NYU WAGNER SCHOOL OF PUBLIC SERVICE

TOWN+GOWN COLLABORATIVE CAPSTONE

STRENGTHENING THE MATERNAL CONTINUUM OF CARE IN NEW YORK CITY

STRUCTURAL CONDITIONS SHAPING ACCESS, CONTINUITY, AND INFRASTRUCTURE

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This project was completed in partnership with Town+Gown:NYC, the New York City Department of Design and Construction and Doula x Design, as the client team for this NYU Wagner Capstone program. The project examined structural, regulatory, and operational barriers affecting the maternal continuum of care in New York City, with a focus on improving access, coordination, and sustainability of community-based maternal health services.

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- Eugenia Montesinos, CNM – Midwifery leadership perspective
- Nashira Baril, MPH – Birth center development and equity perspective
- Rose Duhan – Community health center and primary care perspective
- Maura Winkler, CNM – Birth center operations perspective
- Louise Cohen – Healthcare financing and capital access perspective
- Kiki Blazevski-Charpentier, AIA – Healthcare facility design perspective
- Myla Flores – Community-based maternal care and birth center development perspective
- Kennedy Austin – Community advocacy and doula services perspective
- Wawa Kulatnam - Director of Healthcare Programming, Planning, and Analysis

Each conversation added a distinct and valuable perspective, deepening our understanding of the complexities surrounding maternal health care delivery. We are especially appreciative of the openness with which participants spoke about both opportunities and challenges. Their insights brought clarity to issues that cannot be fully understood through literature alone (Appendix B).

What stood out most was the level of commitment reflected across all interviews. The dedication to improving maternal care, often in the face of structural and operational challenges, was evident and left a lasting impression on our team.

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A. The Issue

Maternal mortality in New York City is driven primarily by fragmentations in continuity of care, especially in the postpartum period. Mental health conditions, including substance use disorder and suicide, were the single largest underlying cause of pregnancy-associated deaths accounting for 31.8 percent of all such deaths, with 86.4 percent of pregnancy-associated deaths considered preventable (NYC DOHMH MMRC 2025). Three structural domains constrain the system's capacity to deliver continuous care:

- **Payment rewards delivery, not continuity.** Medicaid concentrates revenue at the birth event, penalizing providers who deliver prenatal or postpartum care but do not attend the delivery (eMedNY 2025a).
- **Regulatory pathways function as barriers to expansion.** The N.Y. Public Health Law, art. 28 (Article 28) licensure and Certificate of Need (CON) processes impose hospital-calibrated timelines, costs, and facility requirements on community-based providers.
- **Capital is structurally inaccessible.** Community organizations, especially those that are small, safety-net, or rural-serving, often lack the reserves, credit access, and financing pathways required to build and sustain maternal care infrastructure.

The result is a system in which community-based maternal care models remain limited in scale, even when they are clinically appropriate and in demand.

B. Why It Matters

The consequences of this system differ significantly among varying populations. Medicaid financed approximately 42 percent of all U.S. births in 2019 (Gordon et al. 2023) and covered 64 percent of births to Black women and 58.1 percent of births to Latina women. Black women in New York City are several times more likely to die of pregnancy-related causes than white women, and most of these deaths are considered preventable (NYC DOHMH 2025).

C. What This Report Examines

This report analyzes how three structural domains (payment, regulation, and capital) shape the feasibility of delivering maternal care across the continuum, drawing on Medicaid financing and regulatory analysis, stakeholder interviews, and comparative review of freestanding birth centers, hospital-integrated midwifery, and community-based doula services.

D. Key Findings

- **Payment is delivery-centered.** Revenue is concentrated at the birth event, discouraging coordination and undermining investment in prenatal and postpartum care.
- **Regulatory pathways function as barriers to entry.** Community-based providers face long approval timelines, high pre-operational costs, and requirements not aligned with clinical risk.

- **Financial instability limits infrastructure development.** Thin margins, payment delays, and limited financing options prevent expansion even when demand is clear.

E. What Needs to Change: A Three-Part Approach

- **Align payment with continuity:** Ensure prenatal and postpartum care are reimbursed at sustainable rates across care settings.
- **Streamline regulatory pathways:** Reduce uncertainty, align requirements with clinical risk, and remove barriers to entry for community-based providers.
- **Establish infrastructure financing:** Create financing mechanisms that allow community organizations to develop, open, and sustain maternal care facilities.

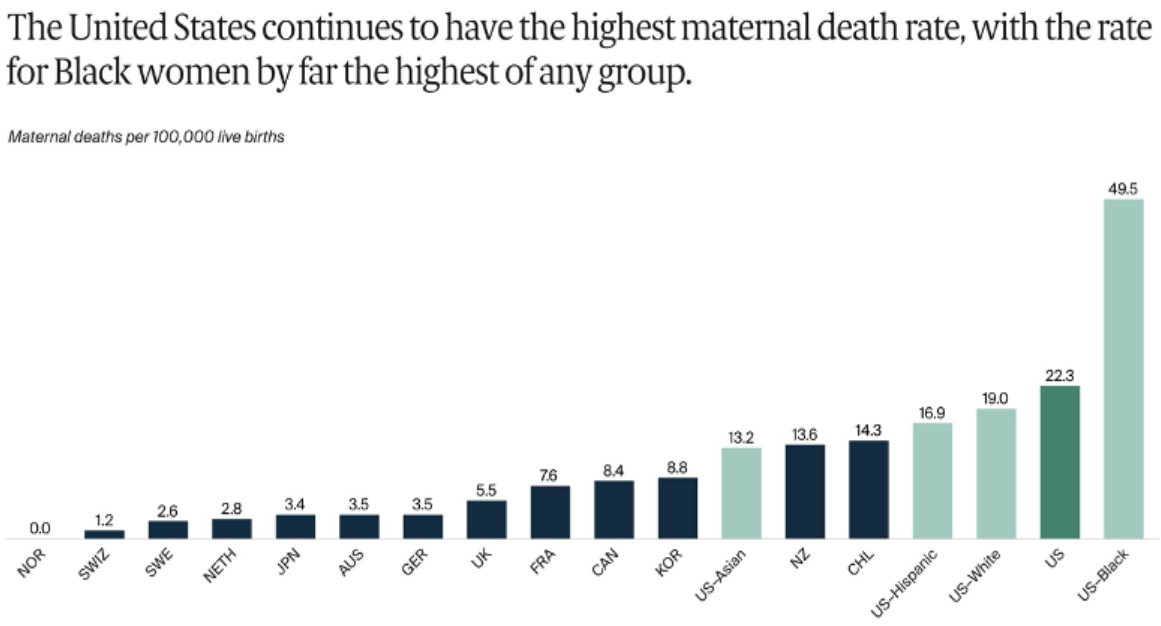
The central question is not whether community-based maternal care works but whether the system allows it to scale.

II. The Maternal Continuum of Care: Context and Landscape

A. The National Picture: An Outlier on Maternal Mortality

The United States is an outlier among high-income countries in maternal mortality. In 2022, the U.S. recorded 22.3 maternal deaths per 100,000 live births, down from 32.9 in 2021, but still more than double the OECD average and significantly higher than peer nations (Hoyert 2024). Maternal mortality also increased sharply between 2018 and 2021, rising from 17.4 to 32.9 deaths per 100,000 live births (Hoyert 2023).

Figure 1. Maternal Mortality Rates: U.S. vs. Peer Nations (2022)



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

These outcomes are highly unequal. In 2022, non-Hispanic Black women experienced a maternal mortality rate of 42.4 deaths per 100,000 live births, more than 2.5 times the rate of 16.7 deaths per 100,000 live births for non-Hispanic white women (Hoyert 2024).

Medicaid financed approximately 42 percent of all U.S. births in 2019 (Gordon et al. 2023) and covered nearly 64 percent of births to Black women and 58.1 percent of births to Latina women (Valenzuela and Osterman 2023). These differences reflect structural features of the healthcare system rather than differences in clinical need. Despite advanced clinical capacity, the organization of care does not consistently support continuous engagement across the prenatal, delivery, and postpartum periods (CMS 2023).

National studies of midwifery-led and community-based models demonstrate that alternative care structures can achieve strong outcomes for low-risk pregnancies, including lower intervention rates and comparable neonatal outcomes. The American Association of Birth Centers (AABC) Strong Start data show primary cesarean rates of 8.6 percent in birth center cohorts, compared with 26.6 percent nationally (AABC 2026) (Alliman et al. 2022) (Wallace et al. 2024). These findings show that different models of care are feasible, but they remain limited in scale within the broader system. The gap is not evidence of what works but the system's ability to support these models at scale.

B. Maternal Care in New York State and New York City

Despite recent policy changes, including expanded postpartum Medicaid coverage and authorization of doula services, disparities in outcomes remain significant. Black birthing people in New York State experienced maternal death rates roughly 4.3 times higher than white birthing people between 2018 and 2021, 65.2 versus 15.1 deaths per 100,000 live births, alongside higher rates of severe maternal morbidity (New York Health Foundation 2023).

Figure 2. Maternal Mortality Rates by Race, New York State (2018–2021)

Race/Ethnicity	Maternal Deaths per 100,000 Live Births
Black, Non-Hispanic	65.2
Hispanic/Latina	22.4
White, Non-Hispanic	15.1

Source: New York Health Foundation (2023); NYS Department of Health Maternal Mortality Reports (2024).

In New York City, these patterns are even more pronounced. Between 2016 and 2020, Black non-Hispanic women were four times more likely to die of a pregnancy-associated cause and six times more likely to die of a pregnancy-related cause compared with their white counterparts (NYC DOHMH 2023). In 2022, Black women accounted for a disproportionate share of pregnancy-related deaths relative to their share of births (NYC DOHMH 2025) (Wagner 2024).

These disparities persist within a healthcare system and related Medicaid financing structure that is heavily centered on hospital-based labor and delivery. Large private and public health systems concentrate infrastructure, financing, and clinical activity around the birth event, while

community-based maternal care providers operate on thin margins with limited access to capital and minimal financial buffers.

C. Postpartum and Behavioral Health as the Primary System Breakpoints

A consistent finding across the Maternal Mortality Review Committee (MMRC) reports is that most pregnancy-associated deaths occur in the postpartum period, often weeks to months after delivery. In New York City, mental health conditions and substance use (including overdose and suicide) constituted the single largest category of underlying causes of pregnancy-associated deaths at 31.8 percent, with overdose accounting for 75.6 percent of deaths within that category and more than three-quarters involving opioids (NYC DOHMH 2025). Hemorrhage, cardiovascular conditions, and other obstetric complications remain major contributors, particularly among Black birthing people.

Figure 3. Leading Causes of Pregnancy-Associated Deaths, NYC (2022)

Leading Cause of Death of Pregnancy-Associate Death	Share of Pregnancy-Associated Deaths
Mental Health Conditions (incl. substance use, overdose, suicide)	31.8%
Cardiovascular Conditions	~12.1%
Cancer	~9%
Hemorrhage	~4.6%
Homicide	~9%
Metabolic/Endocrine Conditions	3.7%

Source: New York City Department of Health and Mental Hygiene (NYC DOHMH) MMRC 2025, NYS OMH 2025. Figures represent approximate shares of pregnancy-associated deaths; the 2025 report uses updated methodology and a different reference period than the prior 2016–2020 MMRC. Full cause-of-death breakdown for remaining categories not available in summary reporting.

Patients frequently disengage from care after delivery, especially those enrolled in Medicaid, due to a combination of insurance-related barriers, fragmented services, and limited availability of providers equipped to address perinatal mental health and substance use. Acute care settings are designed to manage labor and delivery, while outpatient care is often limited to brief, episodic follow-up. Few community-based maternal care facilities exist between these two settings to support patients through periods of instability.

D. Current Capacity and the Infrastructure Gap

New York City has extremely limited public and private care facilities infrastructure designed specifically for perinatal mental health and substance use care, the very conditions driving the majority of pregnancy-associated deaths.

Figure 4. Perinatal Mental Health Infrastructure: NYC Capacity vs. Need

Metric	Value
Annual live births in NYC	~100,000
Est. births requiring perinatal mental health support (15–20% prevalence)	15,000–20,000
Specialized perinatal psychiatric inpatient units (NYC area) (Northwell Health, Glen Oaks)	1
Specialized perinatal IOPs (NYC area) (Motherhood Center PHP; Child Center of NY IOP, Forest Hills)	2
Total psychiatric inpatient beds, NYC (Dec. 2023)	3,999
Decline in psychiatric inpatient beds, NYC (Apr. 2014–Dec. 2023)	−506 beds (−11.2%)
Beds designated specifically for the perinatal psych population	0 designated
Planned integrated SUD/prenatal clinics, expected 2026 ($8M, H+H/Lincoln, South Bronx; ~200 families/year)	1
Black and Hispanic zip codes in Brooklyn have more than 20% fewer maternal health professionals/capita	>-20%

Sources: Postpartum Support International registry; NYS Office of the State Comptroller (2024); NYC Mayor's Office (2024); NYS Office of Mental Health (2025); RAND Corporation analysis.

The pattern is consistent: community-based maternal care facility settings capable of providing additional integrated perinatal mental health and substance use care, short-term stabilization, and structured postpartum follow-up are rare, geographically concentrated in areas served by large health systems, which makes such settings structurally inaccessible to the Medicaid-enrolled populations bearing the greatest burden of adverse outcomes.

E. Structural Racism and Social Determinants of Maternal Health Leading to Locational Inequities

Maternal outcomes in New York City reflect long-standing patterns of structural racism across housing, transportation, employment, and the criminal-legal system that shape who becomes pregnant under what conditions and how easily they can access care. Neighborhoods with the highest pregnancy-associated mortality and severe maternal morbidity often face overlapping burdens of poverty, housing instability, environmental exposure, limited transportation options, and fewer locally-provided health systems in general and maternal health care in particular (Liu, SY)

Figure 5. NYC Neighborhoods with the Highest Maternal Risk Burden

Neighborhood	Borough	Key Indicators
Brownsville/East New York	Brooklyn	Among the highest SMM rates citywide, late/no prenatal care rates exceed the city average by 2x; 90%+ Black population
East Flatbush	Brooklyn	Highest rate in NYC of late/no prenatal care (~16%); second-highest preterm birth rate (~13%)
Central Harlem	Manhattan	Priority neighborhood for pregnancy-related complications per DOHMH
South Bronx (Mott Haven, Hunts Point, Morrisania)	Bronx	Highest borough-level overdose death rate; site of planned H+H/Lincoln SUD clinic
Jamaica/St. Albans	Queens	Priority neighborhood per city maternal health initiative

Sources: NYC DOHMH Maternal Mortality and Severe Maternal Morbidity Surveillance; de Blasio Administration maternal health initiative (2018); NYC Maternity Divide project; NYC DOHMH Environment & Health Data Portal.

These structural conditions directly shape how patients engage with the maternal continuum of care. Patients in high-need neighborhoods are more likely to enter prenatal care late, miss appointments due to transportation and childcare constraints, and lose contact with the health system after the immediate postpartum period. Work schedules, unstable housing, and caregiving responsibilities make it difficult to attend traditional clinic visits, especially when services are fragmented across multiple locations.

Existing public and private care facility locations amplify these structural inequities. Large hospitals and specialty centers are often located far from communities with the highest risk burden. Community-based organizations in those neighborhoods operate in small, resource-constrained settings. Public transportation routes, clinic hours, and benefit eligibility rules were not designed around the needs of pregnant and postpartum people with low incomes. The system requires those at highest risk to travel the farthest, navigate the most complex arrangements, and absorb the greatest logistical burden to receive care.

Any strategy to strengthen the maternal continuum of care in New York City must be evaluated not only on clinical or financial grounds but also on its ability to address these structural inequities. The central question is whether exising Medicaid payment, which includes a capital component, and related regulatory requirements make it harder for potential provider to locate maternal continuum of care services, including perinatal mental health, including substance use disorder and suicide, and other postpartum supports, in the neighborhoods where risk is highest and access is most constrained.

