INSTITUTE FOR MEDICAID INNOVATION

A Blueprint for Improving Maternal and Infant Health Outcomes Under Medicaid

Recommendations from the 2023 Maternal Health Policy Equity Summit

About the Institute for Medicaid Innovation

The Institute for Medicaid Innovation (IMI) is a national 501(c)3 nonprofit, nonpartisan research, policy, and community power building 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.

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.

To remain relevant and responsive to the evolving needs of the Medicaid population, IMI 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 does not lobby or advocate and is not a membership-based or trade association.

About Elephant Circle

Inspired by elephants who give birth within a circle of support, Elephant Circle envisions a world where all people have a circle of support for the entire perinatal period. To achieve this, we practice strategies for tackling systems of power and oppression and strategies for change and resilience, with community-based expertise in health systems, legal systems and the perinatal period. We bring an intersectional, feminist, anti-racist, reproductive justice, design-thinking approach to this work.

Elephant Circle's work is organized into three areas that are interconnected and work together to address the disconnection and exposure to harm that people experience in the perinatal period: community power, public health law and advocacy, and movement building. Our community power work is about building power among those most marginalized during the perinatal period, meeting people where they are and increasing their capacity for attuned support and protective defense. This work includes community organizing, relationship building, birthworker trainings and direct cash assistance. Our public health law and advocacy work addresses legal and policy issues that can promote health and wellbeing in the perinatal period impacting multiple generations at once. This work includes individual legal services and consultation, and state-based national policy work. Our movement building work strives to increase innovation in the field by supporting infrastructure for emerging projects and ideas, especially those that are community-based and led by people who are directly impacted.

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1250 Connecticut Ave, Suite 700, Washington, D.C. 20036

Published in the United States of America in 2024
by the Institute for Medicaid Innovation

Printed in the United States of America

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This report was guided, informed, and reviewed by the participants of the 2023 Maternal Health Policy Equity Summit held in Washington, D.C. They represent a diverse group of Medicaid policy thought leaders and change agents in perinatal and maternal health, as well as individuals with lived experience and community members, who are committed to improving maternal health outcomes in the U.S. and ensuring health equity in the structure and delivery of health services in achieving that goal.

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Thank you to our funders:

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Robert Wood Johnson Foundation

The Commonwealth Fund

Summit Partners

the David & Lucile Packard FOUNDATION

PERIGEE fund

Skyline FOUNDATION

Esther A. & Joseph Klingenstein Fund
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PRITZKER Children's Initiative

W.K. KELLOGG FOUNDATION

Summit Collaborators

THE BURKE FOUNDATION

FUNDERS FOR BIRTH JUSTICE & EQUITY

California Health Care Foundation

JEWISH HEALTHCARE FOUNDATION

AmeriHealth Caritas
Care is the heart of our work

MERCK for Mothers

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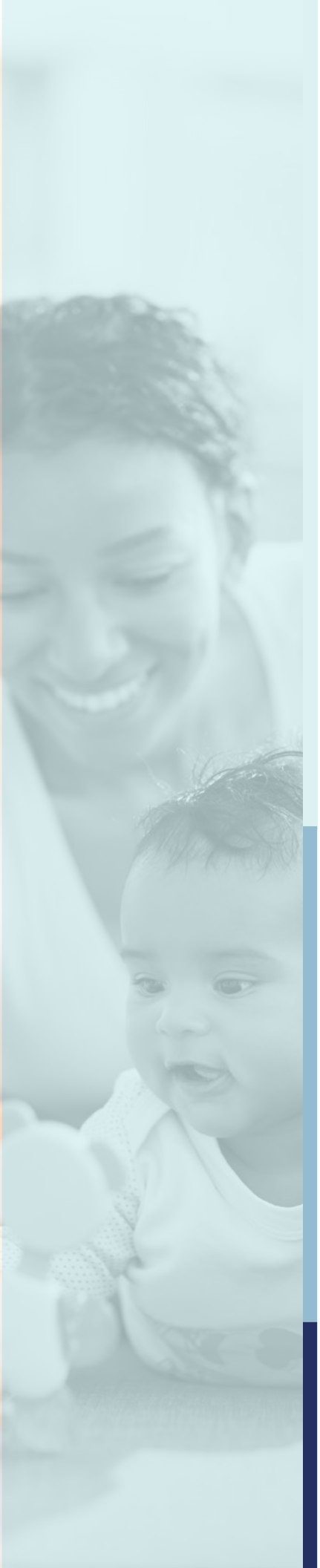
aetna

