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Maternity Care Unbundled

What States, Health Plans, Providers, and Maternal Health Innovators Should Prepare for Ahead of January 1, 2027

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Background and Timeline: A Structural Reset for Maternity Payment

In September 2025, the American Medical Association (AMA)'s Current Procedural Terminology (CPT) Editorial Panel advanced a significant restructuring of maternity care coding, moving away from decades-old global maternity codes toward an "unbundled" framework that allows providers to bill for discrete services delivered across the prenatal, delivery and postpartum continuum and more closely reflect how care is delivered today. Payors and states will observe maternity care through a series of service-level claims rather than a single retrospective bill, enabling more detailed analysis of utilization, quality and equity but requiring substantially different operational and analytic infrastructure.

Exhibit A: Maternity Payment Structure: Bundled vs. Unbundled Across the Care Continuum
(Illustrative example based on CPT 2027 maternity coding structure)

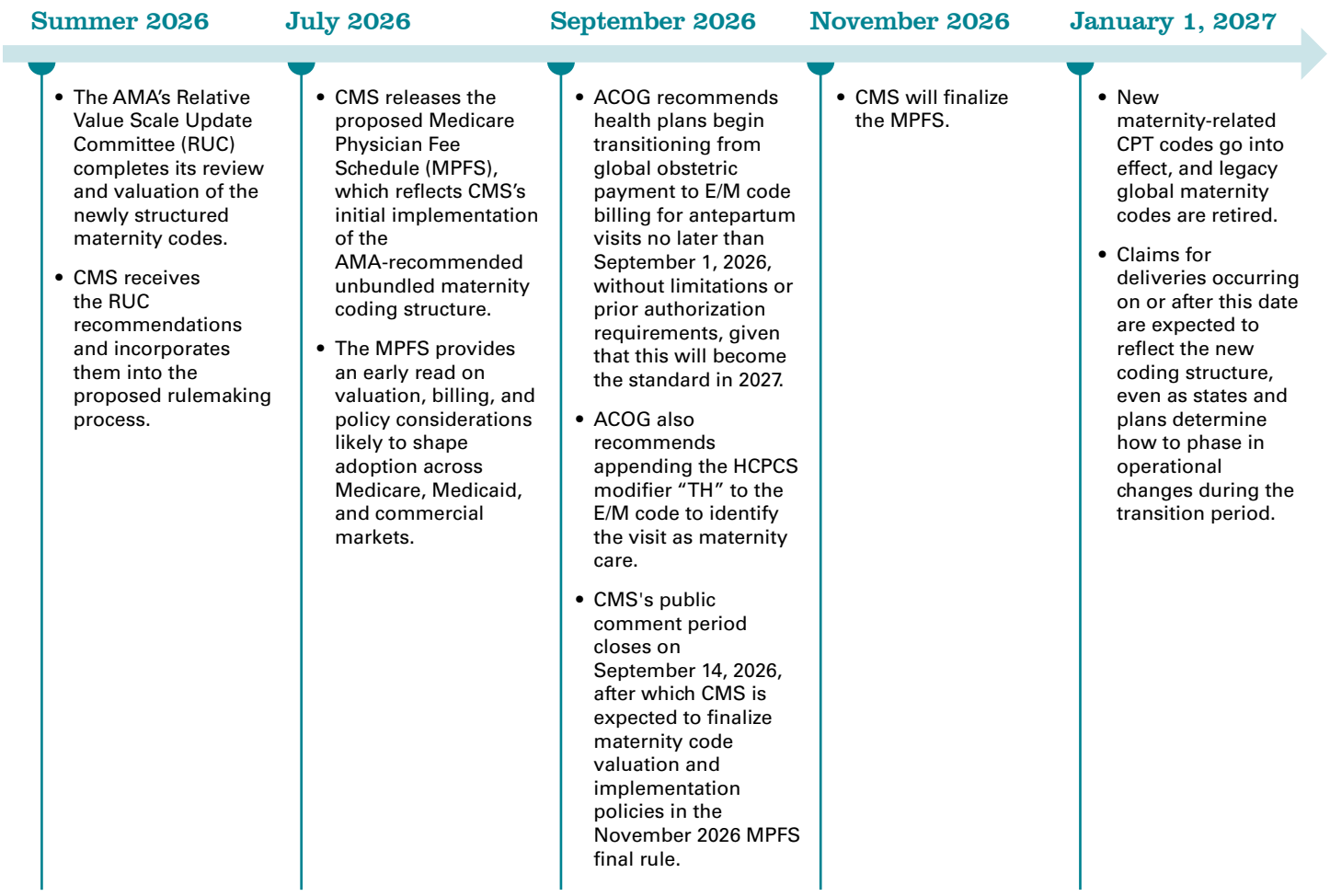
	 **Prenatal Care (Antepartum)**	 **Diagnostics and Monitoring**	 **Labor Management**	 **Delivery Care**	 **Postpartum Care**
Representative Services	Routine prenatal visits, risk assessment, care coordination (including telehealth and home visits)	Ultrasounds, fetal monitoring, labs and fetal diagnostic procedures	Inpatient labor oversight, induction/ augmentation, maternal and fetal monitoring	Vaginal or cesarean delivery and immediate postdelivery care	Follow-up visits, recovery monitoring (inpatient and outpatient)
Bundled Payment and Representative Bundled Codes (Pre-2027)	Payment is included within a single global maternity episode payment, with global maternity codes (e.g., 59400 for vaginal delivery; 59510 for cesarean delivery) encompassing prenatal, delivery, and postpartum services (deleted under 2027 AMA adjustments)				
Unbundled Payment (2027+)	Billed as discrete E&M visits, with **existing** E/M codes (e.g., 99202–99215 outpatient; 98000–98015 telehealth; 99341–99350 home visits)	Billed separately using **existing** service-specific codes for diagnostic imaging and fetal procedures (e.g., ultrasound 76801–76828; amniocentesis 59000; fetal monitoring 59025)	Billed using **new** labor management codes per day (e.g., 59080–59083)	Billed using **new** streamlined delivery-only codes (e.g., vaginal delivery 59431, 59432; cesarean delivery 59502, 59503)	Billed as **existing** E&M services (e.g., 99202–99215 outpatient; 99231–99233 inpatient), combined with some **new** distinct codes (e.g., uterine tamponade procedures using code 59899 and 59160)
Key Structural Change	Visit-by-visit billing replaces retrospective bundle	Diagnostics disentangled from global payment	Labor becomes a distinct, codified phase of care	Delivery separated from prenatal and postpartum services	Postpartum care is separately visible and reimbursed