F. A Hospital-Centered Model with Fragmented Continuity

Maternal care in New York City is organized around a hospital-centered model that does not consistently support continuity across the full care cycle. Stakeholders consistently identify several recurring breakpoints:

- Late entry into prenatal care, particularly in high-need neighborhoods, is driven by insurance barriers, transportation challenges, and limited community-based provider availability.
- Fragmented transitions between settings, with weak coordination between hospital-based delivery and community-based postpartum care.
- Drop-off in postpartum follow-up beyond the six-week visit, despite elevated clinical risk during the first year after birth.
- Limited integration of behavioral health and social supports, despite the direct role that housing instability, transportation, and mental health needs play in maternal outcomes.

These patterns are not isolated gaps but reflect a system design failure.

G. Current Policy and Regulatory Environment

New York's policy environment has begun to acknowledge these gaps, but has not yet fully reformed shifted the underlying structural incentives. Recent reforms, including Medicaid coverage for doula services effective March 1, 2024 (CMS 2024A) and extended postpartum eligibility (CMS 2024A), signal a shift toward supporting continuity OF CARE. The underlying system remains anchored in a hospital-first model. Regulatory frameworks, including Article 28 facility licensure, CON processes, and physical plant standards, were designed for hospital-based care and continue to shape how maternal services are developed and delivered (N.Y. PUBLIC HEALTH LAW, ART. 28). Payment architecture similarly concentrates resources at the point of delivery through global fees and delivery-bundled payments, undervaluing prenatal and postpartum care relative to labor and delivery.

III. Methods

This report uses a mixed-methods approach to examine how structural factors shape the delivery of maternal care in New York City. The goal is not to evaluate individual programs but to identify the systemic conditions—across payment, regulation, and capital—that determine whether different care models can operate, sustain themselves financially, and scale.

The analysis draws on three sources. First, we conducted a targeted literature review spanning peer-reviewed articles, government reports, Medicaid fee schedules, CMS guidance documents, and state regulatory filings. Sources were drawn primarily from PubMed, Google Scholar, the CMS and NYSDOH websites, and the New York State legislative repository, with a focus on publications from 2015 to 2026. The review concentrated on maternal health outcomes, Medicaid payment policy, birth center regulation, doula reimbursement structures, and perinatal behavioral health financing.

Second, we conducted nine semi-structured interviews with stakeholders across the maternal health landscape between January and April 2026. Interviewees were selected to represent sector diversity across the maternal care continuum, including freestanding birth centers, community development financial institutions (CDFIs), public and private hospital systems,

federally qualified health centers (FQHCs), community-based doula organizations, and facility design and development. This purposive sampling strategy prioritized operational perspectives—respondents who directly manage, finance, or advocate for maternal care services—rather than clinical or administrative generalists. Conversations focused on care delivery challenges, financing constraints, regulatory processes, and patient engagement across the prenatal-to-postpartum continuum.

Table 1. Stakeholder Interviews

Interviewee	Organization	Sector
Maura Winkler, CNM	Coit House Birth Center, Buffalo	Freestanding Birth Center
Louise Cohen	Primary Care Development Corporation	CDFI / Capital
Kiki Blazevski-Charpentier	NYC Health + Hospitals, Woodhull	Hospital System
Myla Flores	The Birthing Place Foundation	Community Birth Center
Kennedy Austin	Ancient Song Doula Services	Community Doula Organization
Eugenia Montesino	NYU Langone (hospital midwifery leadership)	Hospital-Integrated Midwifery
Rose Duhan/Derek Tobia	CHCANYS	FQHC Policy and Advocacy
Nashira Baril	Neighborhood Birth Center; Birth Center Equity	Birth Center Development / Equity
Wawa Kulatnam	NYC Health + Hospitals	Public Health System

Interviews were reviewed for recurring structural themes across three domains: reimbursement, regulation, and capital. Findings were triangulated across interviews and against publicly available data, including Medicaid fee schedules, state regulatory filings, and published financial reports from relevant organizations.

Third, we conducted a comparative analysis of three maternal care models: freestanding birth centers, hospital-integrated midwifery, and community-based doula services. These models were selected to reflect different approaches to care delivery and varying levels of integration with hospital systems. The comparison illustrates how payment structures, regulatory requirements, and capital access affect the feasibility of each model.

Limitations

Several limitations should be noted. The interview sample is small (n=9) and was not designed to be statistically representative. Respondents were selected for operational and sectoral relevance rather than demographic or geographic coverage. The sample does not include patients, hospital administrators with budgetary authority, managed care organization (MCO) representatives, or officials from the New York State Department of Health. Each of these perspectives would meaningfully inform questions of payment adequacy, regulatory design, and the lived experience of navigating the maternal care system.

The geographic scope is concentrated in New York City, with one upstate comparison (Buffalo). Findings related to regulatory processes, Medicaid payment structures, and capital access reflect conditions specific to New York State.

Finally, this analysis relies on publicly available Medicaid data—fee schedules, published reimbursement rates, and program guidance—rather than claims-level data. Claims data would permit more precise analysis of reimbursement patterns, denial rates, and payment timing, but was not accessible for this study.

This report does not include direct input from pregnant or postpartum individuals, and no community members were involved in the design or interpretation of the analysis. The absence of patient voice is a significant methodological limitation. The structural conditions documented here—payment design, regulatory barriers, capital constraints—shape the lived experience of navigating maternal care, but the experiential dimension of that navigation is not represented. Future research should center the perspectives of Medicaid-enrolled Black and Latina women in high-need neighborhoods, including their encounters with continuity gaps, provider transitions, and postpartum follow-up failures. Community-based participatory methods would strengthen both the validity and the equity orientation of subsequent policy analysis.

IV. Findings: Structural Conditions Shaping Maternal Care Delivery in NYC

A. Payment Structure and Delivery-Centered Revenue

"Global Fees" and delivery-site bundling disincentivize prenatal and postpartum care.

Delivery-centered payment design. New York Medicaid uses global obstetric procedure codes that concentrate the entire episode's revenue in the hands of the delivering provider. CPT 59400 covers routine antepartum care, vaginal delivery, and postpartum follow-up in a single bundled fee; CPT 59510 covers the equivalent episode ending in cesarean delivery (eMedNY 2025a). Both codes can be billed only by the provider who performs the delivery. A prenatal clinician who manages a patient through the full antepartum course but does not attend the birth cannot bill either the global code or receive payment for services.

The antepartum and postpartum coding structure. Providers who deliver prenatal care without the birth are limited to CPT 59425 (four to six antepartum visits only) or CPT 59426 (seven or more antepartum visits only), each payable once per pregnancy and only after care concludes (eMedNY 2025a). A postpartum-only visit is separately reimbursable under CPT 59430. Critically, the one-unit-per-pregnancy constraint on CPT 59425/59426 means there is

no incremental cash flow during the antepartum period. The prenatal provider submits a single claim retrospectively after all prenatal care is complete. This creates a structural absence of in-period revenue for any provider who renders continuous prenatal care and does not deliver.

The revenue cliff at delivery. The combined effect produces what this report terms a revenue cliff: the provider who captures the delivery captures all the episode's value, while providers who invest in prenatal engagement receive a single, late, and comparatively modest payment. For a provider who renders prenatal care but refers for delivery, the financial return is substantially lower, even though the clinical pathway provides appropriate continuity of care when risk escalates. This structure does not reward coordination; it rewards retention (eMedNY 2025a).

Hospital facility payment mechanics. For facility fees, New York Medicaid pays hospitals via All Patient Refined Diagnosis-Related Group (APR-DRG) upon discharge from inpatient stays (eMedNY 2015). No inpatient facility payment is triggered until the patient is discharged. When a patient is transferred between institutions during labor, the transferring hospital receives the lesser of the full DRG amount or a per diem rate multiplied by the actual length of stay, the "lesser of" transfer rule (eMedNY 2025a). Freestanding birth centers have no equivalent DRG; they may be compensated through outpatient APG rates, which are substantially lower. This asymmetry means that the same clinical event (vaginal delivery) yields categorically different total payments across settings, independent of clinical complexity.

Continuity-reinforcing overlays. New York has introduced several benefits intended to reinforce care continuity, though none fundamentally restructure the delivery-centered revenue model:

- **Doula services:** Medicaid covers doula services statewide, effective March 1, 2024, with reimbursement of up to $1,500 per pregnancy in New York City for up to eight perinatal visits and one labor and delivery encounter (CMS 2023) (eMedNY 2025b).
- **Extended postpartum coverage:** Medicaid postpartum coverage now extends to 12 months following pregnancy, approved by CMS in June 2023 (CMS 2023).
- **Timely postpartum visit incentive:** Providers earn $208.55 when a comprehensive postpartum visit is completed within 12 weeks and billed with CPT II code 0503F alongside the relevant postpartum or global claim, one payment per member per delivery (eMedNY 2025c).

These supplements signal policy commitment to continuity but operate as overlays on a payment architecture whose load-bearing structures remain delivery-centered.

The CPT 2027 global code reform: a structural inflection point. The American Medical Association's Current Procedural Terminology CPT Editorial Panel has approved the deletion of 16 global obstetric codes, including CPT 59400, 59510, 59425, 59426, and 59430, effective January 1, 2027, replacing them with visit-level evaluation and management (E/M) codes with a TH modifier, along with new stage-specific codes for labor management (AMA CPT Editorial Panel 2025). This reform directly addresses the revenue cliff: under the new model, each prenatal and postpartum visit generates a discrete, separately billable claim. The transfer penalty

disappears as providers who render prenatal care but do not attend the birth are no longer denied payment for services provided.

However, the CPT 2027 reform does not resolve all structural barriers:

- It is budget-neutral at the federal level, meaning redistribution rather than net revenue expansion.
- Per-visit payment rates in community and midwifery-led settings are not guaranteed to be adequate until New York Medicaid publishes its adopted fee schedule.
- It does not address the facility-fee asymmetry between hospital and non-hospital settings, which operates through the APR-DRG and APG framework.
- It does not resolve transfer payment ambiguity or managed care contracting barriers.

Implementation decisions by the New York State Department of Health (NYSDOH), particularly through the Office of Health Insurance Programs (OHIP), including the per-visit reimbursement rates adopted for community-based and non-hospital providers, will determine whether the CPT 2027 reform meaningfully strengthens continuity of care in practice.

Institutional implications. The current payment structure creates institutional incentives that favor hospital-based delivery over community-based care. Hospitals earn substantially more per birth through APR-DRG facility payments than community providers can access through outpatient APG rates, independent of relative clinical complexity. Midwifery-led and FQHC-based prenatal models generate revenue streams that depend heavily on billing precision and patient retention through delivery; losing the birth to a hospital, including through appropriate clinical referral, imposes a direct financial penalty under current rules. This incentive structure discourages appropriate escalation and makes community provider financial sustainability contingent on volume and clinical control rather than care quality or continuity.

B. Regulatory Pathways and Provider Entry

Article 28 and the CON process operate as feasibility gates that create pre-operational debt for non-hospital maternal care providers.

Article 28 licensure as a feasibility gate. Article 28 establishes standards for licensing and regulating healthcare facilities, including hospitals, nursing homes, FQHC clinics, certified birthing centers, and diagnostic/treatment centers (D&TCs) (N.Y. art. 28). The New York State Department of Health (NYSDOH) oversees compliance with the CON standards, and Article 28 is not only a permission layer but also financing mechanism and a timeline gate, as it shapes which services a facility can operationalize within Medicaid and other institutional contracting realities.

A central theme across stakeholder interviews was that physical plant standards and survey-readiness expectations drive up costs and become the binding constraint even when maternal services are clinically appropriate at less than hospital-level care. Multiple interviewees highlighted that the cost driver is often not clinical readiness but physical plant and inspection

readiness (Blazevski-Charpentier/Cohen interview). These requirements effectively hospitalize community projects through design standards and facility expectations.

Article 28 compliance also imposes direct financial consequences. One FQHC stakeholder explained that if a health center acquires or integrates an existing primary care practice that fails to meet Article 28 standards, it must renovate door widths, bathrooms, and other facility elements before full integration. During the renovation period, the site carries costs without revenue while awaiting regulatory readiness, a "pay rent now, no patients" dynamic that negatively impacts smaller community operators.

However, Article 28 licensure is not always legally required to operate a freestanding birth center in New York. The Coit House case in Buffalo provides one documented instance of this, as the NYSDOH denied their initial CON application. Upon appeal, the application failed again, but a NYSDOH attorney decided to confirm in writing that the center could continue operating without an Article 28 license. This was because the center had operated for four years, serving a population with few other service options, and it still does so today without enforcement action (Winkler 2026). In this case, Commission for the Accreditation of Birth Centers (CABC) accreditation was sufficient for continued operation and for negotiating facility fees with one Medicaid managed care plan (Fidelis). Whether this pathway is replicable in New York City—where managed care organizations (MCO) contracting norms, NYSDOH enforcement capacity, and market dynamics differ from western New York—has not been established. Other states offer varying models for context: Minnesota deems CABC-accredited birth centers automatically licensed by the state, eliminating the need for a separate state inspection regime; Nevada requires CABC accreditation within twelve months of initial licensure but does not impose hospital-grade facility standards; and Texas licenses birth centers through its Health and Human Services Commission without requiring CABC accreditation, though only four of its ninety-two licensed centers are accredited. None of these frameworks are directly transferable to New York's Article 28 structure, but they demonstrate that CABC-based regulatory pathways function in multiple state contexts.

Caveat: This finding rests on a single operator's account of NYSDOH counsel's communication. It should be treated as legally significant but requiring further research and verification before other operators use it as precedent, particularly in New York City, where enforcement dynamics differ.

CON [Certificate of Need] processes create pre-operational debt. New York's CON process determines whether Article 28 facility expansions, renovations, and service changes are approved. In maternal infrastructure terms, CON functions less as cost control and more as a financial burden generator, impacting timelines, sequencing, and non-recoverable pre-operational costs. Stakeholders repeatedly described being asked to commit substantial resources before they had approval certainty, including leases, architectural drawings, legal fees, and consultant work (Winkler/Flores interview). Multiple stakeholders described an 18- to 24-month, or even years-long, timeline once approval sequencing, construction, and contracting realities are factored in. Three themes explain why larger institutional platforms move faster than stand-alone operators:

- **Hospital renovations within an existing service classification require only administrative review, not full CON.**
- **Hospital expansion with new beds and service lines requires full CON.**
- **Freestanding birth centers face full CON plus the strictest facility regulations calibrated for hospital-grade facilities.**

The Woodhull Hospital renovation illustrates that institutional settings can expand to include birth-center-like spaces without regulatory barriers. Although labeled as birth center rooms, the new spaces remained in the labor and delivery unit, so the hospital did not need a separate CON; only administrative review from a higher level was required. However, even with resources and an agreement, the Woodhull timeline stretched for years due to institutional complexity, regulatory review, and political sensitivity (Blazevski-Charpentier 2026).

Transfer agreements turn safety standards into feasibility gates. Hospitals have no legal obligation to sign transfer agreements with birth centers, despite draft perinatal regulations (in development since 2016) that require centers to have them. Part 795 embeds relationship dependence into the licensure process (10 NYCRR §§795.5, .10), including expectations around clinical governance, transfer readiness, emergency preparedness standards, and clinical staff certifications (NRP — Neonatal Resuscitation Program, BLS — Basic Life Support, ACLS — Advanced Cardiovascular Life Support).

A formal requirement that depends on voluntary hospital cooperation turns a safety standard into a feasibility gate and adds months of uncertainty to project timelines. Several stakeholders framed credentialing and privilege as a hidden operational barrier: a service can be funded, but if the hospital's privileging rules do not recognize midwives or doulas as part of the team, continuity still breaks at the handoff (Winkler/Austin interview).

Facility standards mismatched to clinical risk. Several regulatory gaps constitute reform targets:

- NYSDOH previously committed to harmonizing NY licensure requirements with CABC/national accreditation standards, but has not delivered on that commitment.
- The OB/GYN medical director requirement for licensed birth centers has no clinical justification for low-risk settings and is absent from CABC standards.
- Article 28/CON building standards can be stricter on physical plant, while CABC is stricter on clinical oversight.