community health acceleration partnership

IRVING HARRIS FOUNDATION



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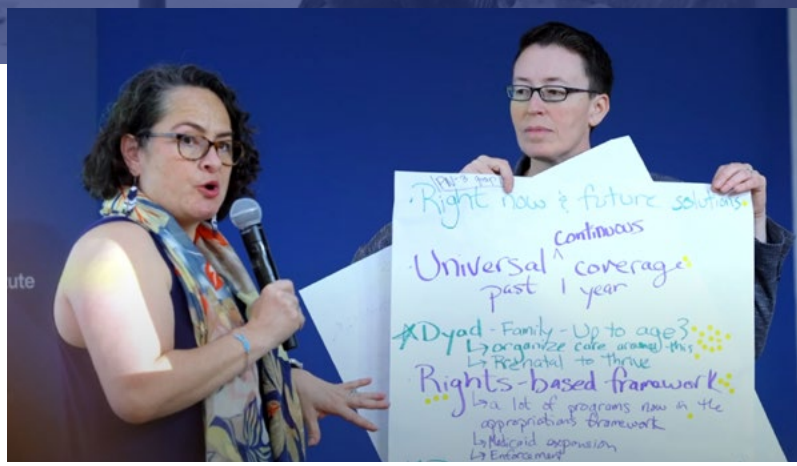
Executive Summary

As federal and state policymakers seek to improve maternal and perinatal health outcomes, policies such as community-based models and an extension of 12-month postpartum coverage have been implemented. The Medicaid program will serve an important role in implementing these innovative changes, including evaluation of health outcomes, assessment of the economic impact, and establishment of strategies to support sustainability. To continue this momentum and with the support of several national foundations, the Institute for Medicaid Innovation convened a two-day summit on Medicaid maternal health equity policy as the first step in the development of such a plan. The event was hosted by the Aspen Institute in Washington, D.C. and held in Fall 2023.

To inform the focus of the summit, a national survey was completed and four Medicaid maternal health-related priority topics were identified. Representatives at state and federal agencies, Medicaid health plans, and national maternal child health leaders (n=348) took the survey and individuals with Medicaid insurance coverage and community-based workers (n=23) participated in a focus group.

An issue brief and background papers on each of the four priority topics were developed to provide foundational knowledge to all summit participants. All issue briefs can be accessed using the following links:

- → Women, Gender, & Maternal Health Priority Topics in Medicaid
- → Maternal and Perinatal Mental Health
- → Doulas and Perinatal Community Health Workers
- → Midwifery-Led Model of Care
- → Prenatal-to-3



Presentations during the summit offered both federal and state perspectives on Medicaid maternal and perinatal health policy. Stories were also heard from individuals about their personal experience with the Medicaid program during their pregnancies and postpartum periods. From all this emerged six guiding pillars that, in turn, guided the development of five Big Ideas that represent the first stage of establishing a **National Strategic Medicaid Maternal Health Agenda**. The **Five Big Ideas** include:

1. **Build, Support, and Sustain the Workforce**
2. **Integrate Services and Systems Across Settings and Sectors**
3. **Collect the Right Data and Make It Open Source**
4. **Establish the Foundation for a Family-based Continuum of Care from Preconception-to-age 3**
5. **Learn from and Build on Emerging Ideas at the Community and State Levels**

Using existing policy levers at the local, state, and federal levels, these **Five Big Ideas** can be translated into actionable steps. Together, the summit participants are committed to continuing efforts as part of a national agenda to improve the maternal and perinatal health outcomes in this country.

Introduction

Medicaid plays a critical role in the health of low-income, reproductive-aged (ages 15-49) women. More than 31 million women are covered through Medicaid, approximately 75% of whom are of reproductive age (CDC, n.d.). Nearly half of all births in the United States are covered by Medicaid, with the share in each state ranging between 20% and 71% (MACPAC, 2020). Pregnant people enrolled in Medicaid face significant challenges obtaining the high quality, evidence-based care that is most likely to yield favorable outcomes. The majority of births in the United States are low- to medium-risk and appropriate for high-value, evidence-based models of care, such as midwifery-led care and freestanding birth centers. Yet the majority of pregnant people enrolled in Medicaid currently do not have access to or coverage of these models of maternity care (Alliman & Phillippi, 2016; National Institute for Health and Care Excellence, 2015). Underutilization of appropriate care models is a problem that confronts all women in the United States, but it places a particular burden on those enrolled in Medicaid. Medicaid enrollees are unable to purchase their own way into alternative or preferred care models. They are likely to have less choice in selecting their providers, settings for care, or health systems than their commercially insured counterparts. They are also less likely to be able to pay for services that fill gaps in care, like more comprehensive childbirth education classes or lactation support. Fortunately, there are opportunities to improve access and coverage to high-value, evidence-based maternal models of care—such as midwifery-led care and doulas—for all people, including those with Medicaid coverage. While these models will not eliminate by themselves inequities and injustices in Medicaid policies, health systems, or communities, the models offer an important counterbalance that has been shown to improve birth outcomes. Furthermore, they offer culturally congruent, person centered, respectful, and high-quality care that pregnant people of color are understandably demanding and need (Black Mamas Matter Alliance, 2018).

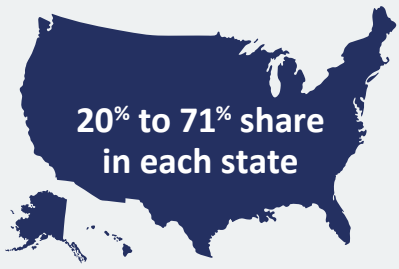
By the numbers

31+ million

women covered through Medicaid

~75% covered women reproductive-aged (15-49)

U.S. births covered by Medicaid



Black and Hispanic women are more likely to be uninsured or have Medicaid coverage, have limited or no access to midwifery-led care, lack community-based support such as doulas, deliver at a hospital with worse quality of care, face individual-level stressors such as racism in the clinical setting, or be affected by the accumulation of such discrimination, racism, and stressors over their lifetimes (Howell et al., 2020; Martin et al., 2018). In one analysis of 14 states, an estimated $114 to $214 million ($148 to $278 in 2023 adjusted for inflation) in savings to Medicaid would be realized if racial and ethnic disparities in maternal outcomes, such as rates of preterm birth, preeclampsia, and gestational diabetes, were reduced (Zhang et al., 2013). Therefore, any effort to understand and address the inequities in maternal and perinatal health must include a focus on Medicaid, the role it has played, and the role it can play in the future.

There is growing political interest in addressing these unacceptable outcomes through improvements to the Medicaid program, including community-based models of midwifery and doula care, and extension of 12-month postpartum coverage. As federal and state policymakers consider opportunities to improve outcomes, they have been exploring a myriad of options, including community-based models of midwifery and doula care and an extension of 12-month postpartum coverage. As policies are adopted and payment models are created, the Medicaid program will serve an important role in implementing these innovative changes, including evaluating health outcomes and assessing economic impact and sustainability. Although various efforts are underway in virtually every state, a national strategic agenda for maternal health under Medicaid—designed to link all stakeholders and partners—is necessary to meet the national goal of healthy maternal outcomes for all. With the support of several national foundations, the Institute for Medicaid Innovation convened a two-day summit on Medicaid maternal policy as the first step in the development of such a plan. The event was hosted by the Aspen Institute in Washington, D.C., and held in Fall 2023.

To inform the focus of the summit, a national survey was completed by representatives at state and federal agencies, Medicaid health plans, national maternal child health leaders (n=348) and a community focus group with individuals with Medicaid insurance coverage and community-based workers (n=23) to ascertain the priority topics as identified by key stakeholders in Medicaid: federal and state policymakers, Medicaid health plans, national and state leaders, and most importantly, individuals with lived experience. The results of the investigative work identified four Medicaid maternal health-related priority topics:*

- maternal mental health
- doulas and perinatal community health workers
- midwifery-led models of care
- prenatal care and coverage to age 3

Based upon this feedback and in preparation for the summit, an issue brief and background papers on each of the four priority topics were developed to provide foundational knowledge for summit participants. All issue briefs can be accessed using the following links:

- → Women, Gender, & Maternal Health Priority Topics in Medicaid
- → Maternal and Perinatal Mental Health
- → Doulas and Perinatal Community Health Workers
- → Midwifery-Led Model of Care
- → Prenatal-to-3

In addition to this information, presentations during the summit offered both federal and state perspectives on Medicaid maternal health policy. Stories were also heard from individuals about their personal experience with the Medicaid program during their pregnancies.

From all this emerged six guiding pillars that, in turn, guided the development of five Big Ideas for advancing policy and improving maternal health outcomes under Medicaid. These Big Ideas represent the first stage of establishing a **National Strategic Medicaid Maternal Health Agenda**.

*The topic of sexual and reproductive health was identified as a top priority by survey respondents. It was decided to dedicate a potential future summit exclusively on that topic and focus this summit on the other priority topics identified.

The Institute for Medicaid Innovation (IMI) recognizes that transgender and nonbinary people become pregnant or seek perinatal health care services. In response, IMI is committed to creating resources that are gender inclusive and affirming, limiting gendered language and only using such terms when specified in Medicaid requirements, statutes, policies, research publications, and database variable names. As such, IMI's resources use both gender inclusive and affirming terms but also gender-specific terms like "women/woman" and "maternal."

Background on Medicaid Maternal Health Policy

Federal law requires all states to provide Medicaid coverage to pregnant women with incomes up to 133% of the federal poverty level (FPL) and allows states to extend that coverage to other low-income pregnant women (Adams et al., 2003; Gifford et al., 2017). The FPL in 2023 for a family of three (in the 48 contiguous states and District of Columbia) was $24,860 in annual income (HealthCare.Gov, n.d.). Across the states, eligibility FPL levels for pregnant women range from a low of 138% in Idaho and South Dakota to a high of 380% in Iowa. Two-thirds of the states (n=35) cover pregnant women at or above 200% of the FPL (KFF, 2022). The median income eligibility limit for pregnant people was 205% of the FPL in 2022 (HealthCare.Gov, n.d.).

In 1965, the time Medicaid was enacted, eligibility for the program was limited to individuals receiving cash assistance (also referred to as welfare), which did not include pregnant women. Not until 1986 did federal Medicaid policy explicitly extend coverage to include pregnant people and infants living in poverty, and in 1988, this coverage became mandatory. In 1989, Medicaid coverage was expanded again to include pregnant people and children under age six with incomes up to 133% of the FPL (CMS, 2015). There has been no change in the federal FPL criterion for pregnant individuals in the last 30 years.

Despite gradual expansion of federal Medicaid eligibility rules to include pregnant individuals, as well as the formal separation of Medicaid eligibility from cash welfare, states have adopted heavy paperwork requirements, frequent eligibility redeterminations, confusing and inaccessible application processes, and work requirements to constrain enrollment in a handful of states. Nonetheless, state flexibility, a legitimate value that promotes program design and administration that reflects local circumstances, is a defining feature of the Medicaid program.

The Public Health Services Act Section 2706, within the Affordable Care Act (ACA), provides that health plans cannot discriminate against any licensed or certified provider, including certified midwives, certified nurse midwives and certified professional midwives. The ACA also includes provisions related to freestanding birth centers under Section 2301, requiring all states with licensed or otherwise state-approved birth centers to cover birth center services under Medicaid. However, Medicaid coverage of maternity services from nonphysician providers such as midwives is difficult to access, and coverage of out-of-hospital births such as at freestanding birth centers, varies by state (Gifford et al., 2017).

History of Medicaid Eligibility

- **1965** **Medicaid enacted** — Eligibility limited to individuals receiving cash assistance
- **1986** Coverage extended to include pregnant people and infants living in poverty
- **1988** Coverage made mandatory
- **1989** Coverage expanded to include pregnant people and children under six with incomes up to 133% FPL
- **2024** No changes in federal FPL criterion

Medicaid Financing and Delivery

Medicaid is administered by the states and territories operating under federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The program is jointly financed by federal and state governments. Federal contributions are defined by the Federal Medical Assistance Percentage (FMAP), which reimburses states for 50% to 82% of the state's Medicaid expenditures (Medicaid.gov, n.d.). The formula provides higher FMAP rates to states with lower per capita income and lower FMAP rates to states with higher per capita income. Certain populations and services have separate federal payment levels. For example, family planning services are reimbursed 90% by the federal government. Although federal Medicaid laws set broad standards for coverage and benefits, many program components are optional and at the states' discretion, such as provider payment rates and the use and structure of managed care.

Pregnant individuals with Medicaid coverage typically receive care in private solo or group practices, Federally Qualified Health Centers, and hospital outpatient clinics. These services generally are paid for through capitated managed care arrangements or fee-for-service, depending on the state. In the past three decades, the trend among state Medicaid agencies has been to contract with managed care organizations (MCOs) with the rationale of presumed cost savings, improved access, coordination of services and supports, and continuity of care. MCOs are responsible for managing cost, utilization, and quality for individuals receiving benefits from their health plan. The Medicaid program represents a delegation of networks and benefits administered by the state through risk-based, capitated, per member per month payments to the MCO. In other words, when state Medicaid agencies contract with MCOs, the network and benefits administered by the state are delegated through risk-based, capitated, per member per month payments to the MCO. Many uninsured people become eligible or are presumed eligible and are first enrolled in Medicaid as a condition of their pregnancy. After confirming the pregnancy, the provider may help enroll the eligible individual in the Medicaid program. If the state requires it and the provider participates, individuals may also enroll in an MCO that will cover their services through the state-defined postpartum period. As of December 2023, 41 states including the District of Columbia have implemented extension of postpartum coverage to one year postpartum. The adoption of this policy may be the fastest national uptake of a state Medicaid option in the history of the program, showing the opportunity and potential of states to be innovative and responsive to the needs of families. The states that have not extended coverage often end postpartum care 60 days after the birth of the child; at that point enrollees may continue to qualify for Medicaid under non-pregnancy related standards. However, many do not quality for non-pregnancy Medicaid and will lose coverage.

As of December 2023, 41 states including the District of Columbia have implemented extension of postpartum coverage to one year postpartum. The adoption of this policy may be the fastest national uptake of a state Medicaid option in the history of the program, showing the opportunity and potential of states to be innovative and responsive to the needs of families.

Barriers to Equitable Coverage and Access

Despite relatively comprehensive covered services, pregnant people enrolled in Medicaid face barriers accessing high-quality care early in pregnancy and in the postpartum period due to a variety of factors, including eligibility and coverage gaps and unmet social needs.

"Churn," defined as a pattern of disruption in insurance coverage, has a direct impact on pregnant individuals enrolled in Medicaid (Sommers et al., 2016). Before widespread implementation of 12-month postpartum coverage, approximately 55% of individuals with Medicaid coverage at delivery experienced a coverage gap in the following six months (Daw et al., 2017; See

also Daw et al., 2020). Gaps in care limit access to postpartum services, including essential mental health screening and treatment and family planning and results in later prenatal care initiation, not having a provider until the time of pregnancy, and reduced control of comorbid conditions. As a result, individuals experiencing churn may have an increased risk of postpartum complications and missed opportunities for care that could affect future pregnancies. Avoiding churn and providing continuous Medicaid coverage during the postpartum period, commonly referred to as the fourth trimester, is critical to avert poor outcomes for both the postpartum parent and infant. While most states now have 12-month postpartum coverage, gaps remain due to single-encounter postpartum care models, limited postpartum visits, and a lack of coordination of care.

Avoiding churn and providing continuous Medicaid coverage during the postpartum period, commonly referred to as the fourth trimester, is critical to avert poor outcomes for both the postpartum parent and infant.

Unmet social needs, including environmental, and socioeconomic, often compounded by stigma and bias, affect a pregnant individual's ability to access perinatal health care. A study examining experiences of pregnant Black women found that three categories of factors were barriers to accessing care (Mazul, Ward, & Emmanuel, 2017). The first included structural factors such as challenges obtaining and maintaining Medicaid coverage, identifying clinicians who accept Medicaid, and having reliable and affordable transportation to and from medical appointments. The second encompassed psychosocial stress, including relationship or legal challenges, lack of social support, and experiences with racism. The third factor was attitudes and perceptions. Ambivalence about the pregnancy and not finding value in the medical appointments are examples of attitude factors (Gadson, Akpovi, & Mehta, 2017). Group prenatal care models, such as Centering Pregnancy®, and community-based maternal models of care, such as doula support, are designed to improve patient education and provide social support with the potential to address some of these unmet social needs (Cunningham et al., 2017; Craswell, Kearney, & Reed, 2016; Institute for Medicaid Innovation, 2020; Bohren et al., 2017; Sama-Miller et al., 2018). Group prenatal and community-based models are particularly effective in reducing preterm birth among low-income Black women (Carter et al., 2016; Ickovics et al., 2007), yet most individuals enrolled in Medicaid are unable to access services provided by doulas and perinatal community health workers due to lack of coverage for these services. Other studies examining the experiences of pregnant people with substance use highlighted significant barriers to harm reduction and substance-use related services (Weber et. al., 2021; Wolfson et. al., 2021; Stone, 2015). Given the impact of unintentional overdose on rates of maternal mortality, this population also warrants special consideration that goes beyond the scope of this report.

We are at the early stages of a comprehensive understanding of the interplay among health equity, churn, and unmet social needs on health outcomes, especially in the Medicaid population (Institute for Medicaid Innovation, 2019). While each of these barriers to high-quality, equitable care needs to be addressed individually, these challenges reinforce themselves and must be tackled in a holistic, intersectional way that requires significant changes in current Medicaid policies. The summit provided an opportunity to bring together thought leaders and change agents to develop the blueprint to tackle these issues and outline the opportunities to collectively advance the work.

Guiding Pillars

The six guiding pillars that guided the development of Five Big Ideas for advancing policy and improving maternal health outcomes under Medicaid included:

1. Medicaid policies and programs need to be accessible, equitable, and accountable to all individuals and families enrolled in the Medicaid program.
2. Adherence to federal antidiscrimination laws ensures racism and other forms of discrimination are not barriers to improving maternal and infant health outcomes.
3. Care should be coordinated from preconception through at least age 3 of a child and include licensed providers other than physicians.
4. All current laws, regulations and policies related to maternal health care—both federal and state—should be fully enforced and, as appropriate, expanded and enhanced.
5. The partnership of individuals with lived experience is central to the work of improving U.S. maternal and infant health outcomes.
6. States are the incubators of innovation and the starting point for improvements in maternal health policies and practices.

Five Big Ideas

Building upon these six guiding pillars, the summit produced **Five Big Ideas** to launch the development of a **National Strategic Medicaid Maternal Health Plan Agenda**.

Big Idea 1

Build, Support, and Sustain the Workforce

While existing policies allow for the integration of high-quality and evidence-based clinicians like licensed/certified midwives, and community-based support providers like community-health workers, and doulas, these providers are not well integrated into or supported in the perinatal care workforce and are too few in numbers. Similarly, the number of available perinatal mental health clinicians who accept Medicaid insurance is insufficient to meet the current and growing demand. Additional and targeted efforts are needed to build, support, and expand the existing workforce. The scope of practice restrictions and exclusionary payment models should be eliminated to facilitate inclusion and integration of the full workforce. Investment in educational pathways for clinicians and community-based workers is needed to meet the current demand for family medicine physicians, licensed/certified midwives, and doulas. Sustainable and equitable reimbursement, along with effective administrative support, is essential to build the workforce. Furthermore, recruitment, training, and retention of Black, Indigenous, immigrant, and multi-lingual clinicians and providers of all types will be key for individuals enrolled in the Medicaid program to have access to culturally congruent care.

Big Idea 2

Integrate Services and Systems Across Settings and Sectors

Individuals and families enrolled in the Medicaid program need all clinicians and providers to coordinate care across all systems, since lack of integration is disruptive and confusing to families, can lead to missed opportunities for care, and contributes to poor outcomes, including maternal and infant mortality. Structural barriers, including racism and bias, often contribute to a lack of integration. Coordination strategies must also address these barriers. In addition to coordination specific to perinatal and child health, physical and behavioral health services and systems need to be integrated across settings and sectors. Furthermore, health systems, payers, payment systems, and their corresponding technology also need to be integrated to support optimal coordination.

Big Idea 3

Collect the Right Data and Make It Open Source

Access to relevant data is critical in understanding the various aspects of poor maternal health outcomes, addressing the causes, and monitoring progress. This requires supporting data collection that is accurate, comprehensive, and aligned with goals that are person-centered, including the consistent collection of data such as race, ethnicity, sexual orientation, disability, and gender identity. The data should be generated by, available to, and accessible to multiple stakeholders. And they should be "open source," that is, data are free from bias, informed by those most impacted, not proprietary, and available in a format that allows anyone to use it. As access to data improves, it will also be important to address concerns around privacy and consequences of sharing information (e.g., criminal liability of individuals who seek care for substance use).

Big Idea 4

Establish the Foundation for a Family-based Continuum of Care from Preconception-to-age 3

Dyadic (parent/child) care that supports the perinatal period (pregnancy through 24 months postpartum) and infant to age three is foundational for health and wellness across the lifespan; not only for the pregnant person but also their children and family, including partners, caregivers, and elders. While the existing infrastructure for care has not been intentionally designed to support such a foundation, it can and should be. Family medicine physicians play an important and pivotal role, especially in rural areas, in supporting the continuum of care from preconception-to-age 3. Designing family-based care for the whole family across a multi-year time span that includes preconception and extends for multiple years, regardless of the outcome of pregnancy, is critical. Designing with and for families who face the biggest barriers and challenges will ensure an optimal foundation for all.

Big Idea 5

Learn from and Build on Emerging Ideas at the Community and State Levels

Innovations in maternal health care need not wait for action at the federal level. Promising efforts can and should be implemented—and, as appropriate, scaled up—at the local and state levels. There, they can be integrated and evaluated more quickly and in a way that is more responsive to the specific local context while also being more aligned with the needs and insights of the people most impacted. It will be equally as important to elevate community and state level ideas to the national level to support shared learning. This approach will develop a wider range of possible solutions across the country and can stimulate development of new programs and strategies in other communities and state Medicaid programs. State Medicaid programs have the power to be responsive to their communities and should use their authority to develop and implement evidence-based programs.

Policy Opportunities

Using existing policy levers at the local, state, and federal levels, these **Five Big Ideas** can be translated into actionable steps. The tables set out to provide examples of specific strategies for each Big Idea. However, the tables are not exhaustive of the breadth and depth of strategies that were identified during the summit, but rather provide a glimpse of tangible strategies and policy opportunities.

Big Idea 1
Build, Support, and Sustain the Workforce

Policy Opportunity 1

Ensure equitable and sustainable reimