to <30 days

Capital Indicators

- DASNY maternal health capital track operational
- Bridge financing fund deployed to first 3 projects
- Perinatal BH facility sites identified in 4 priority neighborhoods
- Time from approval to operation reduced by 25%

System Indicators

- Clear licensure guidance published by DOH
- Transfer agreement templates standardized
- Postpartum follow-up rates in Medicaid population
- Perinatal BH capacity: beds + IOP slots per 100K births

The single test for every intervention: does it make it easier for community-based maternal care providers to deliver continuous care at scale in neighborhoods where adverse outcomes are most concentrated?

Source: Capstone Analysis 2026

The central question is not whether community-based maternal care works.

It is whether the system allows it to scale.

Town+Gown/NYC DDC Public Buildings and Doula x Design

NYU Wagner School of Public Service | April 2026

THANK YOU!

Q & A

Appendix

ROOT CAUSES

The entire payment architecture was designed around a single event: hospital delivery

- Global OB codes (59400/59510) date to an era when OB care was delivered by a single physician in a single hospital
- Medicaid policy assumes the delivering provider also delivered prenatal care — a model that no longer reflects clinical reality
- The one-unit-per-pregnancy constraint on prenatal codes (59425/59426) was designed for billing simplicity, not care quality
- Result: a payment system optimized for a 1970s care model applied to a 2026 delivery landscape

CPT 2027 Reform: AMA will delete 16 global OB codes effective Jan 1, 2027, replacing with visit-level E/M codes. This eliminates the revenue cliff — but per-visit rates and facility-fee asymmetry remain unresolved. NYS Medicaid implementation decisions will determine whether the reform delivers on its promise.

Source: AMA CPT Panel 2025, eMedNY 2025

IMPLEMENTATION

Implementation risk is highest at the institutional level — not legislative or clinical

Risk	Likelihood	Impact	Mitigation
Hospital resistance to community expansion	HIGH	HIGH	Frame as complementary capacity, not competition; engage H+H as anchor partner
CPT 2027 rates set below community cost	MEDIUM	HIGH	Advocate for site-of-care cost analysis before rate-setting; leverage 1115 Waiver rate floor
Political cycle disrupts multi-year implementation	MEDIUM	MEDIUM	Embed in regulatory/statutory frameworks; build cross-administration stakeholder coalition
Construction cost escalation outpaces funding	HIGH	MEDIUM	Build 15-20% contingency into all capital grants; shorten approval-to-construction timelines

- Legislation without implementation is the primary historical failure mode — recent doula and midwifery reforms demonstrate this pattern
- Single-entity pilots cannot close borough-wide gaps; solutions must be evaluated for scalability

Source: Stakeholder Interviews 2026