Governance fragmentation. Multiple decision-makers govern NYC/NYS maternal infrastructure: NYSDOH (facility rules, CON/Article 28), Medicaid/OHIP plus managed care plans (reimbursement and contracting), NYC DOHMH (programs like doula initiatives, city clinics), and hospital systems whose internal credentialing and operational norms determine what services are actually delivered. When authority is fragmented, project implementation stalls because no single actor is accountable for the full pathway from approval through staffing, reimbursement, and operational handoffs.

Regulatory uncertainty becomes financial risk. Article 28 readiness delays carry costs without revenue; CON uncertainty sinks pre-operational capital; and malpractice/liability forces lenders to assess the entire risk package before considering model quality. Large hospital systems can absorb or pool this risk; community operators cannot (Cohen/Winkler interview). Coit House incurred approximately $200,000 in legal fees (practitioner estimate; not independently verified) in its fight against its CON denial—a figure that reflects one operator's experience in Buffalo and may understate costs in the more complex NYC regulatory and real estate environment. One operator documented forced enrollment in New York's high-risk insurance pool despite no disciplinary issues or claims history, at roughly $75,000 per year (practitioner estimate; not independently verified), an amount that can erode the margins of a small community operator.

C. Financial Design and Revenue Stability

The New York Medicaid payment design creates volatile, structurally inadequate revenue streams for non-hospital maternal providers.

Midwife reimbursement constraints. Under New York Medicaid policy, a licensed midwife's professional services are reimbursable only for personally performed, billable services (eMedNY 2024). In hospital outpatient departments, the midwife's professional component is included in the facility's APG payment; it cannot be separately billed (eMedNY 2024). Stakeholders with extensive clinical experience describe this revenue architecture as the primary financial reason freestanding birth centers close (Montesino 2026).

Facility-fee asymmetry. The payment difference between hospital and non-hospital settings reflects the structural absence of an inpatient facility fee category for freestanding birth centers. Hospitals billing APR-DRG for a vaginal delivery generate a facility payment in addition to any professional fee; practitioner accounts estimate the hospital facility component for a routine vaginal delivery at $10,000–$12,000 (practitioner estimate; not independently verified) (practitioner estimate; not independently verified) (Montesino 2026). Freestanding birth centers operating without Article 28 licensure do not generate an equivalent facility fee under standard Medicaid fee-for-service. However, at least one CABC-accredited center (Coit House, Buffalo) has negotiated a facility-equivalent payment directly with a managed care plan (Fidelis). Whether this arrangement is replicable across NYC's larger and more formalized MCO market remains untested (Winkler 2026).

Figure 6. Revenue Comparison: Same Clinical Event, Different Settings

Revenue Component	Hospital (Article 28)	Freestanding Birth Center (CABC 2025)	FQHC
Professional fee (delivery)	Global code (59400/59510)	Global code or antepartum-only	PPS rate per visit
Facility fee	APR-DRG (~$10,000–$12,000 est.) (practitioner estimate; not independently verified) (practitioner estimate; not independently verified)	None (standard FFS); negotiable with MCOs	Included in the PPS rate
Same-day behavioral health billing	Possible (separate encounter)	Possible	Not possible (one-visit-per-day rule)
Postpartum incentive	$208.55 (if 0503F billed)	$208.55 (if 0503F billed)	$208.55 (if 0503F billed)
Doula billing	Separate provider claim	Separate provider claim	Not a PPS-eligible provider type

Sources: eMedNY (2015; 2024; 2025a; 2025b; 2025c); practitioner estimates from stakeholder interviews. Note: Hospital facility payment estimates are approximations from practitioner accounts and should be verified against eMedNY APR-DRG payment calculators or SPARCS data.

The FQHC structural deficit. FQHCs receive PPS reimbursement because of their special federal statutory status under Section 330 and Medicaid law. Unlike standard Medicaid fee-for-service (FFS), which reimburses each service separately, FQHCs receive a single cost-based Prospective Payment System (PPS) rate per qualifying threshold visit. This structure was designed to protect safety-net providers serving high Medicaid and underserved populations. However, PPS also creates operational constraints, including one-visit-per-day billing limits and restrictions on same-day prenatal and behavioral health reimbursement. A 2023 Urban Institute study found that New York Medicaid PPS rate ceilings are exceeded by at least 44 percent for most patient visits , and that FQHCs are reimbursed approximately 70 percent of the true cost of delivering care (Urban Institute 2023). Approximately one-third of Medicaid payments to New York community health centers are delayed through the supplemental payment program reconciliation process (Urban Institute 2023). Three billing rules within the PPS structure create direct maternal care continuity constraints:

- The one-visit-per-day limit prevents billing for both a prenatal visit and a same-day behavioral health visit.
- An off-site rate penalty reduces FQHC reimbursement substantially when providers deliver care outside the health center.

- Doulas are not recognized as a billable provider type within the PPS threshold visit structure.

Managed care administrative burden. A 2023 HHS Office of Inspector General review of 115 Medicaid managed care organizations across 37 states found an overall prior authorization denial rate of 12.5 percent, more than twice the Medicare Advantage rate of 5.7 percent, with some plans exceeding 25 percent (HHS OIG 2023). In New York, where Medicaid managed care dominates maternal coverage and community-based providers operate on thin margins, denied or delayed claims create immediate cash-flow instability for FQHCs, birth centers, and doula organizations that lack the reserves and billing infrastructure of large hospital systems. Each denied or delayed claim represents deferred cash and increased overhead for community providers who lack institutional billing infrastructure.

Doula billing friction. New York's Medicaid doula benefit covers up to eight perinatal visits and one labor and delivery encounter per pregnancy, with maximum reimbursement of $1,500 in New York City (CMS 2023) (eMedNY 2025a). As of April 1, 2025, doulas must bill through Medicaid managed care plans rather than fee-for-service. Stakeholders who operate community doula organizations describe payment timelines ranging from two weeks to twelve months, with no published or enforced standard (Austin 2026).

Transfer-related financial ambiguity. When a patient receives prenatal care from one provider but delivers at a different institution, there is no formal New York Medicaid guidance specifying how payment responsibility is allocated between the referring and receiving providers. The absence of formal policy creates financial risk on both sides of clinical handoffs and may create disincentives to refer even when a specialist handoff would benefit the patient.

D. Capital and Infrastructure Realities

Limited retained earnings and facility-fee asymmetry make it difficult for community-based maternal care organizations to finance the capital, physical plant, and pre-operational requirements associated with Article 28 licensure and Certificate of Need (CON) approval, because New York's CON framework regulates facility establishment, construction, and renovation, while Article 28 licensure requires compliance with state facility and engineering standards.

Limited retained earnings. Nonprofit and small maternal providers are structurally unable to self-capitalize significant infrastructure investment. NYC Health + Hospitals reported net patient service revenue of approximately $8.4 billion in FY2024 and received approximately $2.9 billion in City appropriations, yet still operated at a net deficit (NYC H+H 2024). The public system's capital program depends substantially on the City's capital budget allocations and bond issuances. A freestanding birth center serving 100–150 births per year has access to none of these mechanisms.

Lending and collateral barriers. Community maternal providers typically fail multiple commercial lending screens: they lack bond ratings, have short operating histories, and hold no significant real property as collateral. DASNY's one-step approval is available only to

borrowers with expected ratings of "A" or better; all others require full Board review (DASNY n.d.). DASNY's Tax-Exempt Equipment Leasing Program (TELP) offers tax-exempt rates of approximately 1.62 percent compared to taxable rates of approximately 2.44 percent, but freestanding birth centers operating without Article 28 licensure are not explicitly listed as eligible (DASNY n.d.).

Construction cost pressure. Healthcare construction in New York City carries among the highest per-square-foot costs in the country. Gordian RSMeans data show NYC hospital-grade construction at $582.21 per square foot in 2025, up from $494.19 in 2020, a 17.8 percent increase over five years (Gordian RSMeans 2026). Two practitioners with direct experience on a birth center project independently estimated the total cost of a compliant freestanding birth center in NYC at a minimum of $10 million (practitioner estimate; not independently verified) (Montesino/Blazevski interview). The $5 million state capital grant awarded to the Birthing Place Foundation covers approximately half of the estimated construction costs. It requires the organization to spend first and be reimbursed, imposing a negative cash balance during the entire development period (Flores 2026).

Figure 7. Capital Barriers and Continuity Impacts

Capital Barrier	Mechanism	Impact on Maternal Continuity
Limited retained earnings	Medicaid-dominant payer mix, thin/negative margins	Community providers cannot self-fund infrastructure
Lending and collateral gaps	No bond ratings, short operating histories, and no real property	Excluded from DASNY bond programs and commercial lending
DASNY/TELP eligibility gaps	Non-Article 28 birth centers are not explicitly eligible	Excluded from low-cost tax-exempt equipment financing
Construction cost escalation	$582/sq ft (2025); 17.8% increase since 2020	Project costs exceed available grant funding; cost inflation during approval delays
Reimbursement-after-spending grants	State capital grants require expenditure before reimbursement	Negative cash balance for the entire development period; requires a credit line that CBOs do not have
Pre-operational timing mismatch	18–24 months from construction start to first Medicaid revenue	Debt service begins before revenue; operating cash is depleted before doors open
Malpractice cost burden	~$75,000/year for community birth center operators (practitioner estimate; not independently verified)	Erases operating margin for small-volume providers

CON-related sunk costs	Legal, architectural, and consulting fees before approval	Up to $200,000+ in non-recoverable costs (practitioner estimate; not independently verified) (Coit House example; NYC costs may be higher)

Sources: Gordian RSMeans (2025); DASNY bond and TELP documentation; NYC H+H audited financial statements FY2024; stakeholder interviews (Winkler, Flores, Cohen, Montesino, Blazevski).

Hospital capital advantage: structure, not scale. Large hospital systems' capital advantages reflect structural features of the existing NYS Medicaid financing and regulatory system, not simply organizational size. NYC Health + Hospitals is a Covered Organization for the NYC financial reporting entity because NYC is contingently responsible for H+H's expenses beyond available revenues. Thus, H+H has access to NYC capital and expense funds, and, as a safety-net hospital can apply for supplemental Medicaid payments that cross-subsidize capital investment. A hospital renovation within an existing service classification requires only administrative-level review, dramatically shortening timelines. A freestanding birth center faces full CON review with hospital-grade physical plant standards and timelines consistently described as 18 months or longer. The difference is not that hospitals are better operators; it is that the regulatory and capital structure is organized around them.

E. Synthesis: The Reinforcing Cycle

The three structural domains documented above (payment, regulation, and capital) do not operate independently. They form a reinforcing cycle that locks the maternal care system in its current configuration.

Regulatory uncertainty increases financial risk. Article 28 compliance imposes carrying costs without revenue. CON processes generate pre-operational expenditures before approval certainty. Malpractice exposure makes community models appear unfinanceable to lenders, even when their clinical models are strong. Financial instability restricts access to capital. Capital constraints prevent the development of compliant facilities. Moreover, without facilities, there is no infrastructure to bill through, returning to the payment issue.

F. Comparative Maternal Models in Practice

The following models illustrate how structural constraints manifest differently across care delivery settings.

Figure 8. Comparative Analysis: Structural Position of Three Maternal Care Models

Dimension	Freestanding Birth Center	Hospital-Integrated Midwifery	Community-Based Doula Services
Regulatory pathway	Full CON + Article 28 (or CABC-only with legal uncertainty)	Operates within the hospital's existing Article 28 license	No facility licensure required; individual Medicaid enrollment

Facility fee access	None under standard FFS; negotiable with MCOs if CABC-accredited	Absorbed into the hospital's APG/DRG payment	N/A
Professional billing	Global codes or antepartum-only; visit-level post-2027	Included in facility payment (no independent claim)	Up to $1,500/pregnancy; 8 visits + 1 L&D
Capital requirements	~$10M+ for NYC-compliant facility (practitioner estimate; not independently verified)	Funded through the hospital capital budget	Minimal (no facility)
Primary revenue risk	Revenue cliff at delivery; no facility fee; thin margins	Revenue flows to the institution, not the midwife practice	Payment delays (2 weeks–12 months); MCO transition
Transfer dynamics	Must have a transfer agreement (no hospital obligation to sign)	Transfers within the same institution	N/A (accompanies patient)
Malpractice exposure	High (~$75K/year); forced high-risk pool enrollment reported	Covered under the hospital's institutional policy	Lower; limited scope of practice
Clinical autonomy	High (independent practice)	Constrained by hospital credentialing/privileging	High within scope; not recognized in hospital governance
Scalability constraint	Capital, regulation, malpractice	Hospital system prioritization and politics	Payment adequacy and cash flow
Cesarean rate (national data)	5–8.6% (AABC 2026)	Varies by institution (~20–25% low-risk)	N/A
Key NYC example	Birthing Place Foundation (planned); Coit House (Buffalo)	H+H Woodhull birth center rooms	Ancient Song Doula Services

Sources: eMedNY (2015; 2024; 2025a; 2025b); AABC Strong Start data; Alliman et al. (2022); stakeholder interviews. Cesarean rates: AABC Strong Start participants = 8.56% primary cesarean (Alliman et al. 2022); national low-risk cesarean rate = 26.6% (Osterman et al. 2025).

FQHC Model. FQHCs operate under a PPS rate that the Urban Institute found covers approximately 70 percent of true service delivery costs (Urban Institute 2023). Capital

investment is financed primarily through Health Resources and Services Administration (HRSA) grants, the U.S. Department of Agriculture (USDA) Community Facilities Programs, and Community Development Financial Institutions (CDFI) lending. The FQHC capital component embedded in the PPS rate is narrow, covering rent and interest allocated across all visits; it cannot be separately deployed as a capital planning tool. FQHCs are eligible for DASNY TELP financing as Article 28-licensed D&TCs, which are better positioned than unlicensed birth centers for equipment financing.

Hospital-affiliated ambulatory networks. Hospital-integrated midwifery practices operate within the hospital's capital and billing infrastructure. Midwife professional services in hospital outpatient settings are absorbed into the hospital's APG DRG payment (eMedNY 2025a), meaning midwives generate no independent billing stream. Capital for program expansion depends on hospital system prioritization, shaped by political timing and competing service line claims (Blazevski interview). The financial security is real, but it comes at the cost of clinical and operational autonomy.

Freestanding birth centers. Birth centers face the highest regulatory scrutiny while operating on the thinnest margins. They serve here as a case example of how structural barriers impede community-based care models broadly, not as a standalone solution to maternal mortality. NYC maternal mortality reviews do not identify place of birth as a primary driver of deaths; the dominant causes are postpartum mental health and substance use conditions. Birth centers illustrate how structurally viable models encounter barriers to development under current conditions.

Community-based doula services. Doulas provide continuous, relationship-based support across the prenatal, labor, and postpartum periods. The Medicaid doula benefit represents an important recognition of this role, but operational realities constrain its impact. Payment delays destabilize community practices when institutional cash reserves are absent. The governance barrier is also significant: doulas function as an accountability presence that can challenge hierarchy in the labor room; hospitals may respond by creating internal doula programs that expand access but dilute independence (Austin 2026). The transition to MCO billing (April 2025) adds administrative complexity. Unlike birth centers and midwifery practices, doula organizations require minimal capital infrastructure; their primary constraint is payment adequacy and cash flow stability.

G. Perinatal Mental Health and Substance Use Care Models

Capital constraints are particularly visible in emerging models for perinatal mental health and substance use care. These include inpatient or partial-hospital "mother–baby" programs, perinatal psychiatric day programs, respite centers, and residential or supportive housing with embedded maternal and behavioral health services. These models fill the gap between brief outpatient contacts and acute hospitalization by providing structured, longitudinal support during high-risk periods.

From a structural perspective, these services face many of the same constraints identified for maternal care broadly. They must navigate Article 28 and CON processes that are not designed for perinatal behavioral health; rely on payment structures that do not consistently support

integrated medical and behavioral health care; and secure capital for facilities that combine clinical, residential, and supportive service functions.