Under the updated 2027 CPT guidelines, the restructured code set is a combination of existing codes—including evaluation and management (E/M) codes for antepartum and postpartum care and separately reportable diagnostic imaging/procedural codes—and new maternity-specific codes, particularly for labor management, streamlined delivery reporting and select delivery/postpartum procedures.[1] In total, the CPT 2027 update deletes 17 codes, adds 12 codes and revises six codes. The introduction of separately billable, labor management codes, billed on a per-day basis and differentiated by clinical complexity, represents one of the most significant elements of the redesign, shifting reimbursement toward the intensity and duration of care provided during labor.

This change represents the most consequential shift in maternal health payment policy since maternity codes were bundled in the 1980s. It comes amid persistently poor and, in some cases, worsening maternal and infant health outcomes, widening racial and geographic disparities and the continued growth of maternal health deserts. This has occurred alongside growing recognition that existing payment structures have not kept pace with how maternity care is delivered today, often undervaluing community-based models and care that emphasizes prevention, coordination and higher-acuity needs.

The AMA has modeled the unbundling as budget-neutral nationally; however, neutrality at a national level does not guarantee neutrality for individual states, health plans or provider systems. For example, entities serving higher-acuity or more medically complex maternal populations may experience higher utilization and spending, while those with lower-risk populations could see more modest or even reduced spending. The more immediate challenge for states, plans and providers is making near-term operational and policy decisions with incomplete information, particularly during the 2026–2027 transition period, which will introduce complexity for patients spanning both coding structures.

