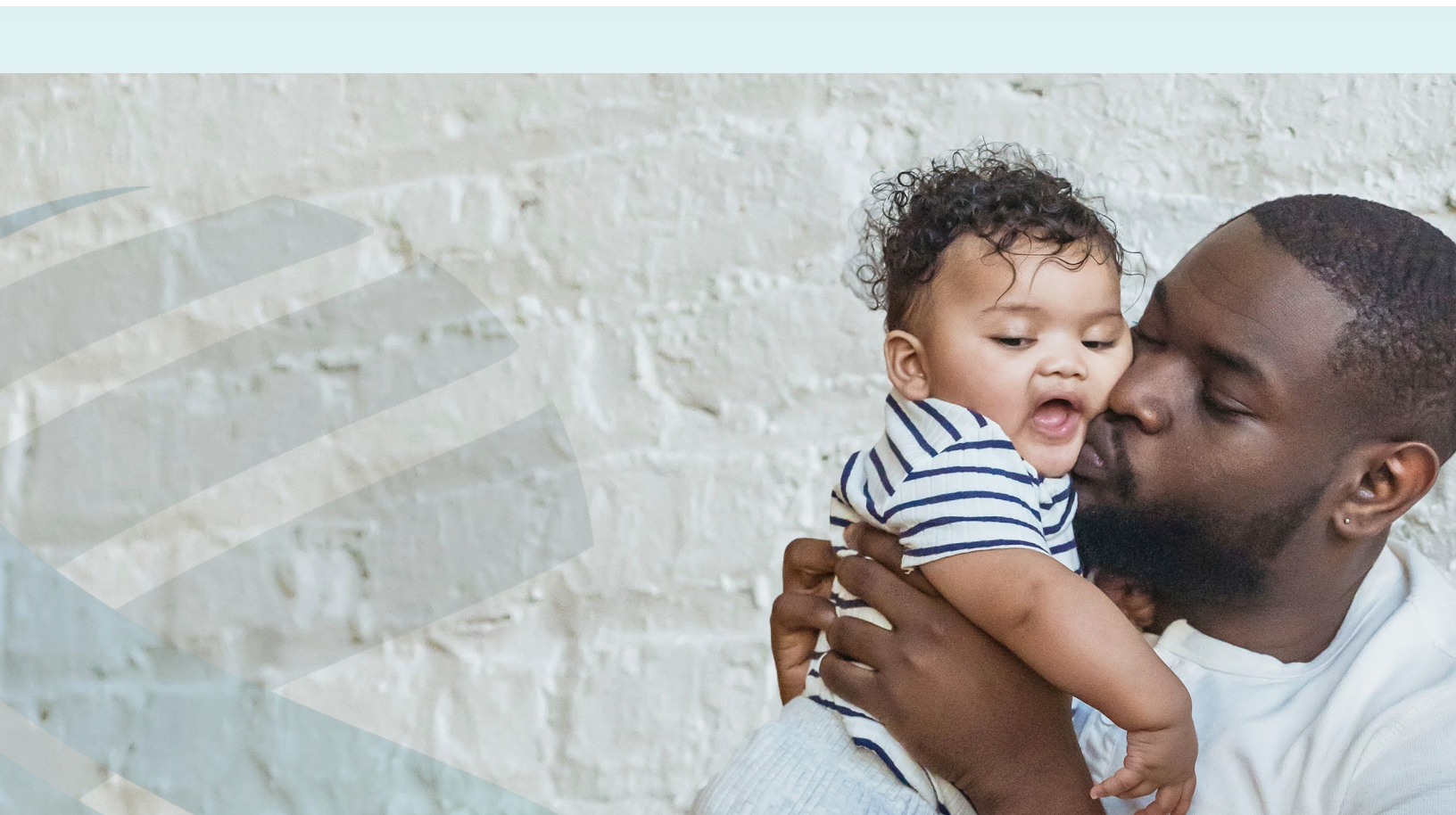




INSTITUTE FOR
MEDICAID INNOVATION

Innovation in Perinatal and Child Health in Medicaid

Investing in the Prenatal-to-Three Framework
to Support Communities and Advance Equity





INSTITUTE FOR
MEDICAID INNOVATION

The **Institute for Medicaid Innovation (IMI)** is a national 501(c)3 nonprofit, nonpartisan research and policy organization focused on providing innovative solutions that address important clinical, research, and policy issues in Medicaid through multi-stakeholder engagement, research, data analysis, education, quality improvement initiatives, and dissemination and implementation activities. To remain relevant and responsive to the evolving needs of the Medicaid population, the Institute seeks to understand what works well in the Medicaid program, identify areas for improvement, and disseminate innovative initiatives and solutions that address critical issues. IMI is currently funded 100 percent through research grants and contracts. IMI does not lobby or advocate and is not a membership-based or trade association.

The **mission** of IMI is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity, and the engagement of individuals, families, and communities.

The **vision** of IMI is to provide independent, unbiased, nonpartisan information and analysis that informs Medicaid policy and improves the health of the nation.

Support for this project was provided by the Pritzker Children’s Initiative.

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Children’s Initiative

The Pritzker Children’s Initiative, a program of the J.B. and M.K. Pritzker Family Foundation, envisions a country where all children arrive at kindergarten ready to learn. We strive for this by catalyzing the equitable expansion of program investments and policies to support infants and toddlers and their families, and to reduce disparities, all starting prenatally. The views expressed here do not necessarily reflect the views of the Foundation.

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Throughout the development of this report, IMI sought input from independent clinical, scientific, and policy experts as peer reviewers who do not have any financial conflicts of interest. Please note that the conclusions and synthesis of information presented in this report do not necessarily represent the views of individual reviewers or their organizational affiliations.

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Executive Summary

This report is being released on the heels of new data from the National Center for Health Statistics about maternal mortality. Following a multiyear rise in maternal mortality in the United States, in 2021 maternal deaths increased nearly 40% over the prior year. The maternal mortality rate for non-Hispanic Black women is 2.6 times the rate for non-Hispanic white women. For all race and age groups, increases in these rates between 2020 and 2021 were significant.¹

Poor perinatal and child health outcomes are a critical public health issue that affects reproductive health. Birth outcomes are intrinsically linked to children's health, early childhood development, school readiness, and the well-being of families and communities. While providers and communities harness strategies to tackle racial and ethnic inequities, the call to integrate community-centered models of care to better serve the Medicaid population has been in place for years but has been vastly underused.

These challenges have cultivated a movement toward embedding services within the local community, provided by those who are committed to delivering culturally congruent care that addresses both social and health needs while combating racism and implicit bias. Doula and perinatal community health workers, midwifery-led models of care, home visiting programs, and colocation of postpartum and newborn services are gaining traction.

IMI conducted a national review of practices and policies implemented to effectively leverage Medicaid to improve prenatal, perinatal, neonatal, and 12-month postpartum outcomes. The goal was to elevate examples of innovation, particularly partnerships between Medicaid health plans with community-based organizations (CBOs) to inform comprehensive and sustainable models and policies grounded in health equity.

The prenatal-to-age-three framework provides the backdrop for the report, followed by a grounding in the policy landscape for perinatal and child health in Medicaid. Innovation was the guiding concept for IMI's request for information (RFI) seeking initiatives that applied an equity lens and went above essential benefits to leverage policies and collaborations in Medicaid. A qualitative review by national experts identified a set of innovative elements that may support initiatives in becoming best practices.

The report presents profiles of 17 innovative initiatives across five themed groups, aimed primarily at improving outcomes and quality of care during the perinatal and postpartum periods. In each group, one initiative is explored in depth. Several initiatives stem directly from state Medicaid priorities, and several others

were either rooted in or developed a commitment to research and formal evaluation. All offer insight into community partnerships.

The emerging themes of innovative initiatives were broader than specific interventions. Instead, they were action-oriented strategies for integrating community and workforce resources to address overall health inequities for the perinatal and child population, particularly for communities of color. These profiles of initiation, implementation, and ongoing evaluation highlight numerous ways to support sustainability and expansion through clinical, research, and policy opportunities—identified by national experts—as well as recommendations from the CBOs and Medicaid health plans that generously shared their work.

These opportunities may provide an agenda for future actions, spanning across stakeholders, including health plans, advocates, and state and federal policy makers, to establish strategic investment priorities centered on pregnant and birthing people, their children, and their families.

Opportunities to Advance Health Equity

For each group of profiled initiatives, opportunities are identified to help launch, implement, sustain, scale up, and expand perinatal and child health innovations. Federal and state Medicaid agencies, Medicaid managed care organizations (MCOs), health care provider organizations and CBOs, and other stakeholders, such as research and philanthropic organizations, can consider clinical, research, and policy opportunities to inform resource investments, including funding and prioritization of efforts.

These are presented not merely as opportunities to improve perinatal health outcomes but above all to advance health equity. Grounded in an understanding of social and structural determinants of health, including racism and oppression, an overarching theme is the importance of positioning Medicaid to support community-led and community-centered models. Innovation is activated by the involvement of Medicaid enrollees and communities. The framework of birth equity emerged across innovative initiatives that position communities to improve perinatal health and support prenatal-to-age-three early childhood outcomes and school readiness.

The following clinical, research, and policy opportunities emerged across the five groups of initiatives, demonstrating innovative elements as described above. Lessons learned and advice from the field is included with each group of profiles.



Clinical Opportunities

Opportunities for clinical service delivery as well as development of models of care and program structure and support.

- **Partnering with CBOs** may offer advantages, including the following:
 - » building on strong community ties with deep understanding of community needs.
 - » new ways to integrate mental health, substance use disorder treatment, and home visiting.
 - » the potential to leverage new Medicaid service providers and simplify administrative burdens for them by coordinating efforts.
- **Grant-style funding by Medicaid MCOs can support community-driven innovation** through the following:
 - » investing in a comprehensive design process.
 - » piloting or expanding high-value, evidence-based models of care while policy and regulatory structures are being developed.
 - » supporting formal evaluation.
- Reimagine traditional individual-based approaches by recognizing the **parent-child dyad** and engaging the **whole family** as a focus for centered health care service delivery.
- To increase access, availability, and cultural congruence, explore ways to expand the care team to include midwives, doulas, and community health workers and **leverage the skills and contributions of all team members**.
- Consider options for integrating **community member leadership in decision-making**, such as advisory boards, designated roles within governing bodies, and positions for community members in program management.



Research Opportunities

Opportunities include traditional research as well as evaluation approaches.

- The use of **structured frameworks and processes** (such as human centered design, the Delphi process, and reproductive justice) can deepen community member and stakeholder involvement in designing and generating new knowledge from programs and address root causes of health inequities.
- Continue the **development of evidence** for community-based perinatal and child program and care models in Medicaid.



Policy Opportunities

Opportunities are offered at local, organizational, state, and federal levels.

- **Continuation of Medicaid benefits through the full first year postpartum** can align systems and reimbursement supporting access to care for prevalent health issues contributing to postpartum morbidity and mortality (e.g., perinatal depression, substance use disorder, hypertension).
- Explore the use of **1115 demonstration waivers and state plan amendments** to develop Medicaid reimbursement for services that expand the community workforce, including doulas and community health workers.
- Explore the use of **contracts with Medicaid MCOs** to promote the uptake of perinatal and child health best practices in their Medicaid programs by requiring services or pilot initiatives such as doulas, home visiting integration, integration with substance use disorder treatment, alternative community health care delivery models, and payment models for perinatal care.
- Consider mechanisms to **minimize Medicaid coverage gaps** for children and adults of reproductive age, especially during the unwinding of the COVID-19 public health emergency, to ensure ongoing access to comprehensive services and continuity of care for prevention, screening, early intervention, and treatment for health conditions that affect growth and healthy development across the life span.

OVERVIEW

“

In order to scale innovation in Medicaid, there is a need for consistent training, credentialing, and reimbursement models. However, addressing the needs of each population also requires tailoring innovations and strategies around the community we're serving, with the community we're serving.

**—Johanna Vidal-Phelan, MD, MBA, FAAP, CHIE
National Advisory Committee Member**

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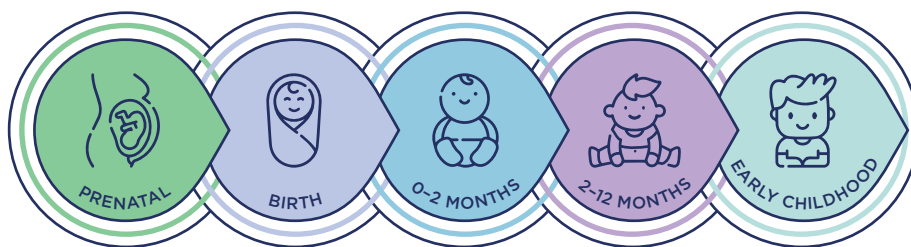
Prenatal-to-Age-Three Framework

The pregnancy, birth, and postpartum phases are transformative times in life and provide a powerful opportunity to support people to thrive. The value of a healthy and satisfying pregnancy lies above all with the pregnant individual; for those who give birth, health during pregnancy and delivery also serves as the point of entry for their children to grow and develop to their highest potential. Adverse conditions and environments caused by insufficient resources and systemic inequities affect reproductive health outcomes, including maternal morbidity and mortality, preterm birth, low birthweight, infant developmental outcomes, and overall well-being.² Extensive scientific and economic research validates community norms: healthy birthing people and young children are essential to thriving communities.

The first three years of life represent a critical period in child development that can have a far-reaching impact on an individual's well-being in the future.² This report highlights models that leverage the Medicaid program to improve outcomes that put infants and toddlers and their families with low incomes on the trajectory for school readiness by age three.

In this report, the term “perinatal” will be used more broadly than in epidemiology, where it is limited to the days and weeks immediately surrounding birth. As the Medicaid program regards pregnancy through postpartum as a continuous episode of health care coverage, the term “perinatal” will be used to reference that continuum; the term “child health” will refer to the continuum from neonatal care through infancy into early childhood. When applicable, programmatic interventions related to certain phases of these continua will be identified specifically. The diagram shown in Figure 1 will label the phases targeted by each initiative that is profiled.

Figure 1: Phases of Perinatal and Child Health



Goals

With Medicaid financing approximately 41% of births in the United States and, together with the Children's Health Insurance Program, insuring 44 million children, the Medicaid program plays a critical role in the health and well-being of pregnant individuals and their children across the nation.³⁻⁴ More than 80% of all Medicaid enrollees are in managed care, including more than 82% of children.⁵⁻⁶ Therefore, in most states, Medicaid health plans have both the responsibility of implementing perinatal and child Medicaid coverage and the opportunity to innovate toward achieving health equity. While providers and communities harness strategies to tackle racial and ethnic disparities, the call to integrate community-centered models of care to better serve the Medicaid population has been vastly underused due to significant barriers to successful, sustainable, and widespread scalability.

Various strategies are available through Medicaid state agencies and health plans to go above and beyond providing the essential pregnancy-related benefits. Data systematically collected to develop a repository of best and promising practices can be used to guide and inform future programs and mandates related to Medicaid managed care state contracts. It can also help identify the policies and procedures that Medicaid health plans need to support sustainability to scale up these interventions from small projects or controlled trials to wider community, state, or national rollout.

This report captures how Medicaid health plans are implementing perinatal and child health initiatives that complement those provided through essential benefits. Profiles of innovative initiatives explore how health plans are achieving this work through partnering with CBOs to inform program development, with a focus on inequities among communities of color. Opportunities for Medicaid programs, provider organizations and CBOs, researchers, and policy makers are provided to inform future strategic investments, particularly the following:

- Medicaid health plans, which use the business model of managed care to improve population health.
- State Medicaid agencies that can implement or integrate key elements or policies within their control.
- Maternal and child health and/or public health departments that may recognize in this report opportunities within Medicaid to build programs that provide needed infrastructure.
- Policy makers and advocates who may find within this report opportunities to inform their work of creating and supporting policies that promote and allow for innovative initiatives to be created and sustained.

Policy Context

In this report, policy levers are considered the mandates, incentives, and flexibilities within the rules or resources of the Medicaid program that have the potential to improve perinatal and child health outcomes. This includes policies and strategies identified by the Prenatal-to-3 Policy Impact Center through comprehensive and systematic reviews of scientific data that have demonstrated effectiveness in providing thriving conditions for children and their families.² These policies play a critical role toward counterbalancing disparities in health and access to quality health care, particularly for Black, Indigenous, and people of color communities that are impacted by historic and ongoing social inequities stemming from racism and oppression. Although health policies alone are not sufficient, pregnant people and birthing families with low incomes rely on the services made available by these policies at a pivotal time in their lives.



Whether our innovations involve bundled payments or HEDIS, we can't let our focus ebb away from the importance of community members feeling respected and having trust. If that's not there, the rest is immaterial.

**—Lindsey Angelats,
DrPH, National Advisory
Committee Member**



Policy levers referenced throughout this report fall into five main categories, highlighted below with selected examples.

1

Eligibility and Enrollment for Medicaid.

Enrollment in Medicaid provides access to health care and ensures an opportunity for enrollees to receive the full set of covered benefits available in their states. For pregnant and postpartum people and parents with infants and young children who have low household incomes, Medicaid coverage is only one piece of a sound foundation for optimal health. But it plays a central role; without health care coverage, preventive services and treatments are cost prohibitive and may not be received. Coverage for individuals who are not pregnant also ensures access to care and counseling related to planning pregnancy and reducing certain risks that can be managed before conception.