No single licensure pathway currently exists under New York State law for integrated perinatal behavioral health and short-term stabilization models. Providers must combine Article 28 outpatient licensure with separate New York State regulatory frameworks for residential or substance use services (OMH - Office of Mental Health, OASAS - Office of Addiction Services and Supports). Two operational configurations are most realistic:

1. **Article 28-based day program model:** Perinatal psychiatry, therapy, and care coordination, with extended hours and formal referral pathways to inpatient or residential settings.
2. **Co-located model:** An Article 28 clinical program paired with separately licensed residential services for pregnant and parenting individuals, through formal partnerships and shared protocols.

The absence of a clear, unified regulatory pathway to integrate mental health with the standard maternal services for a locally-provided continuum of maternal care services increases development timelines, complicates financing, and heightens operational risk to providers.

V. Implications for Policy and Design

A. Reframing the Role of Community-Based Models

The binding constraints on community-based maternal care are structural: revenue flows that reward retention of the delivery, licensure, and CON processes designed for hospitals, and capital pathways that favor large institutional platforms. Within NYC's maternal mortality profile, community-based models are most relevant not as symbolic alternatives to hospital delivery but as vehicles for delivering continuous, culturally responsive care, including perinatal mental health and substance use services, in the neighborhoods where risk is highest.

An important clarification: the argument for expanding community-based maternal care applies to low-risk pregnancies and to the prenatal, postpartum, and behavioral health components of the continuum and is not intended to replace hospital capacity for high-risk or complicated deliveries. Hospital-based obstetric services remain essential for managing preeclampsia, preterm labor, placental complications, and other conditions requiring surgical intervention or intensive monitoring. The goal is not to divert patients from hospitals but to ensure that the large share of pregnancies that are clinically low-risk have access to continuous, community-based care options that the current payment and regulatory structure makes difficult to sustain.

B. Infrastructure as a Maternal Health Intervention

For the capstone client, which began the Medicaid financing inquiry in Spring 2025,[1] and continued with this capstone project to explore the provider impediments to local provision of maternal continuum of care services, the central implication is that maternal health is, in part, a structural problem. High-risk neighborhoods often have limited local capacity for integrated

[1] See at MaternalHealthCapstoneReport_DDC.pdf.

perinatal mental health and substance use care, sparse space for community-based prenatal and postpartum services, and few settings that can offer stabilization or respite outside of acute hospitalization. Building new physical spaces, such as perinatal behavioral health and respite centers, maternal medical homes, or hub sites for doula and community health worker teams, for the maternal continuum of care suite of services, requires navigating Article 28 licensure, CON processes, and capital markets not calibrated to these models. Without adjustments, efforts to respond to Maternal Mortality Review Committee (MMRC) recommendations will continue to depend on one-off pilots, short-term grants, or exceptional institutional champions rather than a predictable pipeline of projects.

C. Designing for Continuity, Equity, and Feasibility

Three design criteria should guide future policy and capital decisions:

1. **Continuity:** Interventions should make it easier to deliver continuous care across the prenatal-to-postpartum continuum in high-risk neighborhoods, with particular attention to perinatal mental health and substance use.
2. **Equity:** Reforms must be equity-explicit, targeting payment changes, regulatory flexibility, and capital support to providers serving Black and Medicaid-enrolled populations, rather than assuming system-wide changes will close gaps on their own.
3. **Feasibility:** Solutions must be operationally feasible for community providers, addressing cash-flow timing, managed care administrative burden, and pre-operational capital needs, rather than simply updating statutory language.

VI. Policy Recommendations

This section translates structural findings into concrete actions across three domains. Recommendations are organized by priority tier based on (1) direct relevance to Town+Gown's ability to continue relevent research projects based, in part, on these findings, (2) feasibility within existing authority, and (3) expected impact on perinatal mental health and postpartum infrastructure.

Figure 9. Recommendation Prioritization Matrix

Recommendation	Domain	Primary Actor	Town+Gown/DOHMH with DDC Role	Timeline
R5: Develop designs and design standards for future maternal continuum of care settings, including perinatal behavioral health (Maternal + BH facilities), informed by potential reforms to financing structure; explore how these potential reforms of the Medicaid fee-for-services reimbursement with capital component model	Design, Finance, Capital + Regulation	DOH, DOHMH with DDC, DASNY	**Direct** (site ID, design, capital planning)	12–36 months

(capital pathways and bridge financing) can support capital finance of facilities by local providers as part of scaling operations for Maternal + BH facilities				
R-C1: Dedicated maternal health capital track	Capital	DASNY, DOH	**Direct** (project pipeline)	12–24 months
R-C2: Bridge financing for pre-operational costs	Capital	DOH, CDFI, NYCEDC	**Direct** (project feasibility)	12–18 months
R-B: Streamline regulatory pathways	Regulation	DOH/OHSM	Advocacy + pilot coordination	12–24 months
R1: Adequate per-visit rates for CPT 2027	Payment	DOH/OHIP	Advocacy	By Q3 2026
R2: Site-of-care reimbursement parity analysis	Payment	DOH/OHIP	Data provision	12 months
R3: Split-episode payment guidance	Payment	DOH/OHIP	Advocacy	12 months
R4: Integrate postpartum visit incentive into base rate	Payment	DOH/OHIP	Advocacy	6–12 months
R-C3: Structured technical assistance	Capital	DOH, CHCANYS	Partner/convener	Ongoing

Tier 1 (future Town+Gown-supported research): Design and financing research projects for Maternal Maternal + BH facilities, including architecture studios, whole system cost-benefit analysis, legal-policy pathway research . Tier 2 (convening/agenda-setting): Regulatory streamlining, pilot coordination . Tier 3 (Systemic-level reform/advocacy): Payment reform, rate adequacy, 1115 waiver alignment,

A. Align Payment with Continuity of Care

Recommendation 1: Support adequate per-visit rate adoption for CPT 2027 unbundling, with equity protections for non-hospital settings.

Problem addressed: The global OB code structure (CPT 59400/59510) concentrates episode revenue at delivery, penalizing prenatal providers who do not attend the birth. The AMA's deletion of 16 global obstetric codes effective January 1, 2027, creates an opening to fund continuity, but only if NYS Medicaid adopts per-visit rates adequate to sustain community-based, midwifery-led, and FQHC-based prenatal care (AMA CPT Editorial Panel 2025).

Why this matters: If the 2027 changes are adopted at rates that favor high-volume hospital-affiliated practices or fail to account for the overhead structures of independent midwifery and FQHC settings, the reform will redistribute revenue without improving access.

Implementing actor: NYS DOH / OHIP, with coordination from Medicaid managed care plans.

Mechanism: NYS Medicaid rate-setting process. No CMS waiver required; requires DOH to publish updated fee schedules and establish per-visit rates for prenatal and postpartum E/M services covering the cost of delivery in community settings.

Near-term steps: DOH publishes stakeholder engagement process for 2027 CPT adoption by Q3 2026. - Medicaid actuaries conduct site-of-care cost analysis comparing hospital-affiliated, independent midwifery, and FQHC settings. - MCO contracts amended to adopt updated code sets with corresponding rate floors. - DOH issues provider guidance specific to birth centers, midwife practices, and FQHCs.

Recommendation 2: Commission a formal site-of-care reimbursement parity analysis.

Problem addressed: Total reimbursement for comparable services differs substantially between hospital and non-hospital settings because of the APG/APR-DRG structural advantage (eMedNY 2025a) (eMedNY 2025a). The facility-fee asymmetry cannot be corrected without being formally quantified.

Implementing actor: NYS DOH/OHIP, Medicaid actuarial unit.

Mechanism: Administrative rate analysis using SPARCS and Medicaid claims data; no new legislation required.

Near-term steps: NYSDOH conducts a formal comparison of total payments across settings for defined clinical events (routine vaginal delivery; postpartum visit). - Findings published with a comment period for provider associations, birth centers, and FQHCs. - Fee schedule adjustments proposed through the standard rate-setting process.

Recommendation 3: Issue formal NYSDOH guidance establishing payment rules for split-episode maternal care.

Problem addressed: No identified primary source describes how New York Medicaid handles payment when a patient receives prenatal care from one provider and delivers with another. This ambiguity creates financial risk on both sides of appropriate clinical handoffs and may disincentivize referral.

Implementing actor: NYS DOH/OHIP.

Mechanism: NYSDOH guidance document (no legislation required) clarifying: (a) antepartum claims are not subject to recoupment when a separate delivering provider later bills a delivery code; (b) the delivering provider’s reimbursement does not subsume the prenatal provider’s claim; (c) these rules apply under both FFS and managed care.

Recommendation 4: Integrate the postpartum visit incentive into the base payment structure.

Problem addressed: The Timely Postpartum Visit Incentive ($208.55, code 0503F) requires a zero-dollar supplemental claim, in addition to the postpartum visit claim, to trigger payment (eMedNY 2025a). This administrative step is a barrier to uptake.

Implementing actor: NYS DOH/OHIP.

Mechanism: Modify existing program to allow automatic payment with CPT 59430 or equivalent postpartum E/M code post-2027.

THE 1115 WAIVER AS A VEHICLE FOR PAYMENT REFORM

New York's NYHER 1115 waiver amendment, approved by CMS on January 9, 2024, and effective through March 31, 2027, authorized approximately $6.69 billion in investments to advance health equity and strengthen behavioral health and primary care services (NYSDOH 2024). The waiver includes a condition requiring New York to increase Medicaid provider payment rates for primary care, behavioral health, and obstetrics care where those rates fall below 80 percent of Medicare rates. This rate floor condition is directly relevant to the reimbursement concerns documented in this report. The waiver explicitly designates pregnant persons up to 12 months postpartum as a target population for complex care services. It establishes Social Care Networks across nine state regions connecting Medicaid members with health-related social needs. NYSDOH should explicitly incorporate perinatal continuity of care into the waiver's equity planning priorities and renewal framework ahead of the March 2027 expiration.

Recommendation 5: Develop infrastructure for perinatal mental health and substance use care.

Problem addressed: Maternal mortality in NYC is increasingly driven by postpartum mental health conditions and substance use, yet the system lacks intermediate care settings between outpatient visits and acute hospitalization. As of 2025, the NYC area has one specialized perinatal psychiatric inpatient unit and two IOPs serving a city of over 8 million with approximately 100,000 births annually.

Implementing actors: NYSDOH and OHIP (payment and regulatory design); NYC DOHMH with DDC (facility planning); DASNY, CDFIs, or NYCEDC (capital deployment).

Mechanism: Coordinated strategy across payment, regulation, and capital: - **Payment:** Adopt reimbursement models supporting integrated perinatal medical and behavioral health services (bundled or day-rate payments), with enhanced rates targeted to high-risk geographies. - **Regulation:** Establish a clear licensure pathway for perinatal behavioral health and respite centers, either a tailored Article 28 category or aligned standards reflecting lower clinical acuity. - **Capital:** Develop dedicated financing and technical assistance tracks for community-based and safety-net providers.

Near-term steps: NYSDOH convenes an interagency working group (OMH, OASAS, DOHMH with DDC, DASNY) to define standardized perinatal behavioral health models. - OHIP pilots Medicaid payment models (day rates) for integrated perinatal behavioral health services, geographically targeted using MMRC data. - NYSDOH issues interim guidance on combining existing Article 28, OMH, and OASAS pathways. - NYC incorporates perinatal behavioral health infrastructure into the NYC capital planning process, including site identification in high-risk neighborhoods.

B. Clarify and Streamline Regulatory Pathways

- **Publish clear licensure guidance** (Owner: NYS DOH/OHSM/PHHPC). At a minimum, NYSDOH should publish a plain-language pathway distinguishing legal operations from state licensure from Medicaid scaling, and what triggers building-driven review versus clinical quality oversight.
- **Standardize transfer agreement expectations** (Owner: NYS DOH/major hospital systems). Create templates and expectations for transfer readiness. Hospitals' lack of legal obligation to sign transfer agreements makes relationship dependence a feasibility gate embedded in 10 NYCRR, Part 795.
- **Review proportionality of requirements** (Owner: NYSDOH, with facility operators/accrediting bodies). Distinguish requirements essential for safety from those inherited from hospital assumptions. Enable community models to expand without unnecessary hospital-grade burdens.

C. Establish Infrastructure Financing

Recommendation C-1: Establish a dedicated maternal health capital track with explicit eligibility for CABC-accredited birth centers.

Problem addressed: CABC-accredited but non-Article 28 birth centers are not explicitly eligible for DASNY TELP and may not qualify for bond programs without a creditworthy co-borrower. NICIP explicitly excludes Article 28-eligible organizations but does not clearly include CABC-accredited centers outside Article 28.

Implementing actor: NYS DOH (regulatory designation); DASNY (program modification).

Mechanism: (a) NYSDOH regulatory designation of CABC-accredited birth centers as eligible healthcare facilities for DASNY financing; (b) establishment of a maternal health capital line within DASNY's programs; (c) potential inclusion in annual State Budget as targeted health infrastructure appropriation.

Near-term steps: NYSDOH and DASNY conduct a joint technical review of TELP and bond program eligibility. - NYSDOH issues guidance confirming CABC accreditation as a sufficient credential for DASNY programs. - DASNY establishes a dedicated maternal health project track with simplified underwriting for community-scale projects.

Recommendation C-2: Create a structured bridge financing mechanism for pre-operational costs.

Problem addressed: State capital grants require reimbursement after funds are spent. Community organizations without credit lines cannot bridge the 18- to 24-month gap between expenditures and revenue.

Implementing actor: Designated financing intermediary.

Mechanism: Revolving bridge loan or pre-development grant fund, milestone-disbursed, with interest-free pre-operational period. The fund should cover: architectural/engineering fees, CON/administrative review costs, legal fees, and the first 90 days of operating capital.

Recommendation C-3: Provide structured technical assistance for regulatory and financial planning.

Problem addressed: Community maternal providers lack the capacity to produce DASNY applications, CON documentation, and financial projections required to access capital programs.

Implementing actor: NYS DOH Office of Primary Care, in partnership with CHCANYS, NYSBCA, and experienced CDFIs.

Mechanism: Funded technical assistance program covering DASNY applications, CON processes, MCO contracting, Medicaid billing setup, and CPT 2027 transition planning. Assistance should be required, not optional, for any capital program application.

Figure 10. Maternal Capital Support Instruments

Instrument	Administering Entity	Eligible Borrowers	Key Terms	Gap Addressed
DASNY Tax-Exempt Bonds	DASNY	Article 28 facilities with "A" rating (1-step) or Board review (2-step)	Tax-exempt rates; requires revenue pledge	Long-term capital for large projects
DASNY TELP	DASNY	Article 28 D&TCs, hospitals; birth centers TBD	~1.62% tax-exempt rate	Equipment financing
NICIP Grants	DASNY	Not-for-profit, non-Article 28	Grant; varies	Capital for non-hospital NFPs
State Capital Grants	NYS DOH	Varies by program	Reimbursement-after-spending	Construction funding (but creates a cash-flow gap)
HRSA Capital Grants	HRSA	FQHCs	Grant is tied to the HRSA cycle	FQHC infrastructure

CDFI Lending	Various CDFIs	Community organizations	Market or below-market rates	Flexible bridge and gap financing
Proposed: Maternal Health Bridge Fund	**DOH or designated intermediary**	**CABC-accredited birth centers, FQHCs, and community maternal providers**	**Milestone-disbursed; interest-free pre-op period**	**Pre-operational cash-flow gap**
Proposed: Dedicated Maternal Capital Track	**DASNY**	**CABC-accredited, FQHC-affiliated, Medicaid-serving**	**Simplified underwriting for <$15M projects**	**Access for community-scale projects**

Sources: DASNY bond process documentation; DASNY TELP; HRSA Health Center Program; stakeholder interviews (Cohen, Flores, Winkler).

Financial Sustainability Checklist

The checklists that follow are operational tools designed for community-based maternal care providers navigating the current system in New York City and New York State. They are not a substitute for the structural reforms recommended in Section VI; rather, they are intended for use while those reforms are being pursued. Each checklist addresses a specific operational risk area: billing and revenue structure; cash flow and working capital; regulatory pathway and licensing; transfer agreements; and staffing and credentialing. Providers should treat these as a starting point for due diligence, not a comprehensive legal or financial guide. Independent legal counsel and billing expertise are strongly recommended before making significant operational or financial commitments, particularly around CON applications, Medicaid contracting, and transfer agreement negotiations.