Key Milestones Over the Next Six Months



The proposed 2027 Medicare Physician Fee Schedule (MPFS), released on July 14, provides the first indication of how CMS may operationalize maternity care unbundling. CMS generally supports the AMA-developed coding framework, including separate payment for antepartum care, labor management, delivery and postpartum services, while proposing modifications to certain valuation recommendations

submitted by the RUC. CMS characterizes the redesign as an opportunity to improve transparency into maternity care delivery, strengthen data available for quality measurement and risk adjustment, and create a stronger foundation for future maternity payment reform. Notably, CMS proposes higher work RVUs than recommended by the RUC for several labor management and delivery services, signaling recognition that portions of maternity care may have been historically undervalued under the global payment structure. At the same time, CMS is seeking comment on potential HCPCS G-codes that could preserve the current global maternity coding and payment structure, including reimbursement that more closely resembles the legacy global payment model, creating an alternative pathway that may balance payment continuity with the transparency benefits of more granular reporting. Importantly, major maternity care stakeholders, including ACOG and the OB Hospitalist Group (OBHG) (the nation's largest provider of hospital-based OB/GYNs), have publicly urged CMS to avoid creating parallel HCPCS G-codes and instead fully implement the new maternity coding framework, arguing that maintaining elements of the legacy global payment structure would increase administrative complexity and diminish the transparency and attribution benefits of unbundling. CMS's public comment period closes on September 14, 2026, and a final rule is expected by November.

What Different Stakeholders Should Be Thinking About Now

A. State Ecosystem: Medicaid Agencies, MCOs, Insurance Regulators, PQCs, Public Health

Even if total maternity spending remains stable, states should expect policy, operational and analytic implications from maternity care unbundling.

In particular, the move from a single bundled claim to multiple service-level claims will fundamentally change how states observe maternity care delivery through claims data. This shift will introduce operational complexity while creating opportunities.

States should begin assessing how unbundling will affect core policy, operational and analytic functions, including:

- **Population risk and utilization patterns** will become more transparent under unbundled claims, potentially surfacing differences in care intensity and service mix across higher- and lower-risk pregnancies that were previously obscured under the global bundle.
- **Data and analytics readiness will be critical**, as states evaluate whether existing systems and dashboards can ingest, analyze and act on more granular maternity claims in near real time.
- **Value-based care alignment** will require reassessment, as unbundling removes the implicit accountability embedded in global payment and introduces new questions about how responsibility for cost, quality and outcomes is defined and attributed.
- **Care model integration** may evolve, particularly for doulas, midwives, maternal health technology companies and care coordination programs, whose services may become more visible, and potentially more actionable, under service-level claims.

- **Budget and rate-setting implications** may emerge, particularly for Medicaid managed care maternity "kick payments" and capitation rates, as states determine how more granular utilization patterns translate into actuarial models.

State Medicaid agencies will lead the design and implementation of maternity payment changes (as the payor of ~40% of births), but unbundling will also require coordination across the broader state ecosystem, including public health agencies and Perinatal Quality Collaboratives (PQCs). These entities will play a key role in translating more granular claims data into actionable insights on care patterns and outcomes, helping ensure that changes in payment align with improvements in care delivery and equity.

States should plan for review and updates to payment policy and claims systems, advance communications to providers and managed care plans, along with iterative claims monitoring and rapid-cycle improvement testing beginning on January 1, 2027.

Early Adopter Spotlight

New York State Medicaid

While national maternity code unbundling does not take effect until 2027, New York State Medicaid has already taken steps, prior to the AMA's redesign, that align with a more granular maternity payment and data environment.

Beginning in 2024, New York required providers billing under global or bundled maternity codes to also submit visit-level Category II CPT codes for each prenatal and postpartum service delivered. These supplemental, nonpayment claims apply to both Medicaid fee-for-service and Medicaid managed care and are intended to improve visibility into the timing, frequency and content of maternity services across the episode.

Subsequent guidance in 2025 reinforced and operationalized this requirement across plans, including through claims editing and submission expectations. New York's approach effectively decouples data capture from payment, giving the state and its managed care plans early experience with visit-level maternity data, services delivered across multiple provider types (including midwives) and claims-based monitoring prior to delivery. The phased approach, starting with nonpayment encounter reporting and followed by plan-level operationalization, offers an early example of how states may stage the transition to fully unbundled maternity payment. As a result, New York is comparatively well positioned to operationalize the transition to unbundled maternity payment, having already established infrastructure to capture visit-level utilization across the episode.