- **Expanded eligibility for Medicaid.**
 - » **Patient Protection and Affordable Care Act expansion.** Since 2014, states have had the option to expand Medicaid coverage to adults with incomes up to 138% of the federal poverty level.
 - » **New populations.** Through 1115 waivers or state plan amendments, states may pursue expansion of Medicaid coverage to individuals otherwise not eligible due to immigration status or adults with incomes above 138% of the federal poverty level.⁷
- **Continuous eligibility.**
 - » **Continuous Medicaid coverage under the COVID-19 public health emergency.** Federal Medicaid funding under the Families First Coronavirus Response Act ensured continuous enrollment in Medicaid for individuals throughout the three years of the public health emergency. States can take steps to manage the pace, volume, and communication about resuming Medicaid redetermination to mitigate loss of coverage after the public health emergency ends.⁸
 - » **Extended coverage postpartum.** The option for states to extend Medicaid coverage of pregnant people to 12 months postpartum became a permanent option in the Consolidated Appropriations Act in 2022.⁹
 - » **Extended coverage of children.** The same act instated mandatory provision of 12 months of continuous eligibility for children in Medicaid and the Children's Health Insurance Program.⁹

2

Covered Benefits.

Early and Periodic Screening, Diagnostic, and Treatment and essential health benefits encompass minimum services and therapeutics available to pregnant and postpartum people and children enrolled in Medicaid. High-value, evidence-based services are continuously evolving, and states can accelerate both the engagement in and impact of the Medicaid program by expanding benefits through reimbursing a wider range of services, treatments, and provider types and reducing barriers to accessing these services.

- **Community-based perinatal providers and birth workers.**
 - » **Community health workers.** In 2014, the regulatory definition of preventive services was updated, allowing coverage of services provided by nonlicensed providers.¹⁰ Community health worker services have been provided through state plan amendments, Section 1115 demonstration authority, Medicaid managed care programs, and grant funding.¹¹
 - » **Doulas.** Using state legislation, state plan amendment waivers, and adjacent actions, many states implement or reimburse doula services through Medicaid as a preventive or extended service or via other mechanisms such as Title V maternal health block grants to implement doula pilots.¹²
 - » **Midwives.** Under federal law, services provided by nurse-midwives are a mandatory Medicaid benefit in all states,¹³ and states can include midwives with other credentials in licensure and Medicaid reimbursement. States can further ensure access to midwifery care through policies that ensure practice autonomy, full scope of practice, payment parity, and Medicaid reimbursement of deliveries at freestanding birth centers and home.
- **Services and therapeutics for the perinatal and child population.**
 - » **Perinatal depression care.** States have used the Early and Periodic Screening, Diagnostic, and Treatment benefit to cover screening for postpartum depression as part of the risk assessment for well-child visits, required perinatal mental health programs of MCOs, and various mechanisms to imbed perinatal mental health services within the Medicaid program.¹⁴⁻¹⁵
 - » **Substance use disorder treatment.** The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act established the requirement for Medicaid programs to cover medication for treatment of opioid use disorder (MOUD), also known as “medication assisted treatment.”¹⁶ States and Medicaid MCOs can further ensure access to MOUD through policies that remove restrictive prior authorizations or benefits maximums, support the addition of new prescribers, and increase the workforce and infrastructure for MOUD programs.

3

Support for High-Value, Evidence-Based Models of Care and Care Delivery Transformation.

Medicaid is a program with myriad resources and strategies that can be coordinated to increase access and delivery of covered benefits. Intentional service designs can promote holistic person-, family-, and community-centered care delivery using coordinated, integrated, and culturally and linguistically congruent program models.

- **Accountable care models.** To support care coordination models, the Centers for Medicare & Medicaid Services (CMS) Innovation Center set a goal to vastly increase the number of Medicaid enrollees receiving care

through advanced primary care or accountable care organizations, which have potential to better coordinate services for families.¹⁷

- **Perinatal care models.**

States have adopted perinatal care delivery programs and models, including pregnancy medical homes and group prenatal care such as CenteringPregnancy.¹⁸ State Medicaid programs and MCOs can provide enhanced reimbursement rates and alternative payment models to support these approaches.¹⁹

- **Maternal opioid misuse (MOM) model.**

The CMS Innovation Center awarded funding to eight states to implement the maternal opioid misuse model to address fragmentation in perinatal care for Medicaid enrollees with opioid use disorder by supporting coordinated and integrated care delivery.²⁰

4 Payment Models and Contracting.

Models of care can be advanced by payment design at the level of state, MCO, or further delegated contract terms for reimbursement rates, financial risk sharing opportunities, and payment processes. Policies that tie payment mechanisms to the goals of improved perinatal and child health incentivize innovation around both efficiencies and long-term investments in population health.

- Pay for performance incentives and reduced or nonpayment policies have been implemented by states to meet quality metrics and increase adherence to clinical guidelines.¹⁵
- The episode of care model encourages providers to reduce costs and improve quality across a set of services.²¹ Linking perinatal bundles with primary care population-based primary care models can optimize perinatal health by addressing longitudinal care and health equity.²²

5 Performance Improvement.

Policies dedicated to performance improvement can prioritize the perinatal and child health population through specific efforts and metrics.

- State-based maternal mortality review committees and perinatal quality collaboratives provide infrastructure to support and implement cross-cutting system quality improvement efforts, especially if linked to the Medicaid program.
- Through performance improvement plans, Medicaid programs and health plans can expand and prioritize quality measures for pregnancy, postpartum, and child health, with incentives to disaggregate data to address racial and ethnic disparities.^{23–24}

Scan for Innovative Initiatives

This report sought to identify the extent to which Medicaid programs on the ground are implementing initiatives that use and maximize existing policies and move beyond them, setting examples for program design, clinical practice, research, and evaluation and informing and fueling further policy innovation.

Methods. In November 2022, IMI opened a national RFI seeking innovative Medicaid initiatives and emerging best practices in partnership with CBOs and/or state Medicaid agencies that could be used to effectively leverage the Medicaid program to improve health equity and perinatal and child health outcomes. Medicaid MCOs were encouraged to submit initiatives, including single organizations with multiple initiatives in different markets or at the national level. Initiatives from CBOs and clinical provider organizations were also accepted if their work was centered on individuals and communities served by the Medicaid program. Organizations described the development and implementation of their initiatives, involvement of community members and interested parties, outcomes, equity considerations, scale and replicability, and lessons learned. The RFI sought to identify initiatives that (a) went above and beyond essential benefits, (b) partnered with community-based organizations, and (c) focused on inequities among communities of color.

Deidentified submissions were reviewed by members of a National Advisory Committee (NAC) composed of esteemed experts in perinatal and child health, health equity, and Medicaid policy. Reviews evaluated each initiative's structure and process, how it centered Medicaid enrollees, how it used the Medicaid program, the initiative's impact, and its path toward sustainability. The reviews culminated in grouping initiatives into action themes. The full process is depicted in Figure 2.

Anchoring Innovation. The national scan sought to capture innovations broadly, from brand-new interventions to innovative implementation strategies such as adopting promising methods into an existing organization, context, or service. Beyond idea creation, innovation was expected to have launched development and/or implementation phases and demonstrate intent to improve services for perinatal individuals, children, and/or communities served by Medicaid. Innovations could also stem from reimagining the use of existing services and models to best leverage the Medicaid program to yield positive outcomes.

Initiatives sought for this report were not expected to meet set criteria for best practices; however, the review did take into consideration elements of best practices, such as how well the initiatives described their effectiveness to date within their own settings and the potential for replication.²⁵

The RFI was designed to solicit information from programs to highlight innovation and best practices in the areas of development and design, implementation, outcomes, and sustainability. Strengths in each area are described:

<p>Development and Design</p>	<p>Implementation</p>
<p>Relevant to urgent perinatal and child health priorities, initiatives that authentically engage community to leverage or reimagine existing models.</p>	<p>Initiatives that applied an equity lens and used authentic community partnerships in their design, development, and implementation.</p>
<p>Outcomes (Process and Impact)</p>	<p>Sustainability</p>
<p>Clear linkages between outcomes and clinical, research, and policy opportunities.</p>	<p>As a publicly funded safety net program, potential or demonstrated sustainability is highly valued in Medicaid, which can be demonstrated by multiyear continuation and/or a clear vision or plan for how to sustain the initiative going forward.</p>

The RFI review drew on qualitative data collection methods to discover themes beyond strong implementation, outcomes, and sustainability; because innovation is a flexible space, its spectrum of possibilities is not limited. The innovative elements in Table 1 emerged in relation to each program phase.

Table 1. Innovative Elements Emerging from National Scan of Innovation in Perinatal and Child Health in Medicaid

Development phase	
Context and population of focus	The program or initiative has a clear focus on improving the health of birthing people, children, and their families in the perinatal period, recognizing the role of the Medicaid program and policy levers as opportunities.
Role of community	The program or initiative engages and collaborates with community members and/or community stakeholders in the program’s design, development, or implementation. The program is intentionally tailored to meet the needs of those who are intended to use it.
Built on or goes beyond evidence or existing models	The program or initiative leverages existing policy or resources when possible and integrates or adopts models or frameworks while upholding elements that make the model unique. It preserves and strengthens what works while acknowledging that solutions may look different in different areas and may still require new constructs.
Implementation phase	
Network and collaboration	The program incorporates a collaborative approach in delivery of services, supporting the health of pregnant people and their children by organizing services and providers in a way that best meets their needs, envisioning ways to support innovative collaboration through the Medicaid program.
Problem-solving or opportunism	Obstacles and opportunities are embraced by the program from design impetus through implementation, and there is motivation to share lessons learned to fuel further innovation.
Outcomes and sustainability	
Increased, improved, or reimaged benefits	Implementation of the program leads to increased or improved use of existing services or benefits. Initiatives strategically use existing resources or leverage novel benefits to improve perinatal and child health care and outcomes.
Research and evaluation	<p>The program integrates a research and evaluation component, especially enhanced by structured frameworks. Pursuing innovation includes assessing its impact; Medicaid innovation research or evaluation involves Medicaid enrollees and communities.</p> <p>Programs consider not just traditional outcomes but adopt a holistic perspective that maximizes outcomes for individuals, families, and communities as well as provider and system of care or services.</p>
Future impact (replicability, scale)	<p>There is enough information to indicate that the program or initiative has potential to be replicated within the Medicaid program in other communities, expanded, and/or implemented elsewhere; there is enough information to inform that process.</p> <p>The concept or model could yield high impact if given support through policy.</p>

Source: Institute for Medicaid Innovation

Profiles of Innovation in Perinatal and Child Health in Medicaid

Most initiatives in this report address prenatal through postpartum health. This finding underscores not only the increased urgency in addressing racial disparities in perinatal mortality and overall health but also the increasing investment in the prenatal end of the prenatal-to-age-three continuum—that the health of birthing people is critical to achieving healthy childhood outcomes. In alignment with current policy momentum, doula services were either central to or included in half of the initiatives. Five action themes emerged across the initiatives that exhibit the transformative potential of innovation when aligned with policy levers and collaboration between Medicaid health plans and CBOs. Within each theme, one initiative is profiled in depth, exploring its development and implementation over multiple phases. Shorter profiles spotlight programs and projects with focused interventions, emerging models, and/or expansion phases.

Advancing a Culturally and Linguistically Congruent Perinatal and Child Health Workforce.

Oregon features prominently in this theme as it led the nation in Medicaid coverage of doula services and continues to offer lessons in addressing implementation. Also profiled are other models of doula integration and community-based services by birth workers of all credentials, demonstrating how diverse skills and competencies support community engagement and provider choice.

Partnering with Maternal and Child Health Home Visiting Programs.

Home visitation is an anchor of the public health model for the perinatal and child populations. These profiles share specific examples of how home visiting programs can be integrated across providers and Medicaid health plans and the potential for funding partnerships that can sustain this effective, individualized service.

Integrating Community in Perinatal and Child Health Program Codesign.

This theme illuminates how community members and those with lived experience reenvision, lead, and shape perinatal and child health. These profiles shift the paradigm from seeking community voices to centering community leadership around holistic strategies—versus centering the existing health system and its often siloed perinatal and pediatric interventions.

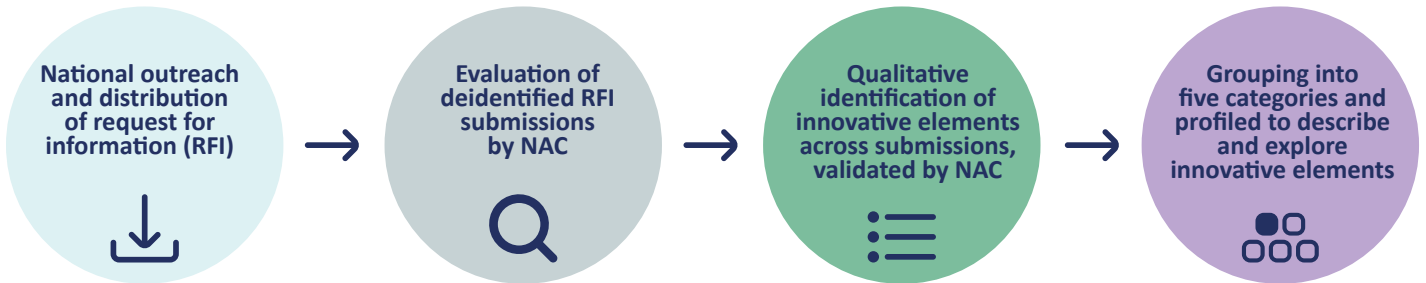
Coordinating Care to Address Maternal Opioid Use.

Against the backdrop of a surge in opioid-related morbidity and mortality, prioritizing the perinatal population requires increased coordination and tailored program design. This section spotlights the specialized resources needed and opportunities for leveraging policy and lessons from the CMS Innovation Center’s MOM model.

Investing in High-Quality Prenatal and Postpartum Care in Medicaid.

While innovation proliferates in the community, most health care is still rendered within brick-and-mortar settings. Best practices and innovative approaches to perinatal performance improvement are needed to support clinicians and bridge innovative approaches originating beyond their care delivery systems.

Figure 2: National Scan for Innovative Perinatal and Child Health Initiatives in Medicaid



Annual Medicaid Managed Care Organization Survey

The Institute for Medicaid Innovation’s (IMI) annual Medicaid managed care survey is one of the first comprehensive efforts to collect robust, longitudinal data on Medicaid MCOs across multiple categories (see Figure 3). The findings from the survey are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. Recognizing that the vivid profiles in this report are just a small sample of innovative efforts across the country, results from IMI’s 2022 Annual Medicaid MCO survey are included as companion data. Survey data in the categories of high-risk care coordination, sexual and reproductive health, social determinants of health, health equity and structural racism, behavioral health, and value-based purchasing are offered to provide context to the individual profiles and support consideration of clinical, research, and policy opportunities. The inclusion of survey data throughout the report does not imply or suggest that the findings are related directly to any of the Medicaid MCOs profiled, nor does it imply that they participated in the survey.

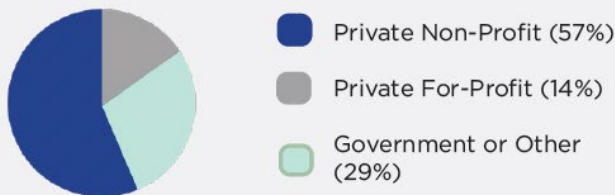
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Creating the infrastructure to work across sectors in the community and build coalitions could be more powerful than anything in the long run.
**—Anne Ekedahl (de Biasi), MHA,
 National Advisory Committee Member**
 ”

Figure 3: IMI 2022 Annual Medicaid Health Plan Survey

Methods and Overview

In its fifth year, the 2022 survey findings represent health plan data from almost every state with Medicaid managed care. The annual surveys collected information at the parent company/corporate levels and are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care.

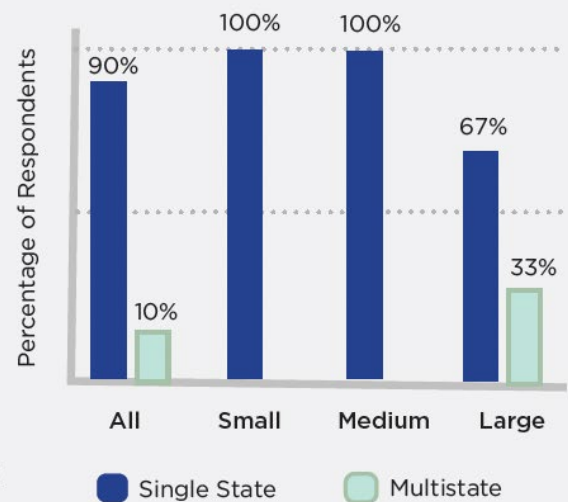
Health Plan Tax Status



Medicaid Health Plan Respondents by Size



Health Plan Markets



Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

ADVANCING A CULTURALLY AND LINGUISTICALLY CONGRUENT PERINATAL AND CHILD HEALTH WORKFORCE

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Expanding doula services is a proven intervention in the movement to improve perinatal care and save lives. It is critical for Medicaid and managed care organizations to fully support community-based doulas as an essential part of a national strategic plan for improved maternal health. Doulas and perinatal health workers offer the most effective and accessible means to equitable community support—one mother, one baby, one family at a time.