MODULE 1: Revenue Architecture

Global OB Code Structure (current, through 12/31/2026)

☐ Confirm which CPT codes the practice will bill for full-episode obstetric care (59400, 59510) vs. antepartum-only (59425, 59426) or postpartum-only (59430).

Red flag: Practice plans to bill antepartum-only codes but has not modeled revenue as a single-payment-per-pregnancy structure. Interim cash flow means operations depend on delivery volume or on outside funding.

☐ If practice does not attend deliveries: confirm that the single antepartum payment per pregnancy (one unit of 59425 or 59426) covers operating costs at expected patient volume.

Red flag: At expected volume and payer mix, antepartum-only revenue does not cover fixed monthly costs. This is a structural viability gap, not a billing error.

☐ Confirm that the postpartum incentive CPT II code 0503F billing process is operational: staff know to submit $a $0supplemental claim alongside 59430 or a global code to trigger the $208.55 payment [eMedNY 2025c].

CPT 2027 Transition Planning (effective January 1, 2027)

☐ Practice has a designated staff member responsible for tracking AMA CPT 2027 implementation timelines and NYS Medicaid fee schedule adoption.

☐ EHR/billing system vendor has confirmed a 2027 code-set update schedule. The confirmed update will include E/M codes with the TH modifier and new maternity-specific stage codes.

☐ Revenue model has been re-projected under visit-level billing assumptions, including an estimate of per-visit rates based on NYS Medicaid's published adoption (when available) and comparable E/M visit rates.

Red flag: Practice assumes the 2027 transition will automatically increase revenue. Budget-neutral CPT change means redistribution, not net expansion. Per-visit rates at NYS Medicaid levels may be lower than global code equivalents at low visit volumes.

☐ Practice has reviewed whether 2027 changes require updates to MCO contracts; if so, contract renegotiation is on the implementation calendar.

MODULE 2: Payer Mix and Managed Care Readiness

MCO Credentialing and Contracting

☐ All clinical providers are credentialed and in-network with Medicaid managed care plans covering the target patient population before the practice opens.

Red flag: MCO credentialing typically takes 90–180 days; starting post-opening means the first months of patient care generate no MCO reimbursement.

☐ Practice has confirmed in-network status with at least three Medicaid MCOs covering the practice's service area (in NYC: Healthfirst, Fidelis/Centene, EmblemHealth, MetroPlus at a minimum).

☐ Practice has confirmed that midwives and/or doulas are recognized as credentialed provider types in each MCO contract. Many MCO contracts default to physician credentialing; midwife-specific credentialing may require explicit negotiation.

Prior Authorization Management

☐ Practice has mapped which services in the obstetric episode require prior authorization under each MCO contract (e.g., specialist referrals, home nursing, postpartum mental health services).

☐ Billing staff is trained on the authorization process for each plan; the denial rate is tracked monthly.

Red flag: No denial tracking process. Given that Medicaid MCOs deny approximately 1 in 8 prior authorization requests nationally [HHS OIG 2023], untracked denials represent material revenue leakage.

☐ Practice has a documented appeals process and assigns staff responsibility for claim appeals.

Doula Billing (if applicable)

☐ Doulas employed or contracted are enrolled in Medicaid and in-network with relevant MMC plans (as of April 1, 2025, doula claims are billed through MMC plans for managed care patients) [eMedNY Doula Policy Manual 2025].

☐ Billing staff understands same-day billing restriction for doula services: two visits on the same day are only allowed when a perinatal visit and a labor and delivery encounter occur in sequence [eMedNY Doula Policy Manual 2025].

☐ Practice has modeled cash flow assuming doula payment timelines of 30 days to 6 months; reserves or a credit line are sufficient to bridge the gap.

Red flag: Practice has budgeted doula revenue at face value without accounting for payment lag.

MODULE 3: Facility Fee and Setting-Specific Revenue

Facility Fee Eligibility

☐ Practice has confirmed whether it is eligible for a Medicaid facility fee (requires Article 28 D&TC or hospital licensure under standard fee-for-service structure, OR individually negotiated MCO rate using CABC accreditation as credential). Note: The Coit House Birth Center in Buffalo has negotiated such a rate with one MCO (Fidelis), but this arrangement has not been replicated in New York City, and MCO willingness to contract on these terms should not be assumed without direct confirmation from each plan.

Red flag: Practice is projecting facility fee revenue without a confirmed pathway to collect it. In the absence of Article 28 licensure or a specific MCO contract, facility fees will not be paid automatically.

☐ If pursuing facility fees through CABC accreditation and direct MCO negotiation: document which plans have agreed to facility-equivalent payment, at what rate, and under what contract terms. Treat plans without a written agreement as professional-fee-only.

FQHC-Specific Items

☐ If operating as an FQHC: confirm PPS rate covers off-site visits (e.g., hospital-based prenatal visits, birth attendance). If the off-site rate is substantially lower, model the revenue impact of any planned out-of-center care delivery.

☐ Confirm one-visit-per-day billing limit is reflected in scheduling templates; same-day prenatal + behavioral health visits will not generate two PPS payments.

MODULE 4: Cash Flow and Working Capital

☐ Project cash flow month-by-month for the first 24 months, modeling: (a) time from patient encounter to claim submission, (b) time from claim submission to payment under each payer, and (c) payment delay risk for MCO claims.

Red flag: Cash flow projection shows a negative balance in any of the first six months, with no identified funding source to cover the gap.

☐ Practice maintains a minimum of 90 days of operating cash or an active credit line before opening.

☐ If state capital grants are part of the funding structure: confirm whether grant funds are disbursed in advance or on a reimbursement basis. If reimbursement-based, the working capital requirement is correspondingly higher.

MODULE 5: Transfer and Referral Financial Planning

☐ Practice has documented which clinical scenarios will result in patient transfer to a hospital and modeled the revenue impact: antepartum-only payment under CPT 59426 if transfer occurs pre-delivery; no delivery payment.

☐ Practice has confirmed with billing counsel that billing CPT 59426 after transfer does not create a recoupment risk if the delivering hospital later bills a delivery-related global or professional code. [Note: No formal NY Medicaid guidance resolves this question; seek written confirmation from payer or billing counsel before assuming.]

☐ Transfer scenarios are incorporated into the volume model: e.g., if 15–20% of patients transfer pre-delivery, what is the revenue impact relative to a scenario where all patients deliver at the practice? Is the practice financially viable in the transfer scenario?

Red flag: Financial model assumes 100% delivery capture. Transfer rates of 10–20% are clinically appropriate and should be expected; viability must hold under realistic transfer assumptions.

C. Infrastructure and Operational Planning Checklist

Purpose: Operator-facing decision tool for community maternal providers in NYC/NYS. Each item is linked to a specific regulatory or operational risk.

MODULE 1: Regulatory Pathway and Licensing

Determining the Right Pathway

☐ Practice has determined whether it intends to seek Article 28 licensure as a Midwifery Birth Center under 10 NYCRR Part 795, or to operate without Article 28 licensure using CABC accreditation as its primary credential.

Note: Operating without Article 28 licensure is legally possible in New York State and does not, on its face, preclude operation. The Coit House Birth Center has operated for four years under CABC accreditation without Article 28 licensure or enforcement action [Interview: Winkler/Coit House]. However, this finding rests on a single operator's account and DOH counsel communication; independent legal verification is strongly recommended before a new operator relies on this precedent. Additionally, the Coit House is located in Buffalo; real estate costs, hospital proximity, and DOH enforcement resources may differ significantly in New York City, and operators considering this pathway in the five boroughs should not assume that Buffalo precedent applies without city-specific legal guidance. For comparative reference, Minnesota treats CABC accreditation as equivalent to state licensure, and Nevada requires CABC accreditation as a condition of its own birth center license—but neither state imposes a CON requirement or Article 28-equivalent facility standards on birth centers.

Note: Article 28 licensure is required to access Medicaid facility fees through the standard fee-for-service pathway and to qualify for certain DASNY financing programs as a D&TC.

Article 28 / CON Pathway (if applicable)

☐ Practice has determined whether planned construction or service change triggers CON review under 10 NYCRR Part 710. CON is required for new hospitals, new Article 28 facility establishment, and projects above applicable dollar thresholds.

☐ Practice has engaged an experienced CON legal counsel before incurring significant predevelopment costs; prior examples have documented $200,000+ in legal fees (practitioner estimate; not independently verified) for contested CON applications [Interview: Winkler/Coit House].

☐ Practice has obtained a pre-application consultation with NYSDOH PHHPC staff to confirm review pathway, applicable physical plant standards, and timeline expectations.

☐ Physical plant requirements under 10 NYCRR Part 795 have been reviewed by an architect experienced in DOH-regulated projects. Confirm: birthing room specifications, ambulance egress requirements, plumbing and medical gas infrastructure, and room dimension standards are achievable in the proposed space.

Red flag: The proposed building cannot accommodate the physical plant requirements at a reasonable cost to renovate. In NYC, most pre-war commercial buildings have structural configurations that may require substantial, costly modifications. Confirm site feasibility before signing a lease.

CABC Accreditation Pathway (if applicable)

☐ CABC accreditation application timeline has been reviewed: allow 12–18 months from initial application to site visit to accreditation.

☐ Clinical policies, patient chart review protocols, adverse outcome review processes, risk stratification criteria, and staff competency documentation required for CABC accreditation have been reviewed against current clinical staff capacity.

☐ Practice has confirmed with each target MCO whether CABC accreditation is sufficient for in-network contracting and whether the MCO will provide facility-equivalent payment under a dual-entity billing model or negotiated rate.

MODULE 2: Transfer Agreements and Hospital Relationships

☐ Practice has identified at least one receiving hospital with obstetric and neonatal capability for intrapartum and postpartum transfers.

☐ If seeking Article 28 licensure: a written transfer agreement with a perinatal center licensed under Article 28 is required per 10 NYCRR §795.2(e), which must include arrangements for automatic hospital acceptance and an ambulance service plan [10 NYCRR §795.4].

Red flag: Hospitals are not legally obligated to enter into transfer agreements with birth centers under current New York State regulations. The transfer agreement requirement falls entirely on the birth center; hospital non-cooperation is a documented feasibility barrier.

☐ If operating without Article 28 licensure: practice has documented the clinical transfer pathway, identified receiving facilities, and confirmed (even without a formal written agreement) that those facilities will accept transfers.

Note: Informal transfer relationships are clinically functional in some cases (e.g., Coit House model in Buffalo) but should not be assumed to be stable, permanent, or replicable in other markets. In NYC, where hospital systems are larger and competitive dynamics differ, informal arrangements carry greater risk of disruption; a formal relationship is always preferable.

☐ Transfer protocol includes: who accompanies the patient, what documentation transfers, how the receiving hospital is notified, and what the reintegration pathway is for postpartum follow-up.

MODULE 3: Staffing, Credentialing, and Regulatory Compliance

Birth Center Director Requirements (10 NYCRR §795.5)

☐ Practice has confirmed that the birth center director meets the regulatory definition: must be a licensed midwife or physician [10 NYCRR §795.5(a)].

☐ Practice has established collaborative relationships with board-certified OB/GYN physicians who practice obstetrics and have privileges at an Article 28-licensed hospital, as required by 10 NYCRR §795.5(g)(1) for licensed birth centers.

Note: This requirement does not mandate that the director be an OB/GYN; it requires that the director ensure these collaborative relationships exist. The regulatory text differs from stakeholder accounts, suggesting that OB/GYN medical directorship is imposed; verify the current regulatory language before designing governance.

☐ Collaborative relationships with pediatricians having admission privileges at the receiving hospital(s) are documented per 10 NYCRR §795.5(g)(2).

Clinical Staff Requirements

☐ All clinical staff hold required certifications: NRP (Neonatal Resuscitation Program), BLS, ACLS as applicable; confirm currency before opening.

☐ A 24/7 clinical staffing plan is in place for admitted patients. If the solo practitioner model is used, an on-call backup arrangement with another qualified provider is documented.

☐ Credentialing files for all providers are complete and up to date before the first patient is admitted.

MODULE 4: Capital and Financing

☐ Total project cost estimate has been produced by an architect or construction cost estimator with NYC healthcare construction experience. Use a base assumption of $500–$600/sq ft for renovations and $700+ for new construction in NYC (practitioner estimate; not independently verified), plus a contingency of 15–20%.

☐ Capital stack is fully identified and committed before construction begins: equity/grant component, loan component, and bridge financing for the pre-operational period.

☐ Practice has assessed DASNY TELP eligibility for equipment financing. If operating as a D&TC or hospital affiliate, TELP is available at approximately 1.62% tax-exempt rate [DASNY TELP]. If not eligible as a standalone entity, explore whether a hospital or FQHC partner can serve as TELP borrower for shared equipment.

☐ If receiving a state capital grant: confirm disbursement structure (advance vs. reimbursement-after-spending) and ensure working capital or credit line is sufficient to cover the spending period before reimbursement arrives.

☐ DASNY bond financing has been assessed for applicability. For community birth centers without an "A" rating, the two-step DASNY approval process (120–180 days) should be included in the project timeline [DASNY Bond Process].

Milestone	Typical Duration	Key Dependencies	Red Flag
Site selection and lease execution	3–6 months	Physical plant feasibility assessment	Lease signed before architectural review confirms physical plant compliance
CABC accreditation application	12–18 months	Clinical policy development; staff hiring	Accreditation is delayed past the opening target
CON or administrative review (if applicable)	12–24 months	DOH PHHPC review; public comment	No contingency budget for delay
Construction and renovation	6–18 months	Permits, contractor availability	Construction cost increase >15% from initial estimate
MCO credentialing and in-network contracting	3–6 months per plan	Provider NPI, practice location confirmation	Credentialing is not initiated until 60 days before opening
Medicaid billing system setup and testing	2–3 months	EHR system, claims clearinghouse setup	First claims submitted without a test cycle
CPT 2027 transition (all practices)	Planning by Q3 2026	AMA code release, NYS Medicaid adoption	No transition plan in place by January 2026

VII. Risks and Tradeoffs

Institutional Resistance

Implementation is a significant failure point in this area. Recent wins, such as doula reimbursements and midwifery birth center authorization, have been followed by implementation breakdowns in which agency discretion and institutional resistance have shaped

outcomes. Hospital may resist community-based expansion for governance rather than clinical reasons.

Doulas function as an accountability presence that challenges hierarchy in the labor room; hospitals sometimes respond by creating internal doula programs that expand access but dilute independence (Austin 2026). This governance barrier compounds operational payment delays, with doula claims reimbursed anywhere from two weeks to twelve months. Without viable financing tools, even optimal payment reforms cannot be implemented. New prenatal and postpartum programs require physical space. The lack of capital investments in communities may leave patients with fewer local options, reinforcing hospital-centric care.

Political Feasibility

Hospitals and OB leadership may resist reforms framed as competition. The regulatory environment involves not only money but also coordination, sequencing, and political timing. Models that rely on heroic negotiation, one-off philanthropy, or idiosyncratic workarounds can demonstrate what is possible but cannot close borough-wide gaps or eliminate racial disparities. The high prevalence of clinical and social risk factors among NYC's birthing population means solutions must be evaluated for scalability. The legal uncertainty around the Coit House distinction in Buffalo, that Article 28 licensure is not required for operation, remains unverified by independent legal analysis. New operators should not assume that a single Buffalo precedent applies in New York City without city-specific legal guidance.

Timeline Realities

Even well-resourced systems face long timelines. Woodhull's renovation stretched for years despite institutional backing, due to regulatory review and political sensitivity. Stakeholders caution against treating regulatory streamlining as a standalone fix: faster approvals alone will not produce scalable community maternal capacity unless the model is also financeable and insurable (Cohen 2026). Postpartum is where the system fails most predictably. Stakeholders documented community encounters where blood pressure checks revealed likely postpartum preeclampsia that discharge processes did not catch, evidence that continuity fails without a structured follow-up infrastructure (Flores 2026).