Earlier this year, New York shared guidance with plans and providers to standardize submission of these supplemental visit-level codes, clarify billing expectations across fee-for-service and managed care and reinforce requirements for encounter data completeness to support program integrity, rate-setting and quality monitoring.

States that have implemented maternity value-based payment (VBP) or episode-based models, such as Arkansas, Tennessee and North Carolina, will likely need to re-evaluate how those models are structured under unbundled payment. In particular, states may need to revisit episode definitions, attribution logic, quality measurement frameworks and risk adjustment parameters, as unbundling shifts reimbursement

toward discrete services and could introduce signals that more directly reflect utilization volume rather than episode-level performance. In some cases, this may create tension with existing VBP models, while also offering an opportunity to redesign them using more granular, service-level data. CMS's Innovation Center's Transforming Maternal Health (TMaH) model, in which 15 State Medicaid Agencies across the country are participating, was slated to launch its VBP model in 2028. CMS has indicated a delay until 2029, in part to navigate the transition to unbundled maternity codes and establish more stable and accurate baselines for various components of the VBP model.

B. Private Payors (Commercial Health Plans and Employer Purchasers)

Private payors, including both commercial insurers and self-funded employers, will play a central role in determining whether maternity unbundling achieves its policy goals or simply redistributes financial risk.

Payors should assess how maternity unbundling intersects with their historical utilization patterns, benefit design packages, provider network composition and quality performance. Even if the changes are designed to be budget neutral in the aggregate, plans will need to assess how unbundling may redistribute spending across providers, services and patient populations. Employer purchasers may need to reassess maternity benefit design, particularly if unbundling makes utilization and cost drivers more visible at the service level. In addition, the shift to service-level billing will change the timing of revenue recognition, as reimbursement is distributed across the pregnancy episode rather than concentrated at delivery.

For employer purchasers, unbundling may elevate the role of maternity navigation programs, centers of excellence and other value-based maternity solutions that can preserve coordination and accountability under a more fragmented reimbursement structure. That framing is consistent with broader employer purchasing efforts emphasizing coordinated care, transparency and value-based payment in maternity care. At the same time, more granular claims may begin to close an important data gap: ACOG notes that strict reliance on global maternity codes leaves payors without large-scale administrative data on visits and labor-management complexity, constraining risk adjustment and payment model design.

Plans and employers will want to consider:

- **Benefit design and network strategy may need to evolve** to better align with comprehensive prenatal care and monitoring, including consideration of services and provider types (e.g., doulas, midwives) that were previously not directly reimbursed under bundled payment.
- **Data analytics and infrastructure investments will be required** to manage a materially more complex billing environment and to link service-level utilization patterns with outcomes, enabling more targeted provider performance assessment.
- **Risk pool composition and acuity mix will shape financial outcomes under unbundling**, as plans with higher-risk populations may see increased utilization and spending that differs from national budget neutrality assumptions, with implications for premium setting over time.

Operational decisions, such as whether to phase in new codes or transition immediately, will shape provider experience and financial predictability. Plans will also need to invest in provider education and internal systems to manage the scale and complexity of the change, as well as determine whether to "phase in" the new codes while still reimbursing under the old codes.

C. Providers: OB/GYNs, Midwives and Health Systems

OB/GYNs and midwives have long raised concerns that global maternity codes inadequately reflect the intensity and variability of maternity care. Unbundling responds directly to those concerns, but it also demands fundamental shifts in coding, documentation and revenue cycle management. Under the new structure, reimbursement will be highly dependent on physician documentation of clinical complexity, timing and care transitions, elevating documentation from a compliance function to a primary driver of revenue accuracy. Labor management is likely to be the primary driver of variation in reimbursement under the new structure, as payment is increasingly tied to the duration and clinical intensity of care during labor.

Providers should engage payors now to clarify expectations for prenatal care billing for pregnancies that will deliver after January 1, 2027.

Providers will want to assess several revenue and utilization considerations:

- **How much of the maternity episode the provider typically delivers and bills for, including how revenue capture may shift** as attribution becomes more explicit across prenatal, delivery and postpartum services.
- **Whether clinical education, documentation, coding and revenue-cycle workflows are ready for service-level billing**, as the expected roughly 15-fold increase in claims volume drives changes in documentation practices, coding workflows and revenue cycle operations. This is particularly important for labor management, where documentation must explicitly support both the timing of labor (e.g., initial vs. subsequent days) and clinical complexity classification.
- **How visit volume, service mix, patient acuity and referral patterns will affect total episode revenue**, requiring providers to model how different care pathways translate into reimbursement and to track expected versus actual performance over time. Unbundling may also create new opportunities to capture services such as monitoring, care coordination or alternative care pathways, which were previously embedded in the global bundle.
- **Where fragmentation in care delivery may affect revenue attribution and utilization management**, as services delivered across multiple providers or organizations may reduce the share of total episode revenue captured by any single entity while improving attribution of services and requiring more explicit governance around which providers bill for each phase of care and how responsibility is assigned across the episode. This is particularly important during labor, where multiple providers (e.g., OBs, laborists, midwives) may be involved across days and settings, requiring clearer attribution of services.

While a fundamental shift in payment will require meaningful investments in operational and billing infrastructure, it also creates a meaningful opportunity to better align reimbursement with the care that is being delivered across the maternity continuum. In particular, unbundling may enable payment models that more accurately reflect differences in patient needs, care intensity and the increasingly team-based nature of maternity care. CMS's proposed valuation decisions suggest that the financial impact of unbundling may depend as much on how labor management and delivery services are valued as on the coding changes themselves.

D. Maternal Health Technology and Innovators

Under the legacy global maternity payment structure, most maternal health technology companies faced structural barriers to direct reimbursement, as payments were tied to a single provider billing for the full maternity episode. The transition to unbundled, service-level reimbursement may create new opportunities for digital health, remote monitoring and care coordination platforms to more directly participate in the delivery and reimbursement of maternity care.

In particular, unbundling aligns with broader shifts in maternity care delivery toward more distributed, technology-enabled models of care, including remote monitoring, virtual care and community-based support.

Emerging areas of opportunity include remote patient monitoring for high-risk pregnancies and digital tools that track fetal activity, blood pressure and other clinical indicators. These solutions may reduce reliance on in-person visits and support earlier detection of pregnancy complications. Virtual maternity care and care navigation platforms are another area to watch, providing 24/7 virtual support, care coordination and access to multidisciplinary maternity care teams throughout pregnancy and the postpartum period. Other technology enabled models combine remote monitoring with patient education, risk stratification and care team engagement to support more proactive and personalized maternity care, particularly in underserved populations.

As maternity care is increasingly reimbursed at the service level, technologies that support monitoring, communication and care coordination may become more directly billable or contractible, particularly when tied to discrete clinical services. Unbundling may also enable greater integration of nontraditional providers and care modalities (e.g., virtual care, remote monitoring, doulas), as services become more visible and attributable within claims data. At the same time, questions remain regarding coverage, coding pathways and reimbursement mechanisms for digital and hybrid care models, particularly within Medicaid.

Looking Ahead

With implementation approaching, maternity care reimbursement is on the verge of a structural reset. Unbundling has the potential to better align payment with care delivery, quality and prevention, while also creating a more robust data infrastructure to support measurement, risk adjustment and future payment models, but only if stakeholders prepare early and deliberately.

Operational readiness, analytic rigor and sustained attention to outcomes and equity will be essential. Part 2 of this series will examine how CMS's implementation of maternity care unbundling, final code valuations and related payment policies shape the financial and policy landscape heading into 2027. Manatt will continue to monitor these developments and is available to support states, plans, providers and innovators as they assess the implications of maternity care unbundling and navigate the transition to a new reimbursement paradigm.

1. E/M codes are the standard CPT codes used to report office visits and other patient evaluation and management services across medical specialties. Diagnostic and procedural codes include services such as obstetric ultrasound, fetal monitoring, amniocentesis, and laboratory testing. While these services have historically been billed using their own CPT codes, they were often delivered as part of a broader maternity episode that was reimbursed through a global maternity payment. The 2027 redesign continues to rely on these existing codes while introducing new maternity-specific codes for labor management and delivery, allowing more components of maternity care to be separately visible and reimbursed.

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