**—Jennie Joseph, LM, CPM, Director,
Commonsense Childbirth Inc.**

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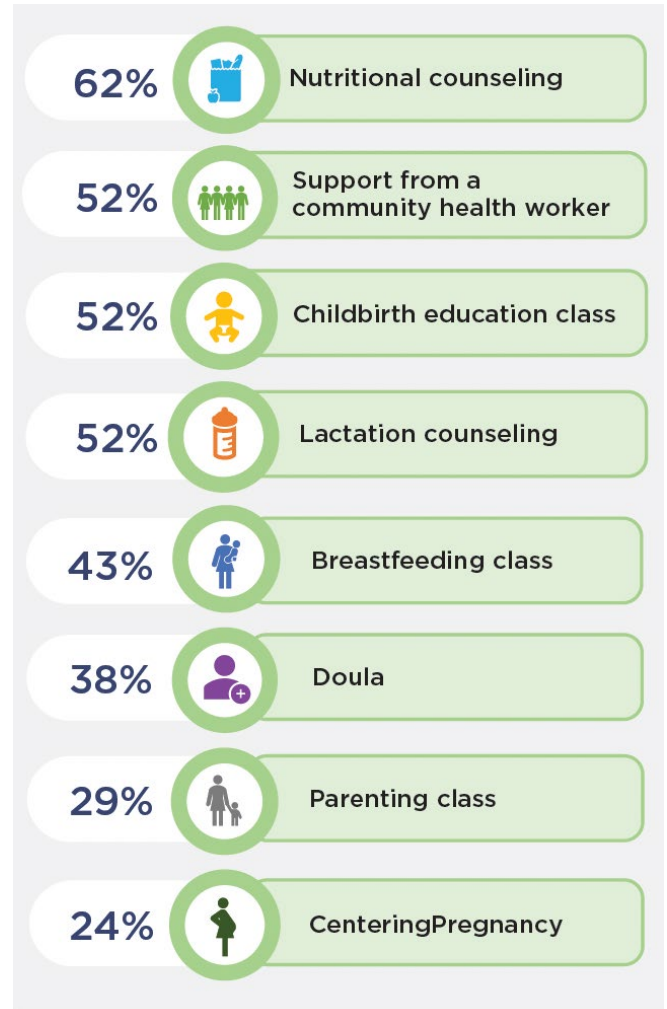
Introduction

The fabric of community is woven with support among its members and has always included family, peers, and elders who guide and support birthing people and young families toward healthy beginnings. In varied ways, public health systems have made efforts to simulate community supports through funding home visiting, care coordination, and peer education programs using grants, health department budgets, and partnerships with philanthropy. Direct health care reimbursement of nonclinical health workers is still in its early phases. Oregon was the first state to launch Medicaid reimbursement of traditional health workers (THWs), such as doulas, in recognition of honored traditions as well as “to help THWs in Oregon become trained and certified to meet current standards, diversify the health care workforce, provide high-quality and culturally competent care to our increasingly diverse populations, and ultimately promote health equity” (Oregon Health Authority).²⁶

Oregon’s head start on Medicaid reimbursement of THWs provides helpful context to consider national initiatives to reimburse the perinatal and children workforce through the Medicaid program. Though Medicaid coverage was implemented in Oregon, the THW benefit was significantly underused for years. Credentialing and billing within Medicaid were barriers that limited the number and diversity of the doula workforce. Even in a high doula use area, such as the Portland metro area, care did not reach the highest-need pregnant people who would benefit the most from the option of doula support.

Health systems are not experts in community-based perinatal supports, but they have high-volume contact with diverse birthing people, resources that support many types of health care workers, and relative market power and scale to negotiate payment for services. This section will profile examples of managed care and health care providers partnering with community-based programs. For example, to increase access to and use of doula support in Medicaid, two hospital systems in Oregon created programs to partner with community doulas, support integration with interdisciplinary care teams, and leverage health system resources to support doulas in completing state credentialing requirements and receiving payment. Several initiatives in this section focus on fostering relationships between community birth workers and labor and delivery staff as well as outpatient care teams. Medicaid health plans have a distinct role to play in advancing a culturally and linguistically congruent workforce as they can develop value-added benefits and alternative payment models within the managed care framework, as seen in Figure 4.

Figure 4. Medicaid MCOs' Covered Benefits for Childbearing People



Source: Institute for Medicaid Innovation. “2022 Annual Medicaid Health Plan Survey.”

Lessons Learned and Advice from the Field

- **Engage, partner, and collaborate with doulas and community health workers** at every stage of decision-making—from development to implementation through evaluation—of Medicaid reimbursement. This approach has the potential for states and Medicaid health plans to operationalize a new service efficiently with high levels of community and provider engagement. Doula programs developed “by doulas, for doulas” help establish community trust.
- Medicaid MCOs are positioned to develop **alternative payment models** that cover both service cost and administrative expenses for doula services that offer high value in quality, equity, and utilization outcomes.
- Consider **embedding birth workers into established clinical practice teams and health systems** to leverage scale by negotiating rates and overhead, providing infrastructure, including for billing and coding Medicaid reimbursement, as well as other forms of support.
- Explore **justice and equity frameworks** to inform program development, research, and evaluation methods of perinatal and child health interventions.
- **Evaluate** the impact of varied models on disparities in birth outcomes, perceptions and satisfaction around birth experiences, health care costs, and drivers of health equity.
- Examine how **Medicaid coverage of the services provided by an expanded birth workforce** (such as doulas and midwives of all credentials) impacts access to comprehensive care and financial sustainability across whole communities.
- Since Federal Medicaid rules require states to implement a **managed care quality strategy** with a plan to address health disparities, states may want to explore including a doula strategy.
- Establishing **equitable reimbursement rates** for doula services and **support for community-developed training** can be critical factors in growing a culturally congruent workforce that can meet network capacity needs.
- Explore ways to support **infrastructure that assists new Medicaid service providers** with enrolling in and receiving reimbursement from the Medicaid program.



Community Doula Program



Primary Organization: Heart of the Valley Birth and Beyond

Health Plan: Multiple Coordinated Care Organizations (CCOs)

Partner(s): Reconnections Counseling, InterCommunity Health Network, Coordinated Care Organization (IHN-CCO)

Location: Linn, Benton, and Lincoln Counties, Oregon

Background

Between 2011 and 2012, the Oregon State Legislature designated four types of THWs in House Bill 3650, and mandated the use of THWs in health systems in Senate Bill 1580. Birth doulas were designated as a fifth THW type in 2013, making Oregon the first state where doulas were eligible for Medicaid reimbursement.²⁷

By 2018, participation in the THW program was low, with only six (6) white, monolingual doulas successfully joining the THW registry. Navigating state requirements and long reimbursement times created significant barriers for community doulas pursuing certification.

Rural and urban communities in Oregon's Linn, Benton, and Lincoln counties shared a common need for advocacy, informational support, and aid in navigating health systems in predominantly white, high-income, and professional economies. Supporting doula care was prioritized as a way to support birthing individuals in their pregnancy journey.

Description

Heart of the Valley Birth and Beyond is a 501(c)(3) nonprofit organization that formed in 2016 to help establish a freestanding birth center to serve Corvallis and the surrounding areas before pivoting to the development and implementation of the Community Doula Program in 2018. Extensive research on birth doula programs informed a proposal for pilot funding that focused on health equity from the local coordinated care organization (CCO). (In Oregon, CCOs coordinate the Medicaid benefit for people regionally.) The successful proposal led to the development of the Community Doula Program in partnership with a community-led board of directors and the IHN-CCO Delivery Systems Transformation Team.

The goals of the Community Doula Program were developed using the four core values, or guiding principles, of SisterSong's reproductive justice framework.²⁸ The Community Doula Program customized the framework for its local aims to:

1. Analyze local and national systems of power that influence gendered, sexualized, and racialized acts of dominance.
2. Design interventions and supports that address intersecting oppressions.
3. Center those made vulnerable by systems of oppression in all decision-making and resource allocation.
4. Join together with local, state and national partners across issues and identities to ensure that every family gets the best possible start in life.

The Community Doula Program focuses on serving priority populations, including those who are: English language learners; racially and ethnically diverse; underhoused; have a history of incarceration or are currently incarcerated; have a substance use disorder; are veterans, disabled, gender expansive, adolescents, medically high-risk; and/or are experiencing pregnancy with low- or no social support. The fastest growing community the program serves is recent, undocumented migrants who are largely from Central America. Approximately 40% of clients are Black or Indigenous, or members of other communities of color. White and low-income clients comprise the remaining 60%, with about half of this group living in rural communities and/or having significant mental health issues or a substance use disorder.

The Community Doula Program provides doulas, free of charge, to populations who otherwise would not have access to them. It uses a “hub” model, where paid and volunteer staff: build referrer relationships; recruit, train, and match clients to doulas; provide free continuing education; conduct research and share knowledge; support the state THW registry; assist with Medicaid and CCO credentialing; contract with CCOs; provide liability insurance; offer reflective supervision; manage complaints, billing, and reimbursement; and provide recertification support.



Community Doula Program

Most recently, IHN-CCO funded the cross-training of THW Doulas as Peer Wellness Specialists. This upskilling enables THW peer support doulas to care for clients during pregnancy and birth, and to continue supports for up to three years postpartum. The project is a collaboration with Reconnections Counseling—an innovative peer support program designed to meet individuals with substance use disorder wherever they are in their journey toward sobriety. Through this collaboration, 90% of clients have retained custody of their children and are parenting. Current grant writing is focused on securing funds to replicate this model in additional counties.

Implementation.....

From recruitment to the point of payment, the Community Doula Program provides workforce support to community-based doulas throughout the phases of their journey. Limited organizational capacity is supplemented with contract staff and student interns.

Recruitment: Diverse community leaders came forward to serve on the program’s board of directors and to train as doulas. The goal from the outset was to establish a culturally and linguistically diverse THW workforce that socially, culturally, and linguistically matched the communities being served by the program. Since 2018, the Community Doula Program has trained 145 diverse doulas who have served 1,059 families.

Education: A doula steering committee tailored a national birth doula curriculum to reflect the unique needs of the community-based doula program. It is now the first and only curriculum created by community-based doulas that is approved by the state of Oregon. Trainings are provided free of charge.

Certification and Mentorship: Navigating an ambiguous state certification process that can result in nearly a year of unbillable time, the program assists doulas with applications to the state registry and liaises with state offices and local CCOs to enable doulas to become billable Medicaid providers. In addition, the Community Doula Program supports doulas by providing mentorship opportunities and reflective supervision.

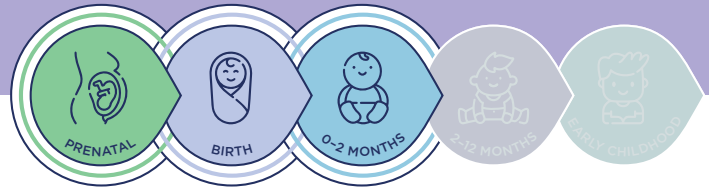
Referrals and Payments: To manage both provider referrals and self-referrals, the Community Doula Program developed a management and referral system called Vishnu, which tracks doulas' areas of expertise, skills, training, and lived experience. It then makes a soft match with an incoming client for a program manager to review and facilitate a connection between the pregnant person and the doula. To ensure timely payment after care is provided, the Community Doula Program pays doulas for their services using grant funds, and then bills Medicaid. The program negotiated with their local CCO for a rate of \$800 per course of care, nearly \$500 more than Medicaid's rate. In June 2022, Oregon Health Authority announced its intent to increase reimbursement to \$1,500.

Outcomes

Program outcomes are tracked through three data sources. Programmatic and implementation outcomes—including training needs, doula expertise, credentialing, referrals, and reimbursement—are tracked through the Vishnu program management software. Clinical outcomes are measured with the Community Doula Program Statistics Project, which tracks over 150 clinical and psychosocial outcomes. Qualitative outcomes are collected through “Measure What We Treasure,” a collection of multimodal, ethnographic data that seeks to understand “the people behind the numbers,” and demonstrates the impact of doulas outside of quantitative data. Clients, as well as all parts of the care team who work with doulas, participate in ethnographic interviews that capture their experiences with the doula's care and measure autonomy and respect. Additional qualitative data is collected through digital storytelling and arts-based media.

Collectively, these data indicate that cohorts served by community doulas have significantly lowered cesarean birth rates, neonatal intensive care unit (NICU) admissions, preterm births, and emergency department visits, as well as higher breastfeeding initiation rates. In addition, clients supported by doulas report higher levels of perceived respect and autonomy relative to the traditional care (i.e., no doula) comparison group. Of the doulas engaged with the Community Doula Program, 100% of those polled reported they would not be able to work as community doulas if the hub model did not exist to streamline the training, credentialing, and billing processes.





Medicaid Covered Doula Program

Primary Organization: Legacy Health System

Health Plan: Multiple Coordinated Care Organizations (Oregon Health Plans)

Location: Oregon

Legacy Health System launched their program with the support of a foundation grant with the goals of:

- Providing access to doulas for all Medicaid patients, including those at highest risk for poor outcomes due to implicit racial bias.
- Integrating a diverse doula workforce into the health system and supporting culturally matched doulas and clients.
- Improving preterm birth and breastfeeding rates.
- Improving patient satisfaction with their birth experience.
- Decreasing the cesarean section rate.
- Decreasing NICU admissions.

Legacy Health System recruits a broad pool of doulas that allows Legacy to match doulas to clients based on how they identify, and/or clients' specific requests. Pregnant people have the option to interview their doula before being matched. Recruitment prioritizes: doulas of color; bilingual/bicultural doulas; those identifying as LGBTQIA+; and doulas who have lived experience with substance use disorder; homelessness; low-income or under-resourced pregnancy; or mental health diagnoses.

Payment/billing: Legacy hires doulas as independent contractors to provide services based on the state's reimbursement method, which includes two extended prenatal doula visits; support through labor, birth, and immediate postpartum; and then two extended postpartum home visits. After care is provided, Legacy utilizes a pass-through model in which they bill Medicaid on behalf of the doula and the doula invoices for the full fee. An experienced doula was hired as the program coordinator to support Legacy in understanding how CCOs develop enhanced rate models and gave input to support a more livable wage and fee schedule. Legacy's contract department negotiated with CCOs and created the contract addendums to include doula services at enhanced rates.

Integration/Support for the Community-based Doula Model: Acknowledging the mistrust and tension that can sometimes exist between community doulas and hospital-based programs, Legacy's program strives to build trust and create an environment of safety for doulas to practice. The program collaborates with the state and the Oregon Doula Association to implement best practice guidelines for doula standards; to maintain a livable wage for doula services and fidelity of the doula's role; and to have doulas figure in a continuity model of care rather than attempting to fit them into a shift work model. As part of their grant, Legacy developed a research component to assess the doula program.

Expansion: The success of the program and the demand for it allowed it to expand from the initial pilot with two prenatal clinics to all Legacy Health Systems clinics and birthing sites in Oregon. Plans exist to expand the Medicaid doula program into Legacy hospitals in Washington once Medicaid coverage is instituted in the state.



Providence Doula Access Collaborative

Primary Organization: Providence Health & Services

Health Plan: Multiple Coordinated Care Organizations (Oregon Health Plans)

Location: Oregon

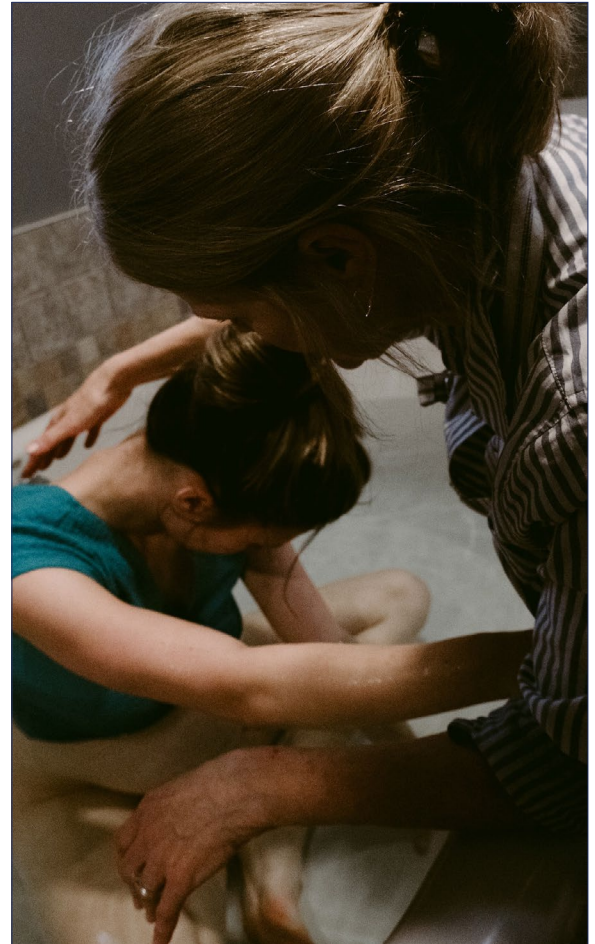
Providence Health & Services developed the Providence Doula Access Collaborative (PDAC), a partnership that aimed to increase the number of and access to BIPOC doulas and fully integrate the value of the THW doula in the hospital delivery care setting, while retaining their community-based focus. At the time of design, there was only one (1) Black THW doula and one (1) Latinx doula within the Tri-County area of Portland. PDAC provides scholarships to BIPOC individuals to complete the THW doula training and registration process. They developed partnerships with local doula training organizations to provide doula training, education, and mentorship to scholarship recipients.

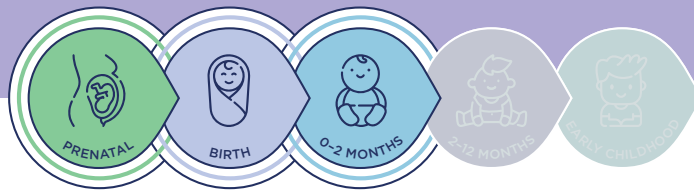
Payment/billing: Providence contracts with both Oregon Health Authority (OHA) directly and with local CCOs to provide the OHA global doula package to patients with Medicaid coverage who are delivering at one of their three Portland service area hospitals. Providence bills Medicaid on the doulas' behalf and is a pass-through for reimbursement to the doula.

Integration/Support for the Community-based Doula Model:

PDAC contracted with a local doula consulting team comprising professional doulas and trainers to support program development and then transitioned ongoing program development to an employed doula coordinator. In listening sessions, birth workers shared the value of the community-based doula model including doulas that reflect the communities they serve and supporting social service referrals, patient autonomy, and health literacy. The hospital supports the integration of the doula model through orientation to the labor and delivery units, the creation of hospital identification badges, as well as via team building and learning sessions for both doulas and nursing staff to better understand each other's roles and their importance to the patient's safety, experience, and outcome.