Replicability Risk

Several of this report's regulatory recommendations—particularly that CABC accreditation can substitute for Article 28 licensure and that MCO facility fees are individually negotiable—draw significant evidentiary weight from a single operator: the Coit House Birth Center in Buffalo. If the Coit House pathway proves non-replicable in New York City, the practical implications for the report's recommendations are substantial. First, MCO contracting norms in the NYC market differ from western New York; the five boroughs are served by a larger number of managed care plans with more formalized credentialing processes, and plans that are contracted with Coit House in a thinner market may not extend the same terms in a competitive urban

environment. Second, NYSDOH enforcement capacity and posture may differ: Buffalo's regulatory environment involves a smaller volume of applications and fewer competing institutional interests, whereas NYC's NYSDOH regional office manages a denser regulatory landscape with stronger institutional stakeholders who may contest non-Article 28 operators. Third, the real estate and capital environment in NYC imposes constraints—construction costs, lease terms, and zoning requirements—that do not apply in Buffalo. A birth center that can absorb $200,000 in legal fees and operate on negotiated MCO rates in a low-cost market may not survive the same path in a borough where pre-operational costs are multiples higher. If the non-Article 28 pathway does not hold in NYC, the report's regulatory recommendations would need to shift toward reforming the Article 28 and CON processes themselves—reducing physical plant requirements, shortening approval timelines, and creating a birth-center-specific licensure category—rather than circumventing them. The comparative models from Minnesota, Nevada, and Texas described elsewhere in this report suggest that states can build functional CABC-integrated regulatory frameworks, but each required legislative or rulemaking action, not operator-level workarounds.

Implementation Risks of Proposed Reforms

The CPT 2027 unbundling reform, while designed to support continuity by allowing per-visit billing, introduces revenue risk for providers currently structured around the global obstetric fee. OB practices that rely on CPT 59400/59510 to cross-subsidize prenatal visits—particularly those with high delivery volumes—could experience net revenue loss if per-visit Medicaid rates are set below the effective per-encounter value embedded in the global code. Smaller practices without administrative capacity to manage higher claim volumes may face billing complexity that offsets the intended benefit. The transition period itself creates uncertainty: providers must adapt billing systems, renegotiate managed care contracts, and absorb potential payment gaps before the new rate structure stabilizes. If New York Medicaid sets per-visit rates too low, the reform could reduce rather than expand the pool of providers willing to accept Medicaid maternity patients.

Regulatory streamlining also carries tradeoffs. Reducing Article 28 and CON requirements for birth centers and community maternal health facilities could lower barriers to entry, but it may simultaneously weaken oversight mechanisms that currently function as quality checks. Hospital systems and professional associations have argued that CON review serves a legitimate safety function by ensuring that new facilities meet clinical, staffing, and emergency-transfer standards before they begin operating. Streamlining that eliminates these reviews without substituting equivalent quality assurance—such as mandatory CABC accreditation, periodic clinical audits, or outcome reporting requirements—risks creating facilities that are easier to open but harder to hold accountable. Any reform should pair reduced regulatory burden with a credible alternative oversight framework.

The hospital perspective on transfer agreements also warrants direct engagement rather than dismissal. Hospitals that decline to sign transfer agreements with freestanding birth centers may be responding to legitimate institutional concerns: accepting transfer patients creates liability exposure for outcomes that originate outside the hospital's clinical control; unscheduled

transfers strain emergency department and labor-and-delivery capacity, particularly in facilities already operating near census; and adverse outcomes at affiliated birth centers can generate reputational risk for the receiving hospital. These concerns do not justify using transfer agreements as a gatekeeping mechanism to block competition, but they do suggest that policy solutions should address hospital risk directly—through liability protections, transfer protocols with defined clinical criteria, and capacity planning—rather than assuming that refusal reflects only anti-competitive intent.

VIII. Conclusion

The maternal care system in New York City is not failing because of a lack of clinical knowledge, workforce capacity, or policy attention. It is failing because of the existing financing and regulatory structure. Payment concentrates revenue at the point of delivery, regulation imposes hospital-calibrated requirements on community providers, and capital access favors large institutions over smaller, locally embedded organizations. Together, these conditions make it difficult to deliver continuity of care and even harder to scale.

The result is predictable. Care remains fragmented. Community-based providers struggle to enter or expand. Patients (Medicaid covered especially) move through a system not designed to support them across the full prenatal-to-postpartum period. The disparities in maternal outcomes are the direct output of these structural choices.

These constraints form a reinforcing cycle. Regulatory uncertainty increases financial risk by extending timelines, generating pre-operational costs, and reducing approval predictability. Financial instability, in turn, limits access to capital. Limited capital then constrains providers' ability to develop facilities capable of meeting regulatory and physical plant requirements, reinforcing the same barriers to entry and expansion. Without facilities, there is no infrastructure to bill through. The cycle keeps maternal care anchored in hospital-based models even when alternatives are clinically appropriate, more accessible, and associated with better outcomes.

Breaking this cycle requires coordinated action across all three domains. Payment reform must support continuous care, not just the delivery event. Regulatory pathways must be clear, proportional, and feasible for non-hospital providers. Capital mechanisms must allow community-based organizations to build, open, and sustain operations. Addressing any one domain in isolation will not be sufficient.

The equity implications are immediate. Black birthing people in New York City continue to experience maternal mortality rates several times higher than their white counterparts, and most of these deaths are considered preventable. When the system makes it difficult to build and sustain community-based care in the neighborhoods where risk concentrates, it limits access precisely where it is most needed.

Every policy, regulatory change, or capital investment should be evaluated against the following single standard: does it make it easier for community-based maternal care providers to deliver continuous care at scale in the neighborhoods where adverse outcomes are concentrated? If the answer is no, the underlying problem remains unsolved.

REFERENCES

- Alliman, Jill, Jennifer G. Bauer, Amy Romano, and Susan Stapleton. 2022. "Freestanding Birth Centers: An Evidence-Based Option for Birth." *The Journal of Perinatal Education* 31 (1): 8–13.
- American Association of Birth Centers (AABC). n.d. "The Birth Center Experience."https://www.birthcenters.org/bc-experience.
- American Medical Association (AMA) CPT Editorial Panel. 2025. "Summary of Panel Actions, September 2025 Meeting (Tab 30 — Obstetric Services)." https://www.ama-assn.org/system/files/sept-2025-summary-of-panel-actions.pdf.
- "Birthing Center of New York – We Deliver…naturally.," n.d. https://www.nybirthingcenter.com/.
- "Birthing Center of Buffalo - American Association Of Birth Centers," n.d. https://www.birthcenters.org/members/birthing-center-of-buffalo.
- "Brooklyn Gynecologist Provides a Closer Look at Black Maternal Health," n.d. https://ny1.com/nyc/all-boroughs/news-all-day/2026/02/18/brooklyn-gynecologist-provides-a-closer-look-at-black-maternal-health.
- "Brooklyn Birthing Center," n.d. https://brooklynbirthingcenter.com/.
- "Buffalo Midwifery Services | The Birthing Center of Buffalo," n.d. https://www.buffalorising.com/2017/02/buffalo-midwifery-services/.
- Carmon, Irin. "Midwives Are Swamped With Home-Birth Requests." *The Cut*, March 26, 2020.https://www.thecut.com/2020/03/midwives-are-swamped-with-home-birth-requests.html.
- Centers for Medicare & Medicaid Services (CMS). 2023. "CHIP State Plan Amendment NY-23-0036 (Postpartum Coverage Extension)." https://www.medicaid.gov/CHIP/Downloads/NY-23-0036.pdf.
- Centers for Medicare & Medicaid Services (CMS). 2024. "State Plan Amendment NY-24-0003 (Doula Services)." https://www.medicaid.gov/sites/default/files/2024-03/NY-24-0003.pdf.
- "Citywide Doula Initiative (CDI)." *NMPP Cares*, n.d., https://nmppcares.org/services/CDI.
- "Citywide Doula Initiative Concept Paper Provider Conference Transcript," n.d. https://www.nyc.gov/assets/doh/downloads/pdf/acco/2022/citywide-doula-initiative-conference-transcript-02252022.pdf.
- "City Health Department Programs Providing Resources to Doulas and Midwives," n.d. https://council.nyc.gov/budget/wp-content/uploads/sites/54/2025/07/Terms-and-Conditions-Doula-and-Midwifery-Report-May-2025-final-1.pdf.

- Commission for the Accreditation of Birth Centers (CABC). 2025. "Accreditation Agreement." https://www.cabc.org/wp-content/uploads/2025/03/Accreditation-Agreement-3.2025.pdf.
- Commonwealth Fund. 2024. "Insights into the U.S. Maternal Mortality Crisis: An International Comparison." June 2024.
- Dormitory Authority of the State of New York (DASNY). n.d. "DASNY Bonds Program." Accessed April 2026. https://www.dasny.org/services/financial/dasny-bonds.
- Dormitory Authority of the State of New York (DASNY). n.d. "Tax-Exempt Leasing Program (TELP)." Accessed April 2026. https://www.dasny.org/services/tax-exempt-leasing-program-telp.
- "Doulas Empower Mothers—But Struggle with Burnout." *Prism Reports*, 25 Aug. 2025, https://prismreports.org/2025/08/25/doulas-empower-mother-but-struggle-with-burnout/.
- "Doula Initiative Shows Progress as Pregnancy Medicaid Coverage Expands." *HealthBeat*, 7 July 2025, https://www.healthbeat.org/newyork/2025/07/07/doula-initiative-progress-pregnancy-medicaid/.
- "Doula Report," n.d. https://www.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2023.pdf.
- eMedNY. 2015. "Inpatient Billing Guidelines." https://www.emedny.org/providermanuals/inpatient/pdfs/inpatient_billing_guidelines.pdf.
- eMedNY. 2024. "Midwife Manual — Policy Section." https://www.emedny.org/ProviderManuals/Midwife/PDFS/Midwife_Manual_Policy_Section.pdf
- eMedNY. 2025a. "Physician Provider Manual — Procedure Codes, Section 5." https://www.emedny.org/providermanuals/physician/pdfs/physician_procedure_codes_sect5.pdf.
- eMedNY. 2025b. "Doula Policy Manual." https://www.emedny.org/ProviderManuals/Doula/.
- eMedNY. 2025c. "Timely Postpartum Incentive Guidance." https://www.emedny.org/listserv/Physician/timelyPostpartumIncentive_-_4-18-25.pdf.
- Gordon, Sarah, Alena Allen, Ashley Kirzinger, and Usha Ranji. 2023. "Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage (2023 Update)." HHS ASPE, April 2023.
- Gordian RSMeans. 2025. Construction Cost Data. Accessed April 2026.
- Fitzsimmons, Emma G., et al. "NYC Doula Law Heads to Expiration as Providers Cite Slow Payments, and Uneven Access."*THECITY*, 27 June 2024, https://www.thecity.nyc/2024/06/27/doula-law-childbirth-eric-adams/.
- "Find a Birth Center - American Association Of Birth Centers," n.d. https://www.birthcenters.org/find-a-birth-center.

- Health Resources and Services Administration (HRSA). n.d. “Health Center Program Compliance Manual, Chapter 21 (FTCA).” https://bphc.hrsa.gov/compliance/compliance-manual/chapter-21.
- “Health Facility Map | State of New York,” n.d. https://health.data.ny.gov/Health/Health-Facility-Map/7dh9-g7ke.
- “Hochul’s Chapter Amendments Could Undermine New Birth Center Law.” https://nysfocus.com/2022/01/20/hochul-chapter-amendments-could-undermine-midwife-birth-center-law.
- Hoyert, Donna L. 2023. “Maternal Mortality Rates in the United States, 2021.” NCHS Health E-Stats. Hyattsville, MD: National Center for Health Statistics.
- Hoyert, Donna L. 2024. “Maternal Mortality Rates in the United States, 2022.” NCHS Health E-Stats. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.htm.
- “In Honor of Black Maternal Health Week, Speaker Adams, Council Leaders, Advocates, and Healthcare Workers Continue Call for Sustained Action to End Maternal Mortality.” https://council.nyc.gov/press/2025/04/17/2848/.
- Kindelan, Katie. “New York City to Offer Free Doula Access in Bid to Reduce Maternal Health Disparities.” *Good Morning America*, 2022, https://www.goodmorningamerica.com/wellness/story/york-city-offer-free-doula-access-bid-reduce.
- Konik, Rochel. “Experience Empowering Births at 4 Birthing Centers in New York.” *Rochelkonik.com*, December 3, 2024. https://rochelkonik.com/2024/12/03/birthing-centers-new-york/.
- LegalClarity. “What Is Article 28 in New York: NY Public Health Law,” https://legalclarity.org/what-is-article-28-of-new-yorks-public-health-law/.
- Love Child. “Love Child — BIRTH CENTERS FOR NY.” Accessed March 1, 2026. http://www.lovechildyoga.com/birthcenter.
- LII/Legal Information Institute. “N.Y. Comp. Codes R. & Regs. Tit. 10 § 795.5 - Midwifery Birth Center Director and Medical Consultants.” Accessed March 2, 2026. https://www.law.cornell.edu/regulations/new-york/10-NYCRR-795.5.
- LII/Legal Information Institute. “N.Y. Comp. Codes R. & Regs. Tit. 10 § 795.10 - Emergency Care.” Accessed March 2, 2026. https://www.law.cornell.edu/regulations/new-york/10-NYCRR-795.10.
- “Mayor Adams Takes Action to Reduce Maternal and Infant Health Inequities by Expanding Access to Doulas and Midwives,” March 23, 2022. https://www.nyc.gov/mayors-office/news/2022/03/mayor-adams-takes-action-reduce-maternal-infant-health-inequities-expanding-access-to.
- “Mayor Eric Adams Announces Expansion of Doulas and Midwives in Childbirth Initiative.” *THE CITY*, 15 Mar. 2022, https://www.thecity.nyc/2022/03/15/mayor-eric-adams-doulas-childbirth/.
- “Maternity Care H+H South Brooklyn,” n.d. https://www.nychealthandhospitals.org/southbrooklynhealth/services/maternal-health/.

- "Maternity Hospital Quality Improvement Network - NYC Health." https://www.nyc.gov/site/doh/providers/resources/maternity-hospital-quality-improvement-network.page.
- "Maternal Health Equity: A Blueprint for Connecticut," n.d. https://www.cthealth.org/wp-content/uploads/2025/11/Maternal-Health-Equity-Blueprint-for-CT.
- "Mama Glow Joins Mayor Adams' Expansion of Citywide Doula Access to Reduce Maternal and Infant Health Disparities." *PR Newswire*, 2022, https://www.prnewswire.com/news-releases/mama-glow-joins-mayor-adams-expansion-of-citywide-doula-access-to-reduce-maternal-and-infant-health-disparities-301510499.html.
- "More Pregnant New Yorkers Are Using Doulas, but Racial and Geographic Disparities Persist." *Gothamist*,n.d,2024. https://gothamist.com/news/more-pregnant-new-yorkers-are-using-doulas-but-racial-geographic-disparities-persist.
- "Mother Lode/Veta Madre." *The Bronx Free Press*, n.d., https://thebronxfreepress.com/mother-lode-veta-madre/.
- Mobilize Maternal Health Coalition. "Policy Initiatives." https://www.mobilizematernalhealth.com/policyinitiatives.
- *NYC Mayor's Midwifery Initiative*. New York Midwives, Mar. 2022, https://newyorkmidwives.org/wp-content/uploads/2022/03/NYC-Mayors-Midwifery-Initiative-March-2022.pdf.
- "NYS Birth Center Classifications," n.d. https://www.health.ny.gov/facilities/cons/docs/birth_center_classification_guidelines.pdf.
- New York City Department of Health and Mental Hygiene. *Citywide Doula Initiative: Concept Paper*. 2022, https://www.nyc.gov/assets/doh/downloads/pdf/acco/2022/citywide-doula-initiative-concept-paper.pdf.
- New York City Department of Health and Mental Hygiene. "Citywide Doula Initiative." *NYC Health*,n.d,https://www.nyc.gov/site/doh/health/health-topics/citywide-doula-initiative.page.
- New York City Department of Health and Mental Hygiene (NYC DOHMH). 2023. "Pregnancy-Associated Mortality in New York City, 2016–2020." https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2023.pdf.
- New York City Department of Health and Mental Hygiene (NYC DOHMH). 2025. "Pregnancy-Associated Mortality in New York City, 2022." Annual Report. https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2025.pdf.
- New York City Health + Hospitals (NYC H+H). 2024. "Audited Financial Statements, FY 2024." https://hhinternet.blob.core.windows.net/uploads/2025/10/nyc-health-hospitals-audited-financial-statements-2024.pdf.

- "NYC Health + Hospitals/Woodhull, Women's Health Services," n.d. https://www.nychealthandhospitals.org/woodhull/services/womens-health
- New York City Mayor's Office. 2024. "Mayor Adams Announces Plans to Open Substance Use Disorder Clinic for Expectant and Parenting Families." March 2024. https://www.nyc.gov/office-of-the-mayor
- New York Health Foundation. 2023. "Racial Disparities in Maternal Health: Opportunities to Leverage Primary Care in New York State." June 2023.
- "NEW YORK STATE BIRTH CENTER ASSOCIATION." https://www.nysbca.org.
- "New York State Health Facilities," n.d. https://opengovny.com/health-facility.
- "New York State Health Facilities Overview," n.d. https://opendatany.com/health-facility.php?state=New+York#google_vignette.
- New York State Department of Health (NYS DOH). 2024. "New York Health Equity Reform (NYHER) 1115 Waiver Amendment." Approved January 9, 2024. https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm.
- New York State Office of Mental Health (NYS OMH). 2025. "Maternal Mental Health Recommendations Report."
- New York State Office of the State Comptroller. 2024. "Percentage of New Yorkers With Mental Illness Rose as Available Psychiatric Beds Declined." March 2024. https://www.osc.ny.gov/press/releases/2024/03/dinapoli-percentage-new-yorkers-mental-illness-rose-available-psychiatric-beds-declined.
- "New York State Public Health and Health Planning Council (PHHPC)." https://www.health.ny.gov/facilities/public_health_and_health_planning_council
- "NY Lags Far Behind on Natural Childbirth – Birthing Center of New York," November 30, 2018.https://www.nybirthingcenter.com/why-new-york-lags-so-far-behind-on-natural-childbirth/.
- NYHOMEBIRTH.COM. "NYHOMEBIRTH.COM," n.d. https://www.nyhomebirth.com/.
- N.Y. Public Health Law, Article 28. https://newyork.public.law/laws/n.y._public_health_law_article_28.
- 10 NYCRR §710.1. General provisions (Certificate of Need). https://www.law.cornell.edu/regulations/new-york/10-NYCRR-710.1.
- 10 NYCRR §795.5. Midwifery birth center director and medical consultants. https://www.law.cornell.edu/regulations/new-york/10-NYCRR-795.5.
- 10 NYCRR §795.10. Emergency care. https://www.law.cornell.edu/regulations/new-york/10-NYCRR-795.10.
- "Obstetrics&Gynecology NYC H+H," n.d. https://www.nychealthandhospitals.org/services/obstetrics-gynecology
- "One Year After Its Inception, Citywide Doula Initiative Delivers Equitable and Accessible Doula Services to West Harlem." *Columbia Spectator*, 23 Apr.

2023. https://www.columbiaspectator.com/city-news/2023/04/23/one-year-after-its-inception-citywide-doula-initiative-delivers-equitable-and-accessible-doula-services-to-west-harlem/.

- Office of the Mayor of New York City. “Mayor Adams: Major Steps Taken to Expand Doula Services and Improve Maternal Health Outcomes.” *NYC Mayor’s Office*, July 2025, https://www.nyc.gov/mayors-office/news/2025/07/mayor-adams-major-steps-taken-expand-doula-services-improve-maternal-health-outcomes.
- Office of the New York City Comptroller. *Audit Report on the New York City Department of Health and Mental Hygiene’s Oversight of Doula Programs in Underserved Neighborhoods*. n.d.,https://comptroller.nyc.gov/reports/audit-report-on-the-new-york-city-department-of-health-and-mental-hygienes-oversight-of-doula-programs-in-underserved-neighborhoods/.
- Response From Ombudsman Liaison Office of the Bronx Borough President Vanessa Gibson. “Delivering Change: Establishing a Birthing Center in the Bronx,” n.d. https://cms2.revize.com/revize/officeofthebronxboroughpresident/Documents/News/Delivering-Change-FINAL-eversion.pdf?t=202601231002390.
- OECD. 2023. *Health at a Glance 2023.* November 2023. https://www.oecd.org/en/publications/2023/11/health-at-a-glance-2023_e04f8239.html.
- Oula. “How to Find a Midwife in New York City: NYC Midwifery.” https://oulahealth.com/blog/midwife-new-york/.
- “Q&A with Mary-Powel Thomas, Director of the Citywide Doula Initiative.” *New York Amsterdam News*, 10 Apr..2025, Accessed 24 Oct. 2025. https://amsterdamnews.com/news/2025/04/10/qe-with-mary-powel-thomas-director-of-the-citywide-doula-initiative/.
- “Remove Barriers to Midwifery-Led Birth Centers,” n.d. https://static1.squarespace.com/static/61a2405954eb4f7e828ad11f/t/61d9d4aa7712034c910417a8/1641665706170/Remove+barriers+to+midwifery-led+birth+centers.pdf.
- “Report on the New York State Department of Health’s Study of Healthcare System Inequities and Perinatal Access in Brooklyn, New York,” n.d. https://www.health.ny.gov/press/reports/docs/brooklyn_perinatal_access_report.pdf.
- “Request for Proposal (RFP): Citywide Doula Initiative,” n.d. https://fphnyc.org/wp-content/uploads/sites/76/2022/01/CDI_RFP_Final.pdf.
- Sanchez, Eileen G. “Her Zip Code: A Doula’s Mission to Uplift Brooklyn’s Underserved Mothers.” *Pulitzer Center*, n.d., https://pulitzercenter.org/stories/her-zip-code-doulas-mission-uplift-brooklyns-underserved-mothers.
- “Sen. Gounardes: New York’s Future Depends on Its Moms,” n.d. https://www.nysenate.gov/newsroom/in-the-news/2025/andrew-gounardes/sen-gounardes-daily-news-new-yorks-future-depends-its.

- "Section 225 of the New York State Public Health Law - Public Health Council." https://www.health.ny.gov/regulations/public_health_law/section/225/.
- Shah, Anish. 2026. "Preparing for 2027: The End of OB Global Billing and What It Means for Your Practice." *Birth Model*, January 2026.
- Urban Institute. 2023. "New York Medicaid PPS Rate Analysis." Commissioned by the Community Health Care Association of New York State (CHCANYS).
- U.S. Department of Health and Human Services, Office of Inspector General (HHS OIG). 2023. "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care." https://oig.hhs.gov/reports/all/2023/.
- Wagner, Mia. 2024. "Testimony: Improving Maternal Health in New York City." Community Service Society of New York, December 2024.
- Wallace, Jacqueline, et al. 2024. "An Alternative Model of Maternity Care for Low-risk Birth." *Health Services Research* 59 (1).
- Wodinsky, Shira. "Black Mamas Matter Alliance Is Making Maternal Mortality Impossible to Ignore." *Well+Good*, n.d., https://www.wellandgood.com/health/bmma-maternal-mortality.
- "Women's Health—Family Health Centers at NYU Langone." Accessed April 13, 2026. https://nyulangone.org/care-services/family-health-centers-at-nyu-langone/womens-health-family-health-centers-at-nyu-langone.
- Valenzuela, Claudia P., and Michelle J.K. Osterman. 2023. "Characteristics of Mothers by Source of Payment for the Delivery: United States, 2021." *NCHS Data Brief*, No. 468. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/databriefs/db468.pdf
- New York City Mayor's Office. 2018. "Maternity and Infant Health Initiative." https://www.nyc.gov

Liu SY, Fiorentini C, Bailey Z, Huynh M, McVeigh K, Kaplan D. Structural Racism and Severe Maternal Morbidity in New York State. *Clin Med Insights Women's Health*. 2019;12:1179562X19854778. Published 2019 Jun 14. doi:10.1177/1179562X19854778

APPENDIX A

MATERNAL SERVICE FEASIBILITY FRAMEWORK (TOOL)

This tool operationalizes recommendations by helping users assess whether a maternal-capable site is regulatory-compliant before major lease, design, or legal commitments are made.

A. Regulatory Readiness

Approvals required

- Does the change sit within an existing Article 28 scope, or trigger a scope change?[4]
- Does the change trigger CON/PHHPC review (and if yes, is it a Tier 1 renovation vs. Tier 2 expansion vs. Tier 3 freestanding pathway)?

Hospital transfer relationships established

- Is there a documented transfer pathway that is realistic in practice (not just a formal requirement)?
- Are expectations clear, given that hospitals have no legal obligation to sign transfer agreements even when centers are required to have them?

Compliance timelines mapped

- Are physical plant constraints identified early enough to avoid "pre-entry collapse" (like the Queens example)?
- Are inspection/readiness timelines planned so the project does not enter a "pay rent, no patients" period?

Licensure vs. operation check

- Does the project require state licensure, or is the immediate goal legal operation and payer contracting (and, if so, which credential is being used, CABC)?

Clinical oversight check

- If the pathway relies on building compliance, what is the plan to ensure clinical accountability (policies, chart review, adverse outcomes, risk stratification), given the mismatch between the DOH building focus and CABC clinical oversight identified by stakeholders?

Quick rating: Facilities can use this as a pre-check, yes/no checklist before committing to lease, design, or legal spend.[4]

- **Green:** Approvals, transfer pathway, and timeline are identified and feasible.
- **Yellow:** One area unrtain (needs expert confirmation/template).
- **Red:** Approvals unclear, or transfer not realistic, or timeline not financeable.

APPENDIX B

INTERVIEW SUMMARIES

Eugenia Montesino, CNM, WHNP, MSN, FACNM (Midwifery Leadership Perspective)
This interview provides insight into the integration of midwifery within a large, multidisciplinary maternal care setting, with a focus on care delivery, operational constraints, and broader system dynamics.

The interviewee described the relatively recent introduction and expansion of midwifery services within an established clinical environment. The model emphasizes integrated care, where midwives collaborate closely with specialists, including those managing higher-risk pregnancies. Patients are initially assessed and then directed toward the most appropriate care pathway, with opportunities for shared or combined care depending on clinical needs. This approach allows midwives to support a wider range of patients than in more restrictive models.

A central feature of midwifery care highlighted in the interview is its holistic orientation. Care extends beyond clinical management to include emotional, psychological, and social dimensions of pregnancy and postpartum experience. Patients are given provider choice and are encouraged to identify the model of care that best aligns with their preferences.

Several structural challenges were identified. Reimbursement differences between provider types were noted as a persistent issue, particularly when similar services are compensated at different rates. Payment models, including bundled or global fees, limit financial sustainability, especially for smaller or independent practices. Malpractice costs and administrative burdens further constrain the viability of community-based or standalone models.

The interview also pointed to broader system-level factors influencing care delivery. These include limited public understanding of midwifery, variability in policy and regulation, and workforce considerations such as recruitment and retention. Compensation levels and working conditions are key drivers of workforce stability.

From a care delivery perspective, continuity into the postpartum period was emphasized. Follow-up includes a combination of in-person and virtual visits, with attention to both physical recovery and mental health, particularly during the early postpartum adjustment period.

The interviewee also reflected on the role of the physical environment and care design, noting that facility layout and infrastructure influences the patient experience, though these factors are not always aligned with patient-centered needs.

In terms of system improvement, incremental changes to payment structures and increased recognition of midwifery services are ongoing areas of development. Comparisons to international models suggest alternative approaches to compensation and continuity of care, though transferability varies by context.

Overall, the interview highlights the potential of integrated midwifery models to expand access and support continuity of care, while underscoring the financial, regulatory, and workforce constraints that shape their implementation.

Nashira Baril, Birthing Center Founder, Health Equity Strategist (Birth Center Development and Implementation Perspective)

This interview provides a detailed view of the development process for a community-based birth center, with particular attention to financing, regulatory barriers, and operational planning.

The interviewee described a multi-year effort to establish a nonprofit birth center model, emphasizing that development timelines are significantly extended by structural and resource constraints. A primary challenge identified was access to capital. Traditional birth center models often rely on personal financing or small-scale funding, which can limit both feasibility and accessibility. In contrast, this model relies on a combination of philanthropy, grants, and public funding to support both capital development and early operations.

Regulatory requirements were identified as a major barrier, particularly when facility standards align with higher-acuity clinical settings rather than community-based care models. Requirements related to building specifications, staffing, and oversight were identified as increasing development complexity and cost. Recent regulatory changes were identified as an important step in making implementation more feasible, although variability across states remains a challenge.

Local zoning and land-use processes were also highlighted as significant factors. Establishing a facility in a residential setting required multiple approvals, community engagement processes, and design revisions. These steps introduced additional delays and uncertainty, even when broader community support was present.

From a financial perspective, the interview emphasized the gap between startup costs, operating expenses, and reimbursement levels. Initial capital needs were estimated at several million dollars, including construction and early operating reserves. The model assumes a gradual ramp-up in patient volume, during which expenses may exceed revenue due to staffing requirements and limited reimbursement.

Reimbursement structures were identified as a key constraint to long-term sustainability. Lower payment rates, particularly for Medicaid, and limited negotiating power with insurers affect revenue potential. Variability in payment structures and the allocation of facility fees were also noted as contributing factors.

The interview also addressed workforce and care model considerations. Midwifery-led care is central to the model, with an emphasis on continuity and patient-centered experience. However, staffing requirements and workforce availability must be aligned with regulatory and operational expectations, particularly during early growth phases.

Despite these challenges, the discussion suggested that initial implementation efforts reduce barriers for future projects by increasing familiarity among regulators, policymakers, and communities. Knowledge gained through early development processes can inform subsequent expansion and replication efforts.

Overall, the interview highlights the complexity of establishing community-based birth centers within existing healthcare and regulatory systems, while also indicating areas where incremental progress may support future scalability.

Rose Duhan, President & CEO, Community Health Care Association of NYS (Community Health Center and Medicaid Financing Perspective)

This interview provides insight into the role of community health centers (CHCs) in maternal care delivery, focusing on reimbursement structures, operational constraints, and continuity of care across settings.

Community health centers operate under a distinct Medicaid reimbursement model, the Prospective Payment System (PPS), which provides a bundled, cost-based rate per visit. This structure is designed to support comprehensive care, including enabling services such as translation and care coordination. At the same time, the model limits billing to one reimbursable visit per patient per day, which can constrain the delivery of multiple services during a single encounter.

CHCs commonly provide prenatal care within their facilities, but most do not offer labor and delivery services. As a result, patients typically transition to hospitals for childbirth and may return to the health center for postpartum and pediatric care. This creates variability in continuity, as communication between hospitals and CHCs is not always standardized and may depend on existing relationships or patient engagement patterns.

Several financial and operational constraints were identified. While CHCs receive enhanced Medicaid reimbursement through PPS, these payments may not fully cover the cost of care. Additional limitations include reduced reimbursement for services delivered outside the facility and restrictions on eligible provider types for billing. For example, services provided by certain care roles may not be directly reimbursable, which affects the integration of broader care teams.

Capital financing within the PPS structure was described as limited in scope. Capital-related costs are incorporated into overall rates through infrequent adjustments, typically tied to significant changes such as new site development or major renovations. As a result, capital investment is not a primary lever for expanding services, and external funding sources are often required for facility development or program growth.

Workforce and infrastructure constraints further affect service expansion. Recruiting specialized providers is challenging, and physical space limitations, combined with regulatory requirements, can delay or restrict the opening of new sites or services. Facility standards and approval processes were noted to be resource-intensive and time-consuming, particularly for smaller or community-based providers.

From a sustainability perspective, CHCs rely on a combination of revenue streams, including Medicaid reimbursement, federal grants, supplemental funding programs, and non-patient revenue sources. Even with these combined sources, financial margins can remain constrained, particularly given the high proportion of patients covered by Medicaid or lacking insurance.

The discussion also addressed the feasibility of expanding maternal services within the CHC model. While prenatal and postpartum services are well aligned with existing structures,

integrating labor and delivery was described as operationally and financially challenging due to requirements for continuous staffing, volume thresholds, and reimbursement limitations.

Overall, the interview highlights the central role of community health centers in providing accessible maternal care services, while also identifying structural constraints related to reimbursement, capital investment, workforce, and system integration that shape the scope of services they can sustainably offer.

Maura Winkler, Licensed Midwife at Fika Midwifery at The Coit House Birth Center (Freestanding Birth Center Operations Perspective)

This interview provides insight into the operational model of a freestanding birth center, focusing on care delivery, reimbursement, regulatory context, and sustainability considerations.

The birth center model is structured around midwifery-led care, emphasizing low-risk pregnancies and continuity of care across prenatal, labor, and postpartum services. Care is typically delivered in a non-hospital setting designed to support a more personalized patient experience, while maintaining established clinical protocols for safety and risk management. Patients requiring higher-acuity care are transferred to hospital settings based on predefined criteria.

Reimbursement was identified as a central factor shaping operations. Payment levels vary across payers, with Medicaid accounting for a significant share of the patient population. Reimbursement rates may not fully reflect the cost of providing comprehensive maternity care, particularly when accounting for extended prenatal visits, labor support, and postpartum follow-up. Payment structures can also differ in how facility and professional services are recognized, affecting overall revenue.

Regulatory requirements influence both the establishment and ongoing operation of birth centers. Licensing standards, clinical protocols, and reporting requirements must be met, and these can vary by state. While these frameworks are intended to ensure safety and quality, they may also introduce administrative complexity and affect the pace at which new centers are developed.

Operational sustainability depends on maintaining sufficient patient volume while managing staffing and facility costs. Birth centers generally operate with smaller teams than hospitals, and staffing models must align with both regulatory requirements and patient needs. Variability in patient volume affects financial stability, particularly in the early stages of operation.

The interview also highlighted the importance of relationships with hospital systems. Transfer agreements and collaborative arrangements are necessary to ensure continuity of care for patients who require escalation. The strength and structure of these relationships influence both clinical workflows and patient experience.

From a system perspective, freestanding birth centers are one component of a broader maternal care landscape. They may expand access to care options for certain populations, particularly

those seeking alternatives to hospital-based delivery, while operating within the constraints of existing reimbursement and regulatory structures.

Overall, the discussion highlights the balance between patient-centered care delivery and the financial and regulatory conditions required to sustain freestanding birth center models over time.

Louise Cohen, Primary Care Development Corporation (Healthcare Financing and System-Level Constraints Perspective)

This interview provides a system-level perspective on the financial, regulatory, and market dynamics shaping maternal care delivery, with particular attention to capital access, institutional incentives, and the feasibility of new care models.

A central theme of the discussion was the distinction between operating revenue and capital financing. While reimbursement mechanisms support ongoing service delivery, they do not cover the upfront capital costs of developing new facilities. Capital funding for healthcare infrastructure is typically limited, competitive, and often directed toward service lines with stronger financial returns. As a result, maternal health infrastructure may not be prioritized within broader capital investment strategies.

The interview emphasized that most capital programs function on a reimbursement basis, requiring organizations to secure upfront funding before receiving public or grant support. This creates a barrier for smaller or community-based providers that lack reserves, access to credit, or fundraising capacity. Financing options such as bank loans, philanthropic campaigns, or mission-driven lenders each carry limitations related to scale, cost, or eligibility.

Institutional incentives were also discussed as a factor shaping the maternal care landscape. Hospital-based systems may prioritize service lines that generate more consistent or higher-margin revenue, thereby influencing capital allocation. At the same time, maternity services represent a stable source of patient volume, which affects how organizations approach alternative care models.

Regulatory processes, including certificate-of-need (CON) requirements and facility licensure, are complex and time-intensive. While these frameworks are intended to ensure safety and oversight, they may also extend development timelines and introduce uncertainty for new entrants. The discussion noted that both regulatory requirements and approval processes should be considered when assessing feasibility.

Liability and malpractice considerations were identified as additional constraints. Maternal care carries relatively high malpractice exposure, which increases insurance costs for both providers and facilities. This risk profile influences organizational decisions regarding whether to offer or expand prenatal and maternity services.

The interview also addressed questions of demand and care preferences. Preferences for care settings vary across populations and are influenced by factors such as prior experiences, perceived safety, and access to services. The discussion suggested that demand for different

care models is not uniform and may not always align with assumptions about patient preferences.

From a strategic perspective, the interview emphasized the importance of defining the problem clearly before identifying solutions. Expanding access to maternal care requires a combination of approaches, including strengthening existing hospital services, enhancing community-based prenatal and postpartum care, and evaluating alternative delivery models within the context of financial and regulatory constraints.

Overall, the discussion highlights the interplay between financing structures, institutional incentives, regulatory frameworks, and patient demand in shaping the feasibility of expanding maternal care infrastructure.

Kiki Blazevski-Charpentier, Director of Capital Budget and Contract Control (Healthcare Facility Design and Infrastructure Perspective)

This interview provides insight into how facility design, capital planning, and infrastructure decisions influence the delivery of maternal health services, with a focus on the relationship between physical space and care models. Healthcare facility design is closely tied to regulatory requirements, clinical standards, and capital constraints. Projects must meet detailed specifications related to safety, workflow, and compliance, which shapes both the layout and functionality of maternal care environments. These requirements can also affect timelines, as design and approval processes often involve multiple stakeholders and review stages.

The discussion highlighted that capital planning decisions play a central role in determining what types of services are developed or expanded. Facility investments are typically evaluated against broader institutional priorities, and projects that align with strategic or financial goals are more likely to move forward. Maternal care spaces must therefore compete with other clinical priorities for limited capital resources. From an operational perspective, facility design influences patient flow, staff workflows, and the overall care experience. Layout decisions can affect how patients move through prenatal, labor, and postpartum care, as well as how care teams coordinate across roles. Design elements such as room configuration, service proximity, and space flexibility supports or constrains different models of care.

The interview also noted that adapting existing facilities to new care models can be challenging. Retrofitting space to accommodate alternative maternal care approaches requires significant investment and is limited by structural constraints of older buildings. As a result, facility design reinforces existing care models, even when there is interest in innovation.

Community-based or smaller-scale facilities may face additional constraints related to site selection, zoning, and building requirements. Identifying appropriate locations and navigating local regulations extend project timelines and increase costs, particularly in dense urban environments.

The discussion emphasized the importance of early alignment between clinical goals, operational needs, and design planning. Integrating these perspectives at the outset helps ensure that facilities are designed to support intended care models, rather than requiring later adjustments.

Overall, the interview highlights how facility design and capital planning are integral to the feasibility and implementation of maternal care services, shaping both what is built and how care is ultimately delivered.

Myla Flores, CNN Champion for Change; Founder of The Birthing Place; Co-founder of Womb Bus and Maryam Reproductive Health + Wellness; President of New York State Birth Center Association (Community-Based Maternal Care and Birth Center Development Perspective)

This interview provides insight into the development of a community-based maternal health model, with a focus on access to midwifery care, birth center development, and challenges related to financing, regulation, and service integration.

The care model described emphasizes midwifery-led, community-centered services that extend beyond clinical care to include education, wellness programming, and postpartum support. Services are structured in phases, beginning with community education and prenatal support, followed by expanded wellness services, and ultimately the development of a birth center. This phased approach reflects both resource constraints and the need to build demand and infrastructure over time.

Regulatory requirements were identified as a significant constraint in establishing birth centers. Existing frameworks may not fully align with midwifery-led models, requiring adaptations to meet licensing standards. In some cases, this includes implementing physician leadership structures to meet regulatory requirements, even when the intended model is midwifery-led. These requirements influence both governance structures and operational design.

Financing challenges are substantial, particularly regarding capital funding. Public funding opportunities require upfront investment before reimbursement, creating barriers for organizations without access to sufficient capital. In this case, grant funding for facility development is structured as reimbursable, requiring funds to be raised and spent prior to reimbursement, which introduces financial risk and operational complexity.

Reimbursement structures and long-term financial sustainability were also highlighted as concerns. The ability to secure facility fees and insurance reimbursement is closely tied to licensing status, which reinforces the importance of navigating regulatory pathways successfully. Without appropriate reimbursement mechanisms, sustaining a birth center model is financially challenging.

The interview also identified gaps in the maternal care continuum. Barriers to early prenatal care engagement include access challenges, logistical constraints, and varying levels of trust in healthcare settings. Transitions between care settings, particularly from prenatal to delivery and into postpartum care, are inconsistent. Postpartum care was identified as an area where patients

have limited structured follow-up, including access to clinical care, lactation support, and mental health services.

Workforce and service integration were discussed as important components of the model. The approach includes collaboration across multiple provider types, including midwives, physicians, lactation consultants, and other support roles. Developing sustainable staffing models requires consideration of training pathways, professional development, and costs such as malpractice coverage.

From a planning perspective, developing a birth center involves both operational and financial modeling. Projections may anticipate gradual growth in patient volume and financial performance over time, with sustainability dependent on achieving sufficient scale and managing upfront capital costs.

Overall, the interview highlights the complexity of implementing community-based maternal care models, particularly in navigating regulatory requirements, securing capital funding, and addressing gaps in the care continuum while building sustainable operations.

Kennedy Austin, Policy Analyst, Ancient Song (Community Advocacy and Maternal Health Equity Perspective)

This interview offers a community-based advocacy perspective on maternal health, focusing on access, patient experience, and structural factors influencing care delivery.

The discussion emphasized the role of community-based support services, including doulas and non-clinical care providers, in supporting individuals throughout the prenatal, birth, and postpartum periods. These services contribute to patient engagement, education, and continuity of support, particularly for populations facing barriers to accessing traditional healthcare systems.

Barriers to care were described across multiple dimensions, including access to providers, coordination between services, and challenges navigating healthcare systems. These barriers affect timely entry into prenatal care, continuity across care settings, and access to postpartum support. Structural factors, including administrative complexity and variability in service availability, were noted as contributing to these challenges.

The interview also highlighted the importance of trust and patient experience in shaping care utilization. Perceptions of care quality, prior experiences, and cultural alignment influences where and how individuals seek care. Community-based organizations help bridge gaps between patients and formal healthcare systems by providing culturally responsive support and guidance.

Workforce considerations were discussed in the context of community-based providers. Expanding access to services such as doula care requires attention to training pathways, certification, reimbursement structures, and integration with clinical teams. Coordination between clinical and non-clinical providers was identified as an area with both opportunities and challenges.

The discussion referenced broader policy efforts to expand access to maternal health services, including initiatives to support community-based care models and improve outcomes. Implementation of these policies varies depending on local context, funding availability, and administrative capacity.

From a system perspective, the interview underscored the complexity of addressing maternal health outcomes through a single intervention. Improving access and continuity of care requires coordinated efforts across clinical services, community-based supports, and policy frameworks.

Overall, the interview highlights the role of community-based advocacy and support services in addressing gaps in maternal care, while pointing to broader structural and system-level factors that influence access, experience, and outcomes.

Interview Summary: Wawa Kulatnam, Director of Healthcare Programming, Planning, and Analysis (Public Health Systems and High-Need Population Care Perspective)

This interview provides a system-level perspective on healthcare delivery and financing for high-need, Medicaid- dominant populations, offering insights into care continuity, reimbursement structures, and cross-sector coordination.

A key theme was the concentration of reimbursement around high-acuity care, while preventive and longitudinal services receive comparatively less consistent funding. This dynamic results in greater system reliance on emergency and inpatient care, even when earlier intervention and ongoing management reduces avoidable utilization.

To address these gaps, some systems are exploring value-based payment models that shift incentives away from volume-driven care toward outcomes. These models allow savings from reduced emergency and inpatient utilization to be reinvested in care management, behavioral health integration, and social support services. However, implementation varies, and financial sustainability often depends on additional funding sources.

The interview highlighted the role of supplemental public funding and institutional support in maintaining care for populations with complex needs. These funding streams help offset under-reimbursement in routine care services but may function as downstream corrections rather than addressing structural payment limitations.

Continuity of care across system transitions was identified as a critical challenge. Mechanisms to support transitions, such as dedicated coordination teams and publicly funded programs, help maintain engagement as individuals move between care settings. These efforts often rely on a combination of healthcare, government, and community-based resources.

The discussion also emphasized the importance of cross-sector collaboration in supporting high-need populations. Effective models typically involve coordination across healthcare providers, housing services, and community organizations. Sustainability may depend on

aligning multiple funding streams, including healthcare reimbursement, public funding for social supports, and time-limited external funding for program development.

Community-based providers face similar financial constraints, including reliance on Medicaid reimbursement with limited margins and restricted access to capital. Approaches that combine outcome-based financing with structural partnerships may offer more stable funding and operational support.

Overall, the interview reinforces the importance of viewing care delivery for high-need populations as a cross-system challenge, where financing, service design, and infrastructure must be aligned to support continuity and reduce reliance on high-acuity care.

Key Takeaways

- The payment cliff is real across populations: revenue concentrates on high-acuity events (ED/inpatient), while preventive/continuous care (primary care, BH, SNF/LTC, care management) is undervalued.
- Back-end financing fills the gap: H+H relies on DSH/supplemental Medicaid payments plus direct City support to cover under-reimbursed care for Medicaid/uninsured patients.
- VBP is the main workaround: value-based models can "legitimize" financing for continuous care by allowing savings from reduced ED/inpatient use to fund care management, BH integration, and social needs work.
- Continuity requires funded transition teams: H+H Correctional Health uses a dedicated Reentry and Transition Services team (city and grant-funded) to maintain handoffs across system transitions.
- Housing is part of the care model: programs like Housing for Health and city initiatives like Just Home illustrate that stability + medical respite/step-down settings reduce avoidable utilization and support safe discharge.
- What we might be underweighting: this is a cross-system design problem, not just Medicaid/perinatal payment; sustainable models require shared accountability across health care, housing, criminal-legal, and community partners.
- Three-stream sustainability package: (1) Medicaid + VBP dollars for clinical care, (2) City/state dollars for tenancy support/navigation, (3) time-limited philanthropy/impact capital for start-up, evaluation, and CBO capacity building, plus funded shared infrastructure (navigators + data-sharing + cross-team coordination).
- Concrete ED cost dynamic: Praewa noted that in an H+H Midtown analysis, the first few days of ED admission/boarding were a major cost driver, amplified by discharge barriers for unstably housed patients.

Across the interviews, several consistent themes emerged:

- Payment design favors hospitals: global and facility fees push revenue toward delivery and away from continuity care.
- Regulatory pathways create pre-operational debt: Article 28/CON timelines + building requirements front-load costs before a patient is served.
- Capital access is structurally mismatched: grants and public dollars often require spending first; community operators can't bridge that gap.

- The implementation gap is the breaker: policy wins exist "on paper," but billing rules, enforcement, and institutional norms determine what's real.
- Postpartum is the biggest continuity failure: multiple interviews converge on the fact that postpartum is the highest-risk, most under-addressed interval. This is not just clinical; it's governance: handoffs, accountability, and monitoring infrastructure are not owned by any single actor.
- We now have 4 real-world pathways to compare (Coit House, Woodhull, NYU Langone, Birthing Place), each with a different regulatory and financial route. Coit House (freestanding/CABC), Woodhull (embedded space inside L&D), NYU Langone (institutional midwifery + postpartum protocol), and Birthing Place (phased community build).
- Article 28 licensure and operating certificate scope sits with NYS DOH's Office of Health Systems Management (OHSM), and CON decisions run through PHHPC.
- Legal distinction we're using throughout: legal operation ≠, state licensure ≠, Medicaid scaling, Medicaid scaling (the barriers show up differently at each stage).