Sustainability/Expansion: PDAC offers scholarships to BIPOC people to train as a doula and THW to continue to grow and develop a diverse doula workforce. PDAC is interested in expanding the program to include on-call doulas, who will be available at short notice for in-hospital delivery support, including those patients who are late to care, traveling, or are without partner support.





Doula Program

Health Plan: Elevance Health

Partner: The Doula Network

Location: Florida, New York, California

For several years, Elevance Health has supported the provision of doula services to Medicaid health plan members in Florida, New York, and California through pilots, value-added benefits, and grant funding across a varied regulatory landscape. In 2022, Elevance Health’s Florida health plan affiliate, Simply Healthcare Plan, Inc. (Simply), was able to expand its doula program after Florida’s Agency for Healthcare Administration added doula care as a benefit that Medicaid managed care plans could offer.

Simply partnered with The Doula Network, a company that contracts with health plans to provide a network of doula providers who can be accessed by health plan members. Simply members are typically referred by a health plan care manager who prioritizes referrals for pregnant members with high risks in pregnancy, such as gestational diabetes, hypertension, and depression. While providers refer to The Doula Network, members can also self-refer.



The Doula Network completes an intake process and connects members to doulas, prioritizing cultural concordance—aligning background, culture, and/or language with clients when a matching doula is available. The Doula Network lists nearly 100 doulas on Simply’s network roster, including doulas who speak Spanish and Creole. The health plan also funds collaborations with Healthy Start coalitions to increase the availability of doulas in the community. Members may request authorization for an out-of-network doula if a doula who meets the member’s needs is not available through The Doula Network or Healthy Start.

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As a Latina physician, I believe it is important that we intentionally develop a workforce that is also linguistically congruent.

**—Johanna Vidal-Phelan, MD, MBA, FAAP, CHIE
National Advisory Committee Member**

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Doulas work with The Doula Network as independent contractors who utilize the company’s software and support team for credentialing, billing, client recordkeeping, training, and liaising with the health plan, hospitals, and providers. Doulas make visits during pregnancy; provide ongoing birth support during labor and delivery; make home visits in the postpartum period; and screen for behavioral and social needs. They connect members to community resources that address such needs as transportation, diaper banks, and clothing.

Simply completed a provider perception pre-survey prior to program expansion to address barriers identified by providers, hospitals, and labor and delivery units. The health plan created educational materials on the integral role of doulas as advocates for birthing people as well as the role of doulas as partners to clinicians in improving birth outcomes. These materials provided instruction to health systems about how to refer members and facilitate effective working relationships.

Table 2. Outcomes from Doula Pilot Program, 2014–2020

Outcomes	Doula pilot group	Nondoula group
Low birth weight ^a	8.1%	12.3%
Neonatal intensive care unit admission ^a	5.9%	11.4%
At least one prenatal visit ^a	99.1%	93.8%
Hospital admissions during pregnancy ^a	13.3%	21.3%
Emergency room visits during pregnancy ^b	42.1%	38.2%
Emergency room visits 30 days postpartum ^b	2.8%	6.5%

Note: Outcomes represent data from Florida (2014–2020), New York (2018–2020), and California (2020).

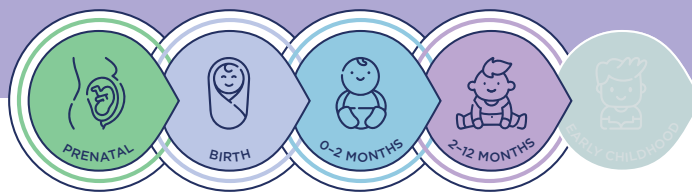
^a Significant at $\alpha < .05$.

^b Numbers were trending down but not statistically significant.

Source: Elevance Health

Elevance Health performed an analysis that combined outcomes from its Florida pilot program with The Doula Network, as well as pilot programs in New York and California, which provided doula services to members through local partner organizations. When comparing pregnancy and birth outcomes for members who did not receive doula services to those who did, pregnant people using doulas had favorable birth outcomes and \$1,675 lower prenatal and birth costs on average (see Table 2).

Simply continues to expand its doula benefits, which reached nearly 300 members in 2022. As a result of positive birth outcomes in the pilot programs in Florida, New York, and California—and because of its experience rolling out the expanded benefits under Florida’s Medicaid program—Elevance Health continues to apply a multi-pronged approach to increasing doula access across its state health plan affiliates. This approach includes implementation of Medicaid covered benefits where available as well as grant funding to community-based organizations or doula collectives to build capacity and provide doula training to diversify the workforce.



Mana Mama

Health Plan: AlohaCare

Partner: Healthy Mothers Healthy Babies Coalition of Hawai'i

Location: Hawai'i

In 2021, Healthy Mothers Healthy Babies Coalition of Hawai'i (HMHB) and AlohaCare, a community-founded Medicaid health plan, collaborated to develop the Mana Mama Mobile Clinic, a holistic, community-based midwifery model of care serving birthing families on the Oahu Island of Hawai'i. Clinical services are provided by licensed midwives, lactation consultants, and a nurse practitioner. Participants also receive comprehensive phone and telehealth support as well as referrals to resources and information, including to all HMHB's community and social service programs.

The program launched when Hawai'i's public health and economy were devastated by the COVID-19 pandemic, which exacerbated inequities suffered by HMHB's target population of high-risk birthing people and infants, especially Black, Native Hawaiian and Pacific Islander, including Compacts of Free Association migrants, and other people of color. HMHB applied for an AlohaCare Imua Loa grant to support the renovation of a former tourist van to become the Mana Mama Mobile Clinic.



Mana Mama Mobile Clinic

Source: Healthy Mothers Healthy Babies Coalition of Hawai'i

Not strictly a grant maker, AlohaCare worked with HMHB to develop the infrastructure to partner together. AlohaCare shares member lists with HMHB for outreach purposes, and flags members with specific needs, such as those with positive depression screenings. Through its mobile and telehealth services, HMHB collects data about members' needs and services received, as well as race and ethnicity data, and shares these with AlohaCare. This allows the health plan to capture progress in addressing health disparities in specific racial and ethnic groups. The two organizations also partnered to develop an innovative method for AlohaCare to pay HMHB for services, including behavioral health, social services, and perinatal services provided by licensed midwives who are not yet able to receive Medicaid reimbursement.

HMHB uses multipronged strategies to address structural and systemic factors that exacerbate inequities and influence the health of mothers and babies, particularly in Black, American Indian and Alaskan Native, Native Hawaiian, Samoan, Marshallese, Chuukese, and other Micronesian races. These multipronged strategies include:

- **Growing and supporting a workforce to provide culturally congruent care.** Services are delivered by an all-female, majority non-white staff who match the diverse patient population they serve. HMHB supports the advancement of new and existing staff, including offering a community-based certified doula training program.
- **Advocacy.** HMHB actively advocates for state Medicaid and health plan reimbursement of licensed and certified professional midwives as well as doulas and works with hospitals and community providers to increase respectful relationships with the full team of birth workers.
- **Care delivery.** In addition to providing mobile clinic services, HMHB offers telehealth options for mental health therapy, which is important on rural islands that lack providers. Their model honors the multigenerational family construct by welcoming all members of the family for services.

Table 3. AlohaCare HEDIS Results MY 2020 and MY 2021

HEDIS measure	MY 2020	MY 2021
Prenatal care	68.63%	82.48%
Postpartum care	52.04%	77.62%

Note: HEDIS = healthcare effectiveness data and information set; MY = measurement year.

Source: AlohaCare

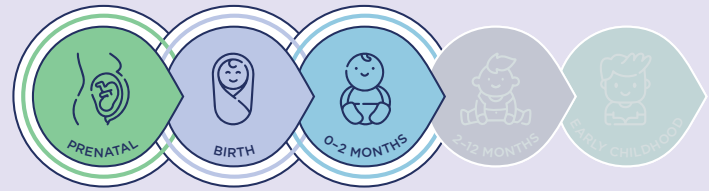
After the first year of the Mana Mama program, AlohaCare observed significant increases in overall prenatal and postpartum care HEDIS measures (see Table 3).

The Mana Mama pilot resulted in members who received HMHB services having a significantly higher rate of prenatal care than those who had not. Given the recent extension of postpartum services to be covered by Medicaid for a full 12 months, AlohaCare and HMHB will work together to optimize postpartum care for members. AlohaCare also analyzes cost and utilization metrics, such as ER Visits, admissions, inpatient days, and overall cost of care (per member per month) for its perinatal population as part of the ongoing evaluation of population health strategies, including Mana Mama.

In 2022, Mana Mama expanded its reach. HMHB won funding for Mana Mama/Anax Angil, a partnership with tribes in rural Alaska and across Turtle Island to address perinatal care access. The partnership aims to give every parent and baby access to high-quality health information, education, advocacy, lactation support, and related resources via telehealth visits and a 24/7 live chat platform. Additionally, a second Mana Mama Mobile Clinic is now serving Hawai'i (Big Island), an area where terrain and existing disparities in maternal and infant health outcomes pose new opportunities for this innovative, multidisciplinary, mobile team to provide services to birthing people, children, and others in the family.

AlohaCare asserts that HMHB's success demonstrates how critical it is for health plans to trust and support community partners who can reach their members in new and innovative ways: establishing trusting relationships with birthing people and their families by providing mobile services in the community; hiring staff who reflect the ethnic, racial, and cultural diversity of their service population; and integrating services to address social determinants of health and medical needs for greater member engagement. Their approach has proven effective for reducing barriers to care, addressing gaps in care, and achieving greater patient/member engagement.

SNAPSHOT Mobile Midwifery Unit and Doula Training



Health Plan: Humana Healthy Horizons in Florida

Partner: Southern Birth Justice Network

Location: Florida (statewide)

Description:

In alignment with Florida’s Health Improvement Plan, which prioritizes inequities in maternal morbidity and mortality rates, Humana Healthy Horizons in Florida strategically established a partnership agreement with Southern Birth Justice Network (SBJN) for calendar year 2023. The partnership will directly support SBJN in expanding birth justice via services that are holistic, humanistic, and culturally centered, through storytelling, popular education, and community organizing while improving access to midwifery and doula care. The funding provided by Humana Healthy Horizons in Florida directly supports the mobile midwifery unit operations in Miami-Dade County, which launched in February 2023. The mobile midwifery unit provides birthing people and their families with respectful, culturally congruent care in neighborhood locations to remove barriers and serve as a comfortable entry point to care. Funding also supports the SBJN doula training program, which seeks to effectively train 15 community doulas at no cost to them, and to create long-term improvements in the quality of life of individuals and families. HumanaBeginnings® Care Managers can refer anyone who may need those services. If SBJN encounters a Humana member who visits the mobile unit, SBJM will refer them back to the HumanaBeginnings® program. After the first year, SBJN will share information with Humana Healthy Horizons in Florida about total individuals served, total doulas trained, overall outcomes, and client/participant testimonials to inform future phases of the partnership.

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For doulas, promotoras, and community health workers, we have to address how you take a person trained in a justice perspective and integrate them into a traditional health system without losing what makes them successful in their work to begin with.

—Pooja Mittal, DO
National Advisory Committee Member

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PARTNERING WITH MATERNAL AND CHILD HEALTH HOME VISITING PROGRAMS

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Recent research has included the integrated [home visiting] model but has not described what integration looks like: the program model home visitors are trained in, additional training needed, what happens at visits, etc. We need to know more about what it takes to make these programs successful.

**—Cynthia Osborne, PhD,
National Advisory Committee Member**

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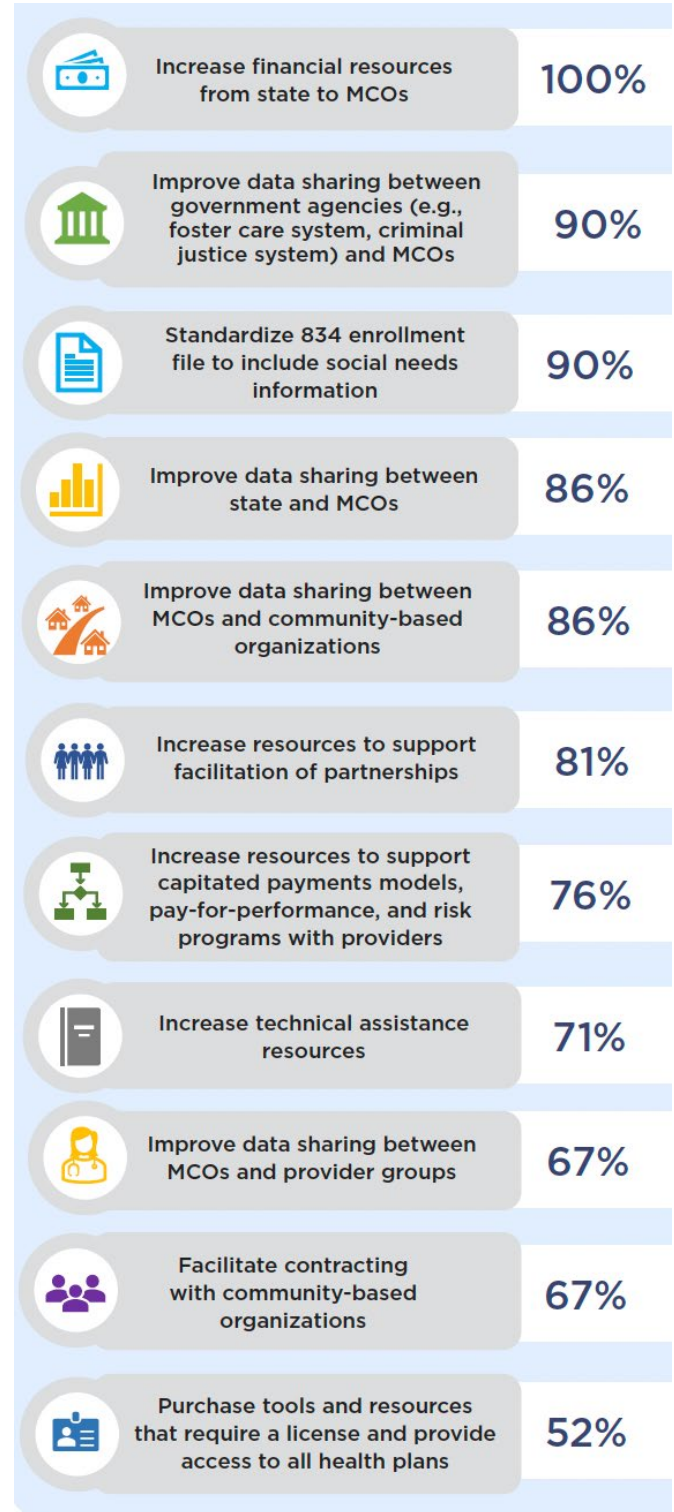


Introduction

Evidence-based maternal and child health home visiting programs support early childhood development and positive perinatal outcomes through regular home visits.²⁹ They have been shown to help level the playing field for systemically disenfranchised populations by increasing early skill building, access to care, and family engagement. Additionally, evidence-based programs also prioritize the coordination of supports and address social determinants of health (SDOH) through surveillance programs, such as lead testing, supplementary resources, and care coordination. Early access to these supports further bolsters early childhood outcomes.

This section profiles three models for integration of home visiting programs with clinical perinatal and childcare providers and managed care models. Home visits are, by definition, individualized and locally specific in nature and therefore vary by community, making integration challenging. However successful integration offers unique opportunities to support relationships between families and health care workers and, at a population level, improve perinatal and child health outcomes. Home visitors' deep understanding of community needs and resources offers enormous potential to enrich data sharing and SDOH resources. Figure 5 explores general strategies that support Medicaid health plans in leveraging community-level SDOH resources, which also apply to maternal and child health home visiting programs.

Figure 5. How State Medicaid Agencies Could Further Assist Medicaid Health Plans in Addressing SDOH Needs

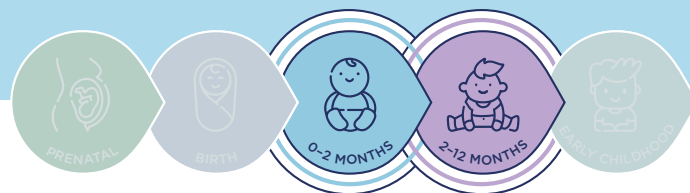


Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

Lessons Learned and Advice from the Field

- Take time to build **relationships with CBOs that provide maternal and child health home visiting programs**. Relationships provide Medicaid health plans with insight into organizational and local factors to inform innovative, effective service integration and payment models.
- **Regional contracting and training hubs** can provide the infrastructure needed to support integration of maternal and child health home visiting programs and workers into interdisciplinary care models.
- Design **care models that braid resources**, including community-based workers, from maternal and child health home visiting programs with clinical and social services.
- **Develop studies of innovative models** integrating evidence-based health care interventions from the physical, behavioral, or public health domains into maternal-child home visiting programs.
- Incorporate **ongoing community involvement and participant feedback** in ongoing program design (such as the Delphi process and advisory boards) with program development, research, and evaluation methods of perinatal and child health programs.
- **Enhance data, research, and accountability** through inclusion of mental health measures in all quality programs and evaluation, such as the CMS's Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP.³⁰
- Consider **Medicaid coverage through 12 months postpartum** as the standard episode for pregnant individuals, to ensure access to comprehensive services and support home visitors' ability to address needs promptly and in partnership with health care teams.
- Identify and develop an action plan to **remove barriers for behavioral health care providers** to participate in Medicaid services to ensure that mental health screening done through home visits can be paired with effective treatment when needed. The action plan should examine all potential places of service, treatment modalities, provider types, participation in managed care networks, and sustainable reimbursement rates.
- Explore how federal, state, regional, philanthropic, and managed care **stakeholder investments can support the integration of home visiting programs** through dissemination, implementation, and training of effective models.
- Consider demonstration pilots for **Medicaid coverage of perinatal community health workers** as an additional strategy to sustainably integrate maternal and child health home visiting programs across the Medicaid service landscape.
- Convene Medicaid stakeholders to **identify barriers and solutions to effective data sharing** across state programs, Medicaid MCOs, providers, and CBOs.
- Explore ways to allow the use of **transportation and childcare benefits** for group health support to complement individual home visiting to strengthen peer and other community health assets and promote the sustainability of effective programs.

Addressing Postpartum Depression in Wisconsin Home Visiting Programs



Primary Organization: University of Wisconsin-Madison

Health Plan: N/A

Location: Wisconsin

Background

Postpartum depression is a significant public health concern posing risks to postpartum individuals, mother-infant relationships, and infant development. As high as 48% of postpartum individuals living with low incomes experience depressive symptoms.³¹ Without treatment, 30–70% of these individuals may experience depression for a year or longer.^{32–33} Given that unrecognized/untreated maternal mental illness impacts two generations, taking a two-generation approach that treats both the mother’s depression *and* the quality of the mother-infant relationship improves infant outcomes.

Postpartum depression is a critical concern in Wisconsin’s urban, rural, and Tribal communities. Wisconsin home visiting programs funded by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program are mandated to screen for depression during pregnancy and postpartum. In fiscal year 2021, MIECHV Programs reported that, as part of their 920,000 home visits nationally, 81% of caregivers received depression screening within three months of enrollment or three months postpartum.³⁴ However, home visitors often lack the training to address maternal mental health, and mothers face significant barriers (i.e., waitlists, transportation, childcare) in their attempts to utilize community mental health services.

Description

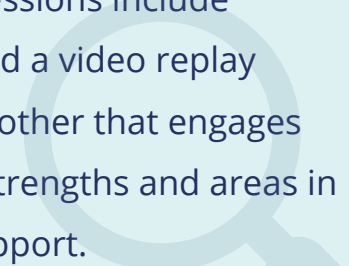
The Mother-Infant Therapy Group (M-ITG) treatment for postpartum depression, which was developed at the University of Wisconsin-Madison (UW), was found to be effective in increasing depression recovery rates, mother-infant relationship quality, and infant emotion regulation.³⁵ To address the critical gap in access to evidence-based, trauma-informed depression care, especially among women of color, the M-ITG has been integrated into community home visiting programs in Wisconsin as well as in psychiatry and community-based pediatric/child development clinics in Colorado and Illinois.

Results suggest that mothers’ mental health needs can be addressed in a collaborative delivery model between community mental health clinicians and home visitors.

Pilot studies indicated improvements in reach, feasibility, and acceptability of the program as well as promising outcomes, such as increased confidence and competence of home visitors for addressing the mental health of mothers. The current, CDC-funded, randomized controlled trial (RCT) examines the dissemination and implementation of M-ITG treatment that uses co-facilitation by community mental health providers and home visitors to develop a sustainable and cost-effective model.

Participants are mothers with infants between 2 weeks and 9 months who receive home visiting services and screen positive for depression on the Edinburgh Postnatal Depression Screen (EPDS). The M-ITG program spans 15 weeks. It starts with two individual sessions followed by 12 weeks of group sessions with other mothers who are experiencing postpartum depression and closes with an individualized family session. The two-hour Mother's Group therapy sessions occur in the community

with five to seven mothers. Mother's Group sessions are co-facilitated by a local mental health clinician and home visiting supervisor, with infant childcare provided onsite. Each mother-infant dyad then comes together with the support of their home visitor for the Mother-Infant Dyadic component of the program, which includes 45 minutes of songs, games, and nurturing, attuned care. The sessions aim to promote sensitive reading and responding to cues, expression of positive affect, and mutually enjoyable, connected interactions. Transportation is provided, and home visitors call participants and make home visits between sessions as needed. After the 15 weeks, the family continues to participate within the MIECHV program.



M-ITG individual sessions include a family session and a video replay session with the mother that engages her in identifying strengths and areas in need of further support.

Implementation

Although the efficacy of the M-ITG treatment for postpartum depression was established in an NIMH funded RCT in the UW Psychiatry Clinic, the researchers noted that its use in community settings was a critical implication for future research since community public health agencies have a broader reach, workforce, and potential for cultural congruence. The community-based model, which began in 2013 at UW-Madison, currently includes a clinical research team funded as the CDC Core Research Project of the UW-Madison Prevention Research Center paired with Wisconsin home visiting programs funded through MIECHV.

UW-Madison is currently working with home visiting programs in four Wisconsin counties, and will be engaging four more, as part of the study. Programs enter into agreements that outline responsibilities for the institutional review board (IRB), data-sharing, and other functions. Mothers and infants who are eligible to participate in the project receive home visiting services and Medicaid. They live in urban, rural, and Tribal communities in Wisconsin and, based on pilot work, are anticipated to be approximately 18% African American, 49% Caucasian, 18% Native American, 12% Hispanic, and 15% are of mixed race.

To improve competence in providing care to women experiencing postpartum depression, professional development trainings, tools, and resources were developed both for group sessions and home visits that allow home visitors to expand their confidence and competence in addressing maternal mental health and supporting mother-infant relationships. These include the M-ITG Manual,³⁶ with session guides for the groups; a Home Visitors' Resource Guide; a Mothers' Resource Guide; a Fathers' Resource Guide; as well as the Brief Parent-Child Early Relational Assessment (B-ERA) Handbook³⁷ and training materials.

The clinical research team used three methods for incorporating community and stakeholder input into the program. First, they conducted interviews and focus groups with home visitors and mothers who participated in M-ITG across its over 15-year span in community settings, with the goal of identifying cultural adaptations for implementation with diverse communities. Through these discussions, the team learned that flexibility for community-adapted materials was best, and opportunities for such flexibility was built into the M-ITG manual accordingly.

Second, the clinical research team consistently engaged the UW-Madison Prevention Research Center’s Community Advisory Board, which comprises nine organizational partners and nine community members with lived experience related to PPD and/or poverty related stressors or other maternal and child health concerns.

Third, the team used the Delphi process with 27 people, including home visiting staff and mental health clinicians who previously used M-ITG as well as clinicians and researchers with expertise in perinatal mental health, over three rounds of structured questionnaires. This was a consensus process to identify core elements of the intervention that must be retained versus elements that could be removed.

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Bringing the community to the table and really listening to them and adopting their input—not just saying thank you for your opinion—can increase community participation and support of initiatives.

**—Françoise Culley-Trotman,
National Advisory Committee Member**

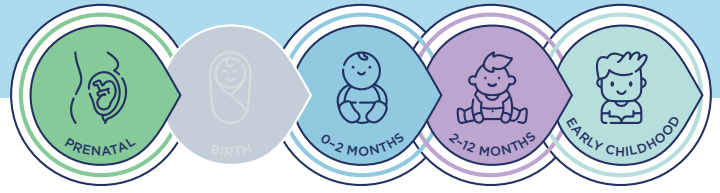
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Outcomes

The pilot study of M-ITG that was integrated into home visiting programs demonstrated a reduction in depressive symptoms and parenting stress from pre-to-post treatment. The current CDC-funded trial seeks to establish evidence to guide further implementation. Meanwhile, through collaboration with existing home visiting programs, M-ITG has successfully engaged families by embedding mental health services in a trusted system of care; reducing barriers to care; and improving access for underserved populations. Results suggest that mothers’ mental health needs can be addressed in a collaborative delivery model between community mental health clinicians and home visitors. Nevertheless, beyond the funded research program, Medicaid coverage of these mental health services, provider types, and places of service, at adequate reimbursement rates, will be important for sustainability and expansion. The Prevention Research Center’s Translational Partners Panel is exploring avenues of sustainability, including collaboration with Medicaid MCOs.

Implementation successes include significant improvements in home visitors’ confidence and competence to address maternal depression; a decrease in symptoms of depression in mothers; and enhancement of the mother-infant relationship. Obstacles that have been overcome are the provision of transportation and childcare that allow mothers to access this group. These obstacles have had important impacts on attendance rates. A remaining obstacle is that many mothers lose Medicaid coverage before they fully recover from depression.

At completion of the CDC-funded initiative, a readily adoptable dissemination/implementation package will be available, potentially supported by regional training hubs, for home visiting and community-based health care programs.



UPMC Maternal Child Home Visiting Partnership

Health Plan: UPMC *for You*

Partner(s): Multiple

Location: Pennsylvania

Pennsylvania's Department of Human Services (PA DHS) had previously required Medicaid MCOs to utilize a designated per member per month (PMPM) allocation for early childhood support to create home visiting models that incorporated evidence-based practices and the use of internal care management teams. Goals included: increased perinatal care; increased pediatric well care; increased screening for social determinants of health; increased pediatric dental care; decreased tobacco use in the home; and more.

In 2022, the state pivoted its approach and notified MCOs of a new expectation to utilize the funding to partner with the existing community-based maternal child home visiting programs across the state, including Early Head Start, Parents as Teachers, Nurse Family Partnership, and locally developed programs based in Bright Futures. In addition to offering evidence-based models, community-based maternal and child health home visiting programs are staffed by people who live in the community. They have multi-dimensional knowledge of local resources and concerns, and provide individualized services for families whom they often know already within the context of their community.

Since the new requirement was announced, UPMC *for You* has met with more than 40 maternal and child health home visiting agencies, covering every county in Pennsylvania, to learn about the needs of the maternal and child health home visiting programs and the communities that they serve. Maternal and child health home visiting programs are not mandated to enter into agreements with MCOs, but many are eager to partner, recognizing opportunities for additional funding and program integration. Nevertheless, their models are bound by specific contracts with state agencies or private funders as well as by fidelity to their respective evidence-based programs. Most have limited experience with IT security and infrastructure and do not have the current capacity to take on additional reporting requirements.

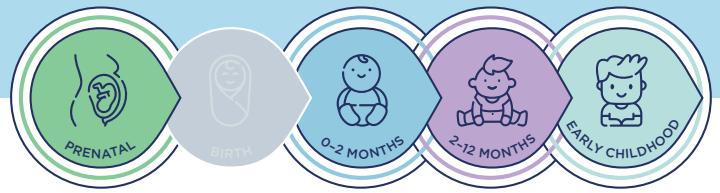
Home visiting programs offer enhanced resources that would be challenging for the health plan to tailor for each community. One rural program has two vans that bring families to events so they can gather with each other and their babies. A Parents as Teachers program provides a personalized gift for the birthing person and a book or toy for the baby.

UPMC *for You* determined that the success of this program would rely on meaningful engagement with each maternal and child health home visiting partner, including tailoring partnerships according to their unique resources and those of the communities that they serve. Existing maternal and child health home visiting programs require various funding arrangements, from fee-for-service to PMPM to staffing to stipends for

data sharing. Some maternal and child health home visiting programs require new data systems to partner with MCOs and tailored approaches to creating process and outcome measures. By gathering this feedback, UPMC *for You* mapped out multiple options for target measurement, payment structures, and divisions of responsibility with the health plan.

At the start of 2023, UPMC *for You* had 10 contracts in place, with over 20 others in development. UPMC *for You* is working toward the goal of having a home visiting partner available for health plan members in every Pennsylvania county. UPMC acknowledges the complexity of its vision and is actively working to identify common best practices with other health plan peers within the state MCO coalition. However, UPMC *for You* is prepared to manage dozens of tailored arrangements to offer members the advantages of having local home visiting programs, especially when coordinated effectively with the health plan. UPMC *for You* expects to see positive qualitative feedback from members and improved outcomes on a wide range of measures—from prenatal and well child visits to perinatal depression screening and referral; to breastfeeding, developmental screening, and family economic goal setting—as well as decreased health disparities for many of these measures.





LA County Home Visiting Medi-Cal Partnership

Health Plan: Blue Shield of California Promise Health Plan (Blue Shield Promise)

Partner(s): First 5 LA

Location: Los Angeles County, California

First 5 LA, an independent public agency, is California’s largest funder of early childhood systems of supports. In 2022, its Board of Commissioners refined its strategic plan to include a set of goals focused on systems change, and adopted a refined North Star statement that, “Every child in Los Angeles County will reach their full developmental potential throughout the critical years of prenatal to age 5.” Home visitation is the largest of First 5 LA’s direct service investments. The organization funds a network of maternal child home visiting programs serving over 22,000 clients per year, most of whom are enrolled in Medicaid. First 5 LA offers three home visiting programs: Healthy Families America and Parents as Teachers—both nationally recognized evidenced-based models—and its own program, Welcome Baby, which serves pregnant and postpartum individuals and their babies until nine months of age.

Blue Shield of California Promise Health Plan provides Medicaid coverage for approximately 3,500 births per year in Los Angeles County. Blue Shield Promise observed a need for additional prenatal supports for members living in the Antelope Valley area of Los Angeles County and identified home visitation as an opportunity to provide members with those supports. First 5 LA was also looking for ways to improve their impact by increasing enrollment in the prenatal period.

In 2019, Blue Shield Promise and First 5 LA launched a non-funded pilot project at two of Blue Shield Promise’s primary care clinics in the Antelope Valley. Clinic staff and providers offer patients who test positive for pregnancy the opportunity to be referred to home visiting programs. The clinic can then send a referral form with the patient’s information to First 5 LA’s home visiting partner. The partner then follows up with the patient to offer enrollment in home visiting and other services. This easy and direct referral path has led to increased enrollment in home visiting during the prenatal period, compared to relying solely on the typical outreach strategies of home visiting programs.

As a result of the successful pilot, Blue Shield Promise engaged First 5 LA in a funded partnership to expand the referral pilot across Los Angeles County—from one home visiting program to First 5 LA’s entire network of 28 programs. The ultimate goal is to reimburse First 5 LA through a value-based payment model. However, both organizations identified the need for an interim phase for iterative codesign of the model, particularly because the two organizations have different data systems and protocols and are governed by different sets of requirements. Blue Shield Promise supported this interim phase through a \$420,000 payor-agnostic Community Investment Agreement across First 5 LA’s home visiting programs.

First 5 LA enhanced its collection of self-reported data from program enrollees to produce aggregate data reports on Blue Shield Promise members specifically, stratified by race and ethnicity. First 5 LA demonstrated an increase in prenatal enrollment in home visiting—from 45% in 2019 to 58% in 2021. From July 2021 through March 2022, seven (7) of eight (8) of First 5 LA’s self-reported outcomes for Blue Shield Promise members improved over the previous reporting period—including prenatal, postpartum, and well-child care;

immunizations; and depression and anxiety screenings. The partners are currently using this data to develop quality targets and a pricing model for a value-based agreement expected to begin in 2023.

In developing this partnership, Blue Shield Promise and First 5 LA found it important to communicate early and often and maintain a “learning stance,” not only with each other but with health care providers, home visitors, and program participants—all of whom provided feedback during the process that shaped program development. Home visitors have expressed appreciation for having new ways to collaborate directly with health plan care management and network provider teams. First 5 LA also hosts quarterly meetings with all the MCOs in Los Angeles County so that MCOs can share information about opportunities, such as this partnership, to achieve the California Department of Health Care Services’ goal to close racial/ethnic disparities in childhood and perinatal measures by 50% by 2025.



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What’s needed for true sustainability is something that works for patients, providers, and the system.

**—Sandra Hassink, MD, MS, FAAP,
National Advisory Committee Member**

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INTEGRATING COMMUNITY IN PERINATAL AND CHILD HEALTH PROGRAM CODESIGN

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The definition of ‘community engagement’ should include involvement of community members in the design, implementation, and ongoing determination of the effectiveness of programs.

**—Andrea Palmer, MPA, MBA,
National Advisory Committee Member**

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Introduction

Between 2018 and 2021, the maternal mortality rate for non-Hispanic Black women increased annually from 37.3 to 69.9 deaths per 100,000 live births in 2021.¹ Alarming trends of racial and ethnic health disparities have raised awareness of the role that unmet social needs, implicit bias, and structural racism have on maternal and infant outcomes as well as the limits of isolated interventions to address these long-standing, interconnected factors.³⁸

Medicaid is the source of payment for 64% of births to Black mothers.³ There is increasing interest in Medicaid joining across sectors to make investments that address systemic issues and root causes by supporting the overall health of communities of color. The profiles in this section step outside of the buildings, workforce, and programs that deliver health care to innovate around the core design of policies and infrastructure governing services to these communities.

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Pathways to improving perinatal and other health outcomes through interventions that tackle interpersonal, institutional, and structural racism are not yet clearly delineated. Nevertheless, racial equity in birth outcomes cannot be achieved without first achieving equitable access to care and eliminating experiences of racism and discrimination in care settings.

**—Malini Nijagal, MD, MPH,
University of California, San Francisco**

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Lessons Learned and Advice from the Field

- Engage a **wide range of stakeholders**—including city agencies, CBOs, health plans, health care systems, and community members—with leadership by those identified in the intended goals (e.g., Black birthing people) to advance strategies that address the root causes of inequity.
- Explore partnerships for **co-location of safety net services within community settings** that are designed and managed by community members to bridge gaps in trust and increase access to health and social services.
- Innovation can be fueled by a **broadened concept of wellness** that includes areas beyond health care—such as arts and culture, workforce development, and economic opportunity—which are integral to the comprehensive wellbeing of individuals, families, and the community.
- Explore the alignment of the **human-centered design process** with program development, research, and the evaluation methods of perinatal and child health interventions as well as the development of data collection methods appropriate for community level interventions.
- Explore ways to allocate, enable, and incentivize the use of **public funding for community reinvestment** as innovative population health management strategies, and explore infrastructure development that improves health at a whole community level versus expanding interventions at the individual level.
- Consider **innovative payment models** within the Medicaid program for social determinants of health resources and community supports that address structural determinants of health.
- Explore programs, investments, and changes in governance or operations that Medicaid health plans can take to **address racial inequity at various levels** of their organization and the investments they make in communities they serve (see Table 4).

Table 4. Actions Taken by Medicaid Health Plans to Address Structural Racism or Promote Racial Equity

Actions	Small Health Plans	Medium Health Plans	Large Health Plans	All Health Plans
Programs/policies for health plan internal staff	67%	100%	100%	86%
Programs/policies for members	33%	33%	83%	48%
Changes to health plan governance or operations	22%	50%	83%	48%
Social investment with financial reserves	11%	67%	83%	48%
Programs/policies for provider groups	33%	33%	67%	43%
Programs/policies for vendors and contracting	22%	17%	50%	29%
Programs/policies for communities experiencing inequities	11%	17%	50%	24%

Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

The San Francisco Pregnancy and Family Focused Pop-Up Village



Health Plan: San Francisco Health Plan

Partner(s): University of California San Francisco (UCSF); San Francisco Human Services Agency; the San Francisco Department of Public Health; Designing Justice + Designing Spaces; and multiple community-based organizations, service providers, and local businesses

Location: San Francisco, California

Background

In 2017, a team co-led by members of the University of California San Francisco (UCSF) Department of Obstetrics, Gynecology & Reproductive Sciences and a maternity focused CBO assembled an advisory group of community members and other stakeholders to oversee a process to address suboptimal care outcomes among Medicaid-insured pregnant people in San Francisco.

They used a human centered design process,³⁹ which revealed excessive barriers to effective care. These included transportation, childcare, and interpersonal racism, ranging from overt to more subtle incidents of discrimination, such as staff leaving them waiting while attending to others. It also included systemic issues, such as lack of coordination and communication between organizations; difficulty trusting care settings because of historical and present harm inflicted on communities of color; and a lack of investment in overall health and wellbeing.⁴⁰ By the end of 2018, the team completed the first two design phases: Inspiration and Ideation, resulting in prototypes to change care delivery, including a one-stop shop for accessing pregnancy-related care and services, designed specifically for the stated needs of the community and delivered within high-need community settings. Using the PRECEDE-PROCEED implementation science framework, the UCSF team, now called SF Respect Initiative, collaborated with community-based organizations, including Designing Justice + Designing Spaces, on the implementation phase: opening the San Francisco Pregnancy and Family Focused Pop-Up Village in 2021.

The SF Respect Initiative reached out to San Francisco Health Plan (SFHP), a public, not-for-profit, Medi-Cal (Medicaid) MCO to become a collaborator in the Pop-Up Village. For SFHP, support for the Pop-Up Village was an opportunity to improve health outcomes and patient experience for a priority population within SFHP's membership that had repeatedly experienced fragmented, siloed, and discriminatory forms of care that placed a high burden on pregnant people trying to access services. SFHP decided to fund the Pop-Up Village as an investment in aligning human services delivery systems and health outcomes.

Description

San Francisco's Pop-Up Village is a monthly community event open to all but designed around the experiences and needs of Black-identifying pregnant people, including individuals currently pregnant or within 12 months postpartum, and their families. For over 18 months, the Pop-Up Village has provided access to government and public health services, clinical care, community-based support services, and activations (including a community lunch, music, dance and yoga classes, food demonstrations, sharing circles, and more) delivered as a one-stop-shop. The Pop-Up Village spans one and a half city blocks in San Francisco's Bayview District and is thoughtfully designed to create an environment that feels safe and healing, shifts power dynamics, and builds community.

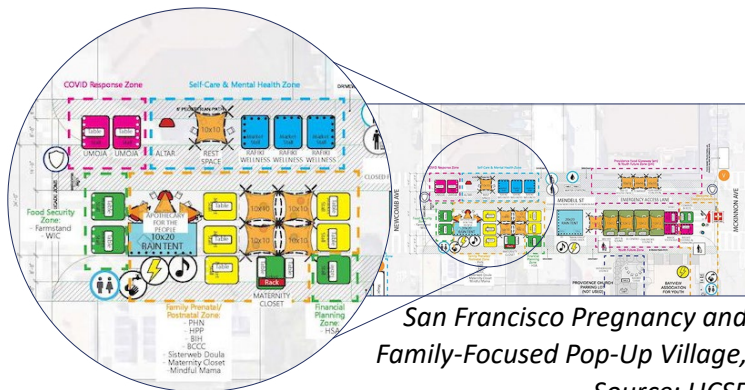
The Pop-Up Village provides infrastructure for a diverse range of cross-sector organizations to come together and deliver their services side-by-side. Anchor organizations serve as leads for each “zone” of the Pop-Up Village and work together to curate the events, provide backbone support, and secure funding. The Pop-Up Village promotes leveraging synergies, identifying gaps, and finding ways to deliver collaborative and coordinated care in an uplifting and dignified environment. Collaborators use principles of anti-racism to ensure care delivery is experienced as respectful, responsive, and community centered. Participating partners within the perinatal care ecosystem include the San Francisco Human Services Agency, three groups within the San Francisco Department of Public Health, one safety net clinic network, and 11 CBOs.



San Francisco Pregnancy and Family-Focused Pop-Up Village, Source: UCSF

Implementation

With a particular focus on Black-identifying individuals, the human-centered design process sought to identify fundamental changes needed to improve pregnancy care experience and outcomes, including access to services, respectful and safe care environments, and greater investment in comprehensive wellness. Pop-Up Village partners bring together many organizations around a shared vision to tackle structural inequities, building trust by “doing business differently,” and meeting the needs of communities through collaboration and coordination.



On the ground, the Pop-Up Village has six zones: Youth/Future; Health & Wellness; Design & Environment; Arts & Culture; Food & Agriculture, and Retail/Vendor.

The Health & Wellness zone offers onsite enrollment to public programs, such as Medi-Cal, CalFresh, and WIC. It also offers clinical services, such as drop-in mental health therapy, ultrasound, and appointment scheduling at San Francisco Health Network. Finally, it offers specific programs, such as housing support and doula services, and alternative medicine options, including herbal

medicine, massage, and acupuncture. The Youth/Future Zone is the second largest area in the Pop-Up Village, with the San Francisco Department of Early Childhood as the primary anchor, with multiple San Francisco family resource centers (all CBOs) providing childcare and developmental screening information and testing; teen resources; childcare supplies; and fun activities.

The events also include a community lunch, food prep demonstrations, organic produce distribution, artistic performances, and a live DJ. The model acknowledges that optimal health and wellness requires investment into areas beyond traditional health care, including food and agriculture, workforce development, economic opportunity and arts and culture. Through this comprehensive and community-focused model of care delivery, the Pop-Up Village strives to tackle the structural inequities that have led to disparities.

Outcomes

The initial outcome goals of the Pop-Up Village were to demonstrate the feasibility of bringing together diverse organizations, ensure high visitor satisfaction, and successfully engage Pop-Up Village service providers and visitors. During its first year, the number of core health and wellness organizations committed to providing services at each event grew from nine to 17. In its first six months there were 18 to 61 attendees per event. By the third six-month period, attendance ranged from 70 to 100, with 35% of attendees identifying as Black, and one third being pregnant or postpartum. Of 55 visitors surveyed, 81% said they learned about services for the first time at the Pop-Up Village, 60% found services easier to access at the Pop-Up Village compared to usual sites, and 96% said they would come again.

The Pop-Up Village model has proven to have widespread appeal to a broad range of stakeholders, including city agencies, CBOs, health plans, health care systems, and community members. Enthusiasm around participating in the Pop-Up Village model has been overwhelming. Staff from CBOs, city agencies, and other organizations consistently participate despite the fact that events take place on Saturdays and that there is no financial incentive for them to do so. Interviews with attendees highlighted that a) city/institutional agencies feel more approachable and less intimidating to clients when such agencies are in the same space as community partners, and b) partners have a more positive impact delivering services within an uplifting, respectful, and anti-racist environment. Centering community voices in design, strong and consistent communication, and an intentional focus on anti-racist practices have been the keys to success.

Currently in its second year of operations, the Pop-Up Village continues to build its model. Once its organizational and financing structures are codified, the Pop-Up Village will start planning to launch in a second neighborhood, with the location and services based on community input. The organizers have assembled a robust UCSF-based research team dedicated to Pop-Up evaluation. SFHP has become a multi-year funder of the implementation phase. The values and approach of the Pop Up Village are closely aligned with the state of California's CalAIM initiative to transform Medi-Cal by improving quality outcomes, reducing health inequities through a comprehensive Population Health Management (PHM) Strategy, and adopting whole person care that recognizes social drivers of health.⁴¹ CalAIM also calls for Medicaid health plans to make contributions from their annual net income toward community reinvestment.

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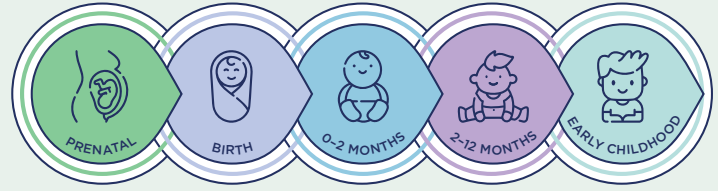
I have seen great policies passed, but when people are not able access the services created through those policies, the policies are not worth much. Anti-racist and anti-discriminatory policy development can help create safe spaces for people to access the things they need.

—Sarah Mann, JD, National Advisory Committee Member

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SNAPSHOT

California Coalition for Black Birth Justice



Health Plan: Health Net

Partner(s): UCSF Preterm Birth Initiative and Cherished Futures for Black Moms & Babies

Location: California (statewide)

Description:

In California, Black birth justice advocates supported the California Dignity in Pregnancy and Childbirth Act and the California Momnibus, and continue to develop other transformative initiatives across the state. In recognizing the absence of a mechanism to bring these efforts together, Black women leaders from the UCSF Preterm Birth Initiative and Cherished Futures for Black Moms

& Babies have established the California Coalition for Black Birth Justice (the Coalition). This coalition serves as an intentional space for Black women to co-create birth justice solutions to advance equity for Black birthing families in California, exclusively defined and vetted by Black community members and experts. The Coalition co-founders and strategic advisors of this initiative all have lived experience as Black birthing people, birth justice advocates, clinicians, doulas, and researchers. Institutions across different sectors (e.g., clinical care, policy, education, research, etc.) can access this coalition, fostering a sustainable, cross-disciplinary collaboration to address the many layers of birth equity.

We imagine a California that invests in Black women’s leadership, innovation, and collaboration in order to reduce racial birth inequities.

Health Net, a California Medicaid health plan, provided funding to develop the strategic plan to culminate in two outcomes:

- the formation of the Coalition itself, and
- a California Black Birth Justice Agenda with actionable recommendations.

With Health Net’s support, the Coalition for Black Birth Justice kicked off a series of strategic planning sessions with key partners and advisors to inform the statewide collaborative priorities and structure. The Coalition will begin mobilizing partners across the state around the actions in the agenda and deepen their work with health care organizations.

COORDINATING CARE TO ADDRESS MATERNAL OPIOID USE

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It is crucial to support the maternal-infant dyad during this important time in the health of the child and the mother.

**—Sandra Hassink, MD, MS, FAAP,
National Advisory Committee Member**

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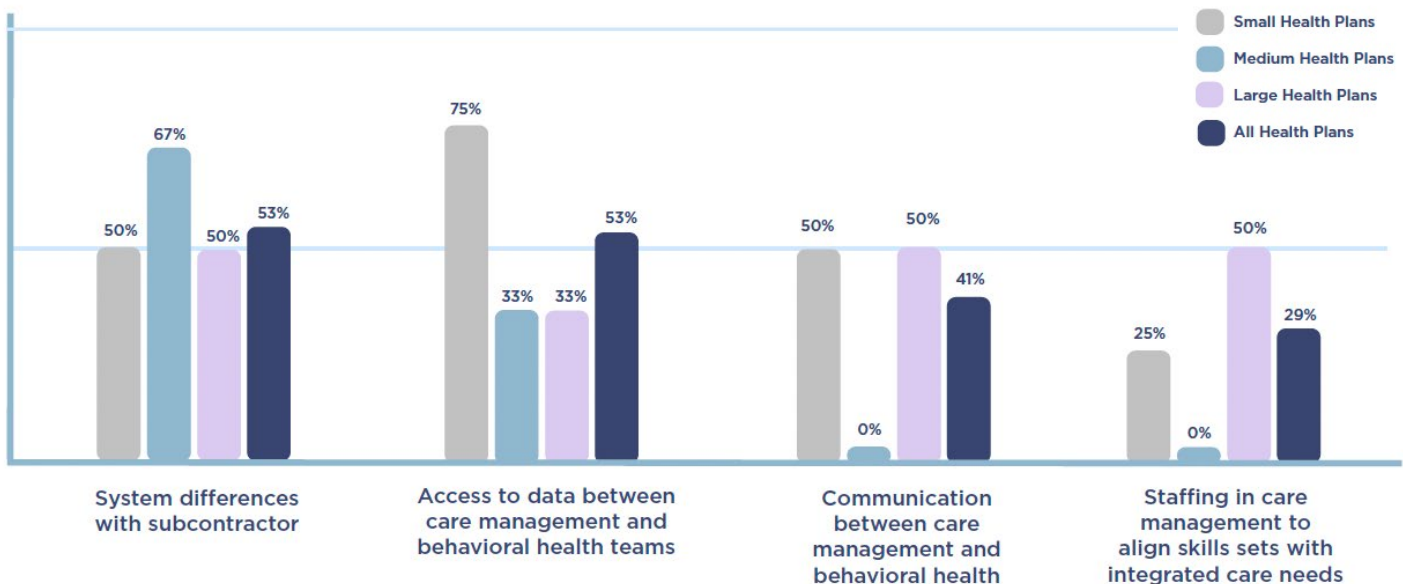


Introduction

Maternal opioid use disorder (OUD) and neonatal abstinence syndrome (NAS), a postnatal withdrawal syndrome in newborns, have increased nationally and across all demographic groups.⁴² Medicaid programs have the greatest opportunity to address the chronic condition of substance use disorder (SUD) in perinatal and child health, since Medicaid is the largest provider of health care coverage for pregnant people, infants, and families. Maternal OUD presents one of clearest opportunities to apply the concept of dyadic care, as opioid use directly impacts both physical and psychological factors in the maternal-infant relationship. Profiles in this section explore how two Medicaid MCOs have invested resources to address these opportunities within their perinatal care coordination programs, reflecting the growing national priority to address this issue.

The CMS Innovation Center MOM model is an important initiative to provide context for these and other initiatives addressing maternal OUD and NAS. The MOM model was launched as a next step in CMS’s multipronged strategy to support federal efforts to combat the opioid crisis. The MOM model supports approaches that foster “coordinated and integrated care”⁴³ for pregnant and postpartum people with opioid use disorder and their infants. The CMS Innovation Center awarded grants to eight states to implement the MOM model with care delivery partners. Among these partners were CBOs as well as health systems and payers who provided physical and behavioral health care, including medication-assisted treatment (MAT) through innovations in care coordination and service integration.⁴³ The experience of Medicaid programs and partners in these states will serve as a crucial source of information and guidance for efforts nationally.

Figure 6. Medicaid MCOs' Operational Barriers to Behavioral and Physical Health Integration



Source: Institute for Medicaid Innovation. “2022 Annual Medicaid Health Plan Survey.”

Lessons Learned and Advice from the Field

- Explore ways to increase the **integration of individuals with lived experience and experience treating substance use disorder** into and in support of perinatal interdisciplinary care teams, including prenatal and behavioral health providers, care management program staff, doulas, lactation support, peer recovery specialists, and community health workers (see Figure 6).
- Explore policy-driven incentives to **expand the MAT workforce** and services for the perinatal population.
- Partner with CBOs to engage individuals with substance use disorder and **address social determinants of health** as part of SUD program engagement.
- Identify ways to link the **guiding principles of substance use disorder recovery** to inform care management program design.⁴⁴
- Monitor findings from the multi-state **CMMI MOM Model** initiative to inform the ongoing development of other programs addressing maternal opioid misuse and NAS.
- Align **program evaluation models** across local and Medicaid managed care initiatives with broader research and evaluation—such as the CMMI MOM model to accelerate data-informed and evidence-based program implementation.
- Expand the evidence-base for interventions designed to address opioid use disorders among pregnant and postpartum people and infants.⁴⁵
- Explore opportunities to **align Medicaid MCO contracts with state/county public health strategies** as well as multi-sector collaborations, such as CMMI MOM model programs, to achieve public health goals.
- Bring together Medicaid stakeholders to identify additional **education and flexibility needed regarding CFR 42 Part 2 regulations** to facilitate siloed components of treatment and data sharing.
- Continue to identify the opportunities for **texting and telehealth flexibilities** to accelerate access to and engagement in substance use disorder recovery.
- Consider ways to **support high-risk care coordination** through data sharing opportunities at the state level (see Figures 6 and 7).

Figure 7. Data State Medicaid Agencies Could Provide to Help Medicaid Health Plans Better Administer High-Risk Care Coordination



Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."



Health Plan: Healthy Horizons in Florida

Partner(s): Southern Birth Justice Initiative; March of Dimes Miami-Dade County Birth Equity Collaborative; Azalea Project, Healthy Start; and others

Location: Florida (statewide)

Background

As the CMS Innovation Center’s MOM model is implemented across eight states through 2024, the call for innovation elsewhere remains urgent. Florida is not a MOM model state. However, it is one of six states with mandatory NAS reporting within 30 days of birth, which provides frequently updated data on this population health indicator. In response to rising opioid use and its risks for pregnant and postpartum people, their infants, and families, Florida’s Agency for Health Care Administration set contractual goals for its Medicaid managed care organizations to address NAS. In 2019, Humana Healthy Horizons in Florida launched a specialized NAS prevention program, within its overall HumanaBeginnings[®] program, which connects expectant mothers with experienced, maternity registered nurses who provide education, support, and guidance throughout pregnancy and the postpartum period. The NAS program invests in specialized care management staff, including field care managers and partners, with selected hospital systems that have a shared focus of improving standardization of care and maternal and infant outcomes.

Description

The goals of the program are to help pregnant and postpartum members who have OUD to utilize MAT; achieve full-term pregnancies; utilize postpartum contraception, including long-acting reversible contraception (LARC); and prevent and shorten NICU admissions for NAS or other reasons. Eligible program participants are identified through monthly reports that flag claims for pregnant and postpartum Medicaid members ages 12 to 51, of all races, ethnicities, and languages, who indicate opioid/other drug or alcohol misuse; prescriptions for either opioid medications or opioid abuse treatment; or have given birth to a child with NAS.

A specialized SUD nurse care manager works with field care managers to provide individualized support to facilitate access to community resources, SUD/behavioral health (BH) services, and prenatal and postpartum care. The specialized care manager typically begins the relationship at pregnancy, which continues through approximately 12 weeks postpartum. However, the program can start at any point the member is willing to participate and can continue through one year postpartum. The care managers work to engage members in services, including prenatal care, social work, behavioral health treatment, and nutrition services.

Implementation

Specialized care managers with experience in SUD treatment are key to the program design. Humana determined that this professional background, plus the desire to specialize in this work, are critical for successfully engaging members. Care managers communicate with members in a non-judgmental way to develop rapport, allowing them to deliver accurate information while addressing difficult topics. This enables members to both open up to program staff as well as stay engaged throughout the program. Humana began

with two specialized care managers and expanded the team to four; each has experience working in SUD treatment programs for pregnant people. They also have expertise in the resources available in their state regions and develop and maintain relationships with community treatment partners. In 2022, the program added field care managers who are also nurses and support the HumanaBeginnings® program by visiting members at home, hospitals, and at other community locations. In 2023, community health workers were added as additional field staff who specialize in connecting members to community resources. The specialized NAS program care manager serves as the member’s primary “go-to” resource and point of coordination for field staff. Humana hires care managers and field staff who speak Spanish and Creole and share the cultures of many members and communities in Florida.

Care managers frequently utilize a secure video conferencing platform that Humana introduced during the COVID-19 pandemic. The platform is now widely used, especially for the team working with members with OUD, and is well-received within the HumanaBeginnings® program. The team employs outreach and engagement strategies throughout the full perinatal continuum and is poised to support members whenever they are ready to engage. However, staff increasingly received feedback from members that they wanted to communicate by text, preferring to avoid phone conversations, often requesting, “can you just text me that information?” In response, Humana committed to a multi-month process involving their texting vendor and their health plan’s legal, privacy, and compliance teams to fully enable this option, which will go live in April 2023.

Humana has been building its network provider team to better care for pregnant and postpartum members with OUD. They expanded their partnerships with providers who prescribe MAT during pregnancy and are actively working to increase prenatal providers’ collaboration with MAT prescribers. The specialized care managers facilitate collaborative efforts at the member level, and Humana continues to develop approaches at the network level.

Using funding that is not earmarked solely for health plan members, Humana Health Horizons in Florida provided grants and developed partnerships with community-based organizations that help pregnant and postpartum individuals receive culturally accessible care and/or address challenging social determinants of health. In addition, their teams develop relationships with organizations to coordinate resources for members. Community partners include:

- The Southern Birth Justice Initiative
- The March of Dimes Miami-Dade County Birth Equity Collaborative
- The Azalea Project
- Multiple state collaborative groups

Teams from Healthy Start programs across the state are included in interdisciplinary care team meetings. Through this collaboration, members access needed resources, such as car seats and cribs, and receive referrals to other resources for food, housing, and transportation.

Outcomes

The state sets annual NAS/1,000 goals. In 2019–2020, Humana Healthy Horizons in Florida was meeting state NAS/1,000 goals in five of 11 regions; as of 2022 it met or exceeded them in 10 regions. In the region where the program is not yet reaching the target, Humana’s rate of NAS has continued to decrease.

Successful completion of the prenatal and postpartum program is recognized when the member is actively engaged with care management, attends both prenatal and postpartum appointments, and meets the prenatal and postpartum care plan goals. If a member only enrolls upon delivery, successful completion is recognized when a member is actively engaged with care management and attends a postpartum visit, between six to 12 weeks after delivery. Partial program completion is also recognized when members are still engaged with care management and health care services, even if they do not attend a postpartum appointment.

Program outcomes have improved (see Table 5) because of multiple enhancements, including added field staff; collaborations with hospitals that allow staff to visit members immediately after delivery; increased community partnerships; more members accessing doula services as a Medicaid benefit; and word of mouth between members who report hearing that “Humana sends someone out to meet you.”

The program team is now using reports on other service utilization, including MAT, behavioral health services, and LARC use. They have not yet set targets for these metrics but are tracking and trending the data to identify opportunities to improve comprehensive care for their members.

Humana is focusing on several aspects of the program to continue to improve outcomes and increase engagement to support members:

- Recruiting care managers who have experience in SUD treatment and cultural congruence as program staff is critical to the success of the program.
- Gaining collaboration with hospitals to allow care managers to visit members onsite while they are inpatient, since in-person engagement can be the most effective facilitation of comprehensive care, especially at times of transition episodes of prenatal, postpartum, and inpatient care.
- Increasing the number of MAT providers.

Table 5. HumanaBeginnings® NAS Program Case Completion 2020–2022

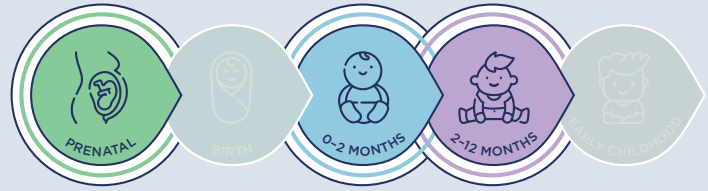
	2020	2021	2022
Prenatal case completion	59%	78%	76%
Postpartum case completion	58%	74%	80%

Note: NAS = neonatal abstinence syndrome.

Source: Humana Healthy Horizons in Florida

SNAPSHOT

HumanaBeginnings® Continuation through 12-months postpartum



Health Plan: Humana Healthy Horizons in Florida

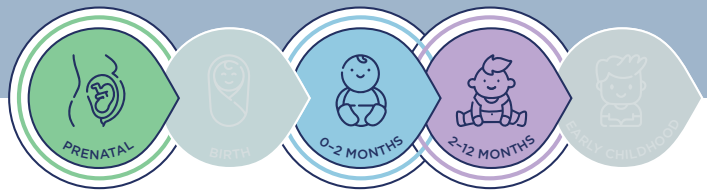
Location: Florida (statewide)

Description:

In July 2022, when Florida implemented extended Medicaid coverage through 12-months postpartum, Humana extended its perinatal care management program, HumanaBeginnings®, to all interested new members for the full coverage period. In addition to collaborating with behavioral health (BH) providers, OB/GYN providers, and NICU/pediatrics providers, care managers coordinate with community resource providers, such as Healthy Start and WIC. They also coordinate with other Humana programs, such as Healthy Behaviors, lactation consultants, and weight management; and with Humana disease management programs for HIV, hypertension, diabetes, hepatitis, sickle cell, and serious mental illness. HumanaBeginnings® sends health education materials, such as the Centers for Disease Control and Prevention’s HEAR HER campaign, which seeks to raise awareness about urgent maternal warning signs during and after pregnancy.



Source: CDC



Collaboration with Firefly, Tennessee’s MOM Model

Health Plan: Amerigroup, Tennessee, Inc. (Elevance Health)

Partner(s): Multiple

Location: Middle Tennessee

Firefly, Tennessee’s MOM model, is a patient-centered service delivery program that aims to improve quality of care for Medicaid-enrolled, Middle Tennessee pregnant and postpartum individuals who have OUD and their infants. The program is led by Tennessee’s Medicaid program, TennCare, and Vanderbilt University Medical Center, the primary care delivery partner.⁴³

Amerigroup Tennessee, Inc. (Amerigroup) is one of the state’s Medicaid managed care organizations. It identifies eligible participants through near real time (NRT) data about pregnant and postpartum members from claims for MAT prescriptions, behavioral health services, and treatment of NAS. Amerigroup provides a care coordination program in collaboration with the specialized treatment providers of comprehensive obstetric and well-woman care; mental health and substance use disorder treatment; and pediatric care, including NAS treatment and lactation services.

Amerigroup noted that the Firefly program has amplified the resources available for members who too often struggle to access respectful and timely health care. Many of the services provided to Firefly participants are considered standard Medicaid benefits, but with Firefly Amerigroup has experienced a higher level of engagement with and coordination of the behavioral health component than in other partnerships. Firefly lead agencies initiated quarterly collaboration meetings with partners, at which Amerigroup’s executive director of behavioral health represents the health plan. In addition, Amerigroup meets with Firefly partners’ care teams. The health plan led a process of adapting these interdisciplinary care team meetings into extended “rounds” that serve as individualized care conferences and ensure care coordination handoffs between the MCO and Firefly.

Firefly has implemented a data sharing process that provides health plans with monthly reports about member engagement. Amerigroup plans to incorporate this data into expanded analyses of program opportunities and outcomes. Amerigroup also established its own reports and ongoing tracking of members’ programmatic milestones (see Table 6).

The CMS Innovation Center is utilizing a flexible, mixed-methods evaluation design of the MOM model and has already produced an interim report highlighting key program activities and features as well as the early successes and challenges of each state’s program. Firefly has been recognized for its co-located service model; its use of process maps to link services to program outcomes; and its data collection and reporting efforts, which are anticipated to support sustainability models with managed care organizations.^{20,43} Amerigroup is committed to actively collaborating with the Firefly MOM model program to improve outcomes for its pregnant, postpartum, and infant members affected by OUD.

Table 6. Amerigroup Members in Firefly as of November 2022

Outcomes	Number
Ever enrolled	66
Disenrolled	35
Currently enrolled	31
Babies born to members	37
Number diagnosed with NAS	6
Graduated	4

Note: NAS=neonatal abstinence syndrome. Source: Amerigroup Tennessee, Inc. (Elevance Health)

INVESTING IN HIGH-QUALITY PERINATAL AND CHILD HEALTH CARE

“

Providers are asking for quality measures that go beyond national rankings in HEDIS and identify more meaningful ways to assess quality.

**—Françoise Culley-Trotman,
National Advisory Committee Member**

”



Introduction

Prenatal-to-age-three quality frameworks are evolving beyond a limited set of perinatal and child measures;⁴⁶ however, wide-scale innovation in performance improvement programs has lagged. Medicaid MCOs, state Medicaid programs, and perinatal quality collaboratives have flexibility to implement initiatives and measure quality across various domains, but it is challenging to scale these programs—and their payment levers—broadly enough to move the needle on population health outcomes. This section profiles a national Medicaid MCO performance improvement program and two state Medicaid programs that scale up investments in high-quality perinatal and child health care. Table 7 provides additional information about factors that would support the implementation of value-based payment and/or alternative payment models for Medicaid MCOs.

Table 7. Changes to State Requirements and Guidance That Would Assist Medicaid Health Plans to Effectively Implement VBP and/or APMs

Changes	Percentage of Health Plans
Better education for providers on state and health plan expectations	79%
Reporting of consistent metrics	68%
More flexibility in the design of VBP components (e.g., member attribution, benchmarking)	47%
Removal of data sharing restrictions	47%
Provision of additional policy and/or fiscal levers for MCOs to ensure provider engagement in VBP models	42%
Policies to facilitate data sharing between payers and providers	42%
Streamlined VBP design across payers, including aligned performance measures	42%
Better education for health plans on state expectations for VBP	37%
Removal of requirements that limit VBP and APM model development	37%
Development of a multi-year proposed VBP strategy to allow for longer term contracts with Medicaid	32%
Multi-payer alignment in VBP strategies	32%

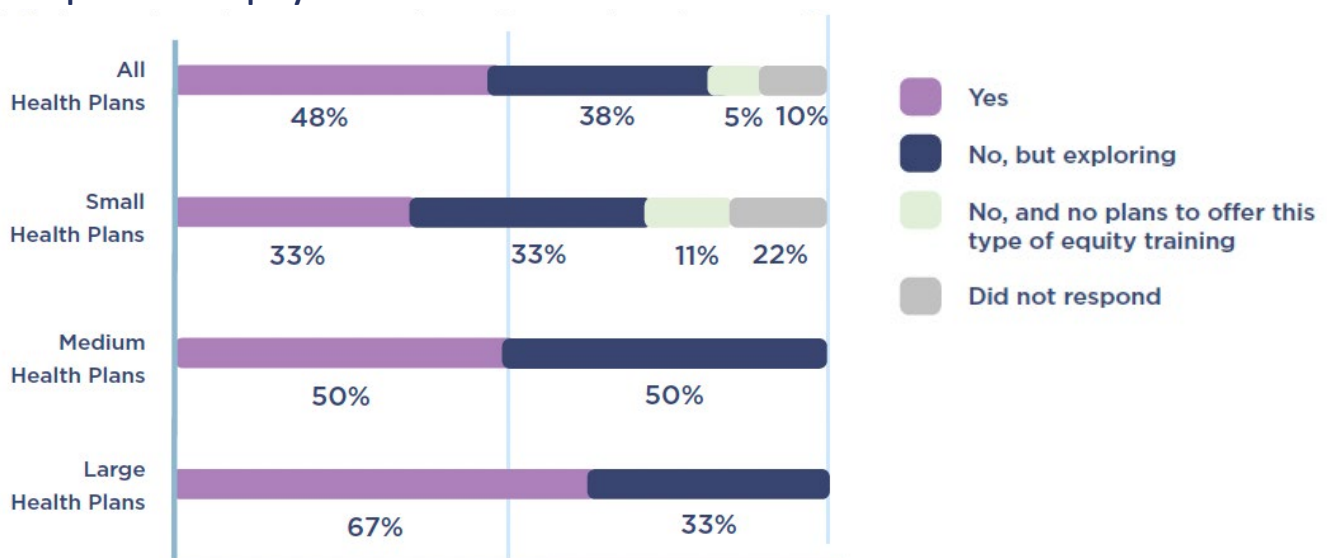
Note: APM = alternative payment model; VBP = value-based payment.

Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

Lessons Learned and Advice from the Field

- Consider **prioritizing perinatal and child health populations** within managed care population health strategies.
- Identify ways to support specialty care providers with **streamlined access to interdisciplinary clinical, community, and health plan resources**, including at the level of accountable care organizations or practice associations.
- Explore **roles for Medicaid enrollees to inform and shape strategies** used by quality improvement teams.
- Explore the impact of **implicit bias and anti-racist training** investments across provider networks and Medicaid managed care teams (see Figure 8).
- Perform analyses to examine **disaggregated data on specific racial and ethnic subpopulations** to inform improvement strategies.
- Evaluate pregnant and postpartum individuals' **perceptions of quality improvement initiatives**.
- Explore opportunities to incentivize **alternative payment models for prenatal and postpartum care** to drive investment in perinatal quality improvements, including improvement of health equity goals.
- Bring together Medicaid stakeholders to explore how **expanded Medicaid coverage and benefits** can advance both managed care and provider quality improvement investments.
- Consider leveraging Medicaid **performance improvement programs** to prioritize perinatal quality measures and address health disparities within perinatal subpopulations to improve health equity.
- Explore ways to best **integrate Medicaid managed care organizations** into state-based maternal morality review committees (MMRCs) and perinatal quality collaboratives (PQCs).

Figure 8. Percent of Medicaid Health Plans Providing Maternity Focused Training to Providers or Partners to Improve Birth Equity



Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

Specialty Provider Enablement Program



Health Plan: Elevance Health

Location: 24 markets

Background

Elevance Health provides health coverage for 420,000 births in the United States each year, with 47% of these covered by Medicaid. Across Elevance Health's state plans, its network obstetricians, midwives, and family practice providers were unaware of key resources that are in place to support them in caring for pregnant and postpartum members. Limited bandwidth and expertise hindered provider service associates from prioritizing engagement with obstetric (OB) providers, leaving them unclear about health outcomes for their practice populations as well as about the availability of programs to help close gaps in care. Outreach to health plan members to drive meaningful change and timely interventions was insufficiently coordinated.

To address these gaps, Elevance Health identified an opportunity to increase clinical collaboration with network OB providers. The Specialty Provider Enablement Program (SPEP) was launched to increase awareness of available maternal/child programs, such as Medicaid covered doula services; and health plan resources, such as health plan wellness programs; as well as to enhance engagement with quality metrics and incentives to improve care for members.

Description

The SPEP program deploys nurse clinicians who have obstetric practice experience as OB practice consultants (OBPCs) to provide one-to-one practice level support for network maternity care/obstetric providers. This provider-facing initiative allows OB practices to have a clinical liaison with expertise in their specialty; to offer support through data-sharing and action planning for improvement; and to discuss best practices to ensure that members are receiving high quality, evidenced-based care. OBPCs collaborate with OB providers and office administrators through in-person and virtual touchpoints as often as necessary and, at minimum, quarterly. Reports identify and prioritize provider offices and practices with high-volume deliveries and quality improvement needs.

The OBPC services are paired programmatically with Elevance Health's OB quality incentive program, which allows high-performing OB providers to receive enhanced reimbursement based on key birth outcomes, HEDIS® measures, and other metrics. The incentive program and its metrics are updated annually. OBPCs offer participating providers consistent, transparent feedback and data, and they share best practices to support OB providers in achieving their targets. Since its inception in 2016, the SPEP model has expanded to include 24 Medicaid markets (see Figure 9) and serves close to 2,500 providers.

Implementation

The maternal child health division of Elevance Health's enterprise population health department launched the SPEP program in 2016. It launched initially as a site-visit based model, employing OBPCs who lived in the states or areas where their assigned maternity care providers worked. Like the major shift to telehealth in clinical care during the pandemic, the SPEP program also pivoted to virtual face-to-face visits between OBPCs and OB providers and their office staff. This was extremely well-received by providers and actually

increased the frequency of engagement. The need for OBPCs to have local knowledge also increased during the pandemic as they joined forces with care management teams within the state health plans to identify resources for members who faced increasing basic needs and health care access issues. OBPCs met with community partners and ensured that health plans stayed connected to community trends, priorities, and initiatives that were relevant to OB providers and members. From that point forward, the OBPC team has continued to support providers (virtually and in person) and served as a liaison for partnerships between the health plan and local community-based programs for the perinatal population.

OBPCs are the main point of contact for OB providers. As clinicians, OBPCs knowledgeably navigate across the complexity of managed care when providers identify barriers in getting needed treatment for their patients. Since they are experts in everything related to OB quality metrics—from the billing codes used to capture care to the resources available to support members in getting care—OBPCs deliver dashboard data through actionable discussions. OB providers reflect back to the OBPCs their clinical concerns about hitting targets and their own priorities in providing evidence-based care. These conversations allow the OBPCs, as a team, to coalesce network feedback on the development of custom prenatal and postpartum quality measures and to support OB providers during the launch phase of new measures.

As part of this process, and under Elevance Health’s equity strategy, the program will seek to address disparities in postpartum morbidity and mortality in the upcoming year. OBPCs will support the rollout of a new measure focused on postpartum care for Black mothers with hypertension. OBPCs will share screening tools and educational materials to increase providers’ awareness regarding early identification and intervention for Black pregnant and postpartum members at high-risk. The OB quality incentive program has already incorporated an aligned measure. Dashboard data will include racial and ethnic breakouts on rates for metrics with significant racial and ethnic disparities, such as preterm birth.

To grow as champions of equity, since 2021, OBPCs (as well as all maternal child member-facing staff) are required to complete an implicit bias training and incorporate it into their quality improvement role with OB providers. Elevance Health also provides this training, which includes continuing medical education credits, for network OB providers who figure in the top 500 by volume of deliveries. All providers have access to the “Promoting Birth Equity” training module, another implicit bias training opportunity that is made available through each health plan’s provider webpage. As a further enhancement, the March of Dimes Implicit Bias training will be available to providers, OBPCs, and OB case managers in 2023.



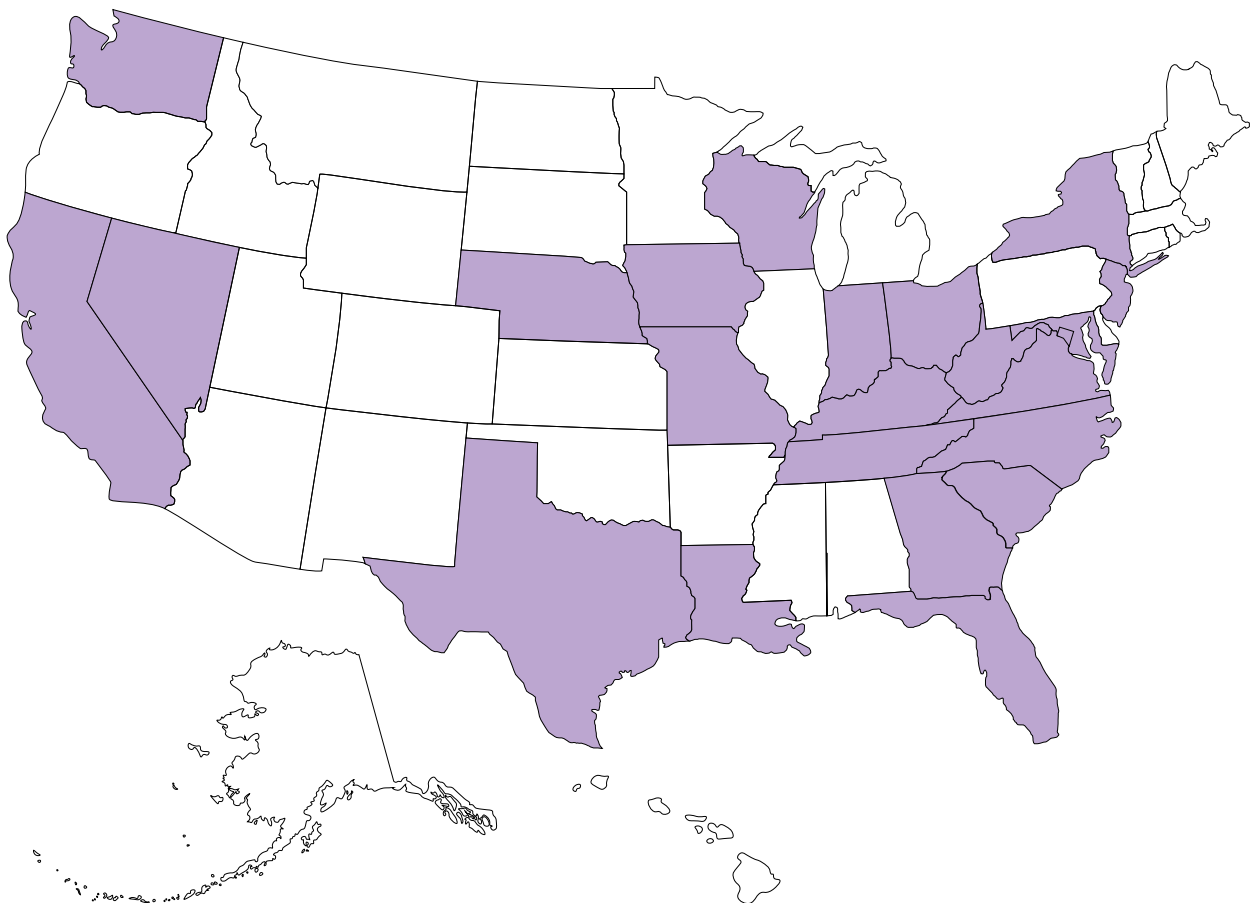
Outcomes

The evaluation of the SPEP model has shown favorable clinical outcomes and positive participant feedback. As a result of the initiative, OB providers report having an improved experience with the health plan. The program has grown rapidly, adding 19 new OBPCs to the team in 2022. OBPCs have also largely eliminated the use of the health plan's toll-free support number by OB practices.

Elevance Health used its Advanced Analytics team to conduct two formal evaluations of SPEP in October 2020 and September 2021. The evaluation demonstrated that for Medicaid enrollees, by 2021, there had been a 19% decrease in low-birth weight rates; a 14% favorable impact on overall adequacy of prenatal care; a 9% reduction in primary c-section rates; a 91% increase in postpartum visit compliance; a 22% increase in vaginal birth after cesarean rates; and a 5% savings in total birth costs since 2019. Elevance Health plans to further analyze its evaluation data in the context of policy levers such as extension of postpartum Medicaid coverage. Results from the 2022 evaluation will, for the first time, include data broken down by race and ethnicity to inform future efforts to improve health equity.

Program feedback collected from OB providers ensures that the program is meeting provider needs and helps assess what changes have been implemented into their practice. When surveyed about the value of the SPEP model, providers spoke about the importance of the OBPC role in linking staff, providers, patients, and insurance, to help them meet their goals and manage OB patients.

Figure 9. 24 Markets Where the Specialty Provider Enablement Program is Operating



SNAPSHOT

Predictive Modeling Enhancement to Pregnancy Identification and Risk Assessment



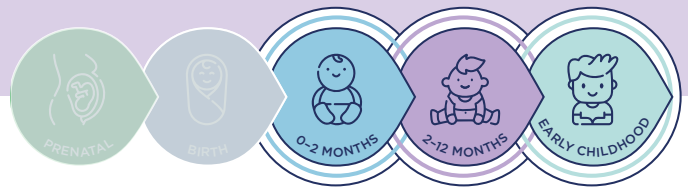
Health Plan: Elevance Health

Location: National

Description:

In 2021, Elevance Health’s predictive modeling algorithm was enhanced with additional prenatal diagnoses and data beyond physical health to identify pregnant members with increased risk for operative delivery and/or a newborn admitted to the NICU. These enhancements have resulted in a greater than 10% increase in the number of high-risk members who are directed to care management services. Once members are identified, they are paired with a nurse case manager who collaborates with them, their providers, and their support systems on areas of self-care and health care, such as nutrition and blood pressure monitoring. Members are also connected to local community-based supports, including doula and community health worker services. Ongoing predictive modeling throughout the pregnancy identifies emerging risks over time, prompting earlier interventions with the goal of improving health outcomes and reducing health disparities.





Medicaid Coverage of Dyadic Care

Pilot Health Plans: Anthem Blue Cross and San Francisco Health Plan

Pilot Partners: California Children’s Trust and University of California, San Francisco

Organizations: California Department of Health Care Services, Medi-Cal managed care health plans in California, New York State Department of Health, and Medicaid managed care plans in New York

Location: California and New York

An emerging focus in Medicaid is the two-generation approach to health care, which recognizes that the health and well-being of parents and caregivers and their children are inextricably linked.⁴⁷ In perinatal and child health, dyadic care specifically refers to a set of services delivered to “parents or caregivers and their children together, targeting family wellbeing as a mechanism to support healthy child development and mental health.”⁴⁸ Dyadic services range from screening caregivers for risks that affect children’s health, to helping families gain access to health-related services such as safe housing, to psychoeducational services to help all members of the family achieve optimal mental health and resilience.⁴⁹ “Simply put, dyadic approaches to mental health means supporting parents to support their babies.”⁵⁰

The prototype for primary-care-based dyadic services is the three-tier HealthySteps program,⁵¹ though other programs and approaches also exist. Dyadic approaches are, at their core, practical in design as they build on the existing, almost universal infrastructure of well-child care. Families, including those enrolled in Medicaid, interact with the health care system the most frequently during the first three years of their child’s life. Dyadic care is a supportive enhancement to well-child care that leverages the unique periodicity of the well-child visit—and the unique relationship between clinician and patient that those visits generally reflect.⁵²

Because Medicaid coverage and benefits are tied to individual enrollees, a call has been made for innovation in Medicaid reimbursement for two-generation approaches and dyadic care. Both the child and caregiver may not be covered by Medicaid, and even if they are, reimbursement may be through separate payors, including the state, health plans, or care coordination or accountable care entities.

In San Francisco, the Children’s Health Center HealthySteps program led a pilot Medicaid reimbursement model for dyadic care between November 2020 and June 2022. Covered under this pilot were dyadic behavioral health (DBH) services to support family well-being, healthy child development, and mental health provided to families with children under age five.⁵³ Services were provided by the integrated behavioral health team of the Children’s Health Center at Zuckerberg San Francisco General Hospital and Trauma Center and were reimbursed by the two Medi-Cal health plans serving San Francisco County: Anthem Blue Cross and San Francisco Health Plan. The pilot was supported by a grant to the University of California, San Francisco Center for Child and Community Health from the Stupski Foundation and financial consultation from the California Children’s Trust through contributions from the Zellerbach Family Foundation, the David and Lucile Packard Foundation, and Genentech, a member of the Roche Group.

The pilot implemented new billing and coding strategies, including use of health and behavior assessment and intervention codes, use of behavioral health prevention codes, and allowance of *International Classification of Diseases, Tenth Revision (ICD-10)* Z codes for well-child visits to enable reimbursement of the services. During the billing pilot, more than 1,300 dyadic encounters were captured, an additional 10% beyond typical annual

primary care visits (N = 12,595), for the empaneled population. Researchers noted that these encounters were likely undercounted by approximately 30% because electronic medical record data reporting infrastructure was also being developed as part of the pilot. More than half of the dyadic encounters were provided to children younger than 12 months.⁵⁴⁻⁵⁵

After the successful pilot and concurrent advocacy efforts, the California Department of Health Care Services announced its change in policy to include dyadic services in the Medi-Cal program statewide. Effective January 1, 2023, the department requires all Medi-Cal managed care health plans to provide DBH services, including DBH well-child visits, comprehensive community supports services, dyadic psychoeducational services, dyadic family training and counseling for child development, and dyadic parent or caregiver services. Medi-Cal enrollees under age 21 and their caregivers are eligible. Eligible providers include a wide range of behavioral health clinicians and certain providers and nonclinical staff rendering services under a supervising clinician. Family therapy that does not require a mental health diagnosis also became a Medi-Cal benefit phased in between 2020 through 2023, including therapy for couples when it benefits the health of the child.^{49,56}

Effective April 1, 2023, the New York State Medicaid program also expanded benefits to allow for reimbursement of services to prevent childhood behavioral health issues. The change allows for use of *ICD-10* code Z65.9 (problem related to unspecified psychosocial circumstances) to justify medical necessity for prevention-based individual, group, and family therapy services—including psychotherapy without patient present. New York State Medicaid managed care plans must accept the Z65.9 code to allow for reimbursement of psychotherapy services when provided by qualified Medicaid-enrolled providers to Medicaid members younger than 21 years.⁵⁷

For more than 30 years, dyadic care models have been primarily supported through grant funding by government, philanthropic, and other entities.⁵⁸ Medicaid fee-for-service reimbursement is a step toward other payment options through Medicaid, including alternative payment models. It is also a significant step toward sustainable, broad-scale investments in provision of and increased access to the prenatal-to-age-three model via the firmly established systems of well-child care as well as integrated models of primary and behavioral health care.

“

*If we do not allocate resources to support prevention and health promotion efforts to target families who are pregnant and who have young children, it will be impossible to move beyond the status quo of a health care system that reacts only when pathology is detected.*⁵⁰

**—Kate Margolis, PhD, University of California,
San Francisco Weill Institute for Neurosciences**

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Conclusion

This report examines ways Medicaid health plans have incorporated a health equity lens and community partnerships into their perinatal and child health initiatives. Perhaps more importantly, it demonstrates how community-centered models provide new opportunities for Medicaid partners to advance health equity by following their lead.

Codesign of culturally congruent models, addressing both social and health needs, has unique potential to address root causes of perinatal health disparities. Innovation is the implementation of initiatives that leverage existing models or imagine new ones to yield better outcomes and experiences. From these initiatives can emerge an ideal combination of high-value, evidence-based care plus authentic partnerships to lay new foundations for birth equity.

To successfully implement Medicaid initiatives in perinatal and child health, Medicaid MCOs and state Medicaid agencies must sound the call and act on the urgency to prioritize birthing families within Medicaid. The initiatives in this report demonstrate that innovation and positive momentum are fueled by collaborations between Medicaid stakeholders; a sustained action orientation supports initiatives to develop into best practices.

Clinical, research, and policy opportunities provide a guide for starting and scaling these interventions to meet their expressed needs and informing strategic investments. Resources are critical to elevate the significance of the perinatal and child population. Ultimately, keeping pregnant and postpartum people, infants and children, their families, and their communities positioned in the center of the health equity lens can improve overall population health.

Glossary

- **Community-based doula:**
A doula who is a trusted member of the communities they serve and who often offers services at low to no cost to the recipient. Community-based doulas often provide an expanded set of services over the private-pay doula, including connecting individuals with community resources and increasing the number of home visits pre- and postpartum.⁵⁹
- **Community health worker (CHW):**
“A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.”⁶⁰
- **Culturally congruent care:**
Care designed and delivered in agreement with the preferred cultural values, beliefs, worldview, and practices of the health care consumer and other stakeholders. The addition of linguistically congruent means that the care is provided in the preferred language of the health care consumer.⁶¹
- **Doula:**
A nonclinical support worker who provides continuous emotional, informational, and physical support for individuals before, during, and after labor. This includes explanations and guidance on medical procedures, lactation support, physical comfort measures during labor, education on coping skills and infant care, and encouragement of bodily autonomy and personal advocacy in the medical institution.⁶²
- **Dyad:**
In perinatal and child health care, the term “dyad” does not merely refer to two individuals, parent and child; it refers to the parent-child unit and relationship. Although the Greek etymological root dy- means two, “dyad” is defined as two individuals who are in a relationship⁶³ and “one thing that consists of two parts.”⁶⁴
- **Dyadic care:**
Care provided to the parent or caregiver together with the child.

- **Equitable reimbursement for doula services:**

A combination of:

- » the “reimbursement rate provided to doulas for serving Medicaid enrollees must allow them to effectively provide the physical, social, and emotional support that is at the core of their work. Specifically, the payment amount and structure must account for the realities of the number of clients that a doula can serve in any given month or time period.”⁶⁵

and

- » a “sustainable living wage sufficient to attract, support, and retain the doula workforce to provide care.”⁶⁵

- **Evidence-based home visiting programs:**

These are maternal and child health home visiting programs that meet the US Department of Health and Human Services (HHS) criteria for evidence-based models.⁶⁶

- **Health equity:**

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification. “Health equity” or “equity in health” implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.⁶⁷

- **Maternal and child health home visiting:**

This “includes models identified as evidence-based and others that offer a series of home visits to families during pregnancy and early childhood by trained staff, typically of at least one year duration and under a structured curriculum or formal protocols.”⁶⁸

- **Prenatal-to-age-three framework:**

This recognizes the importance of focusing effort on the earliest years of childhood, inclusive of the prenatal time period, as they have a profound impact on lifelong health and well-being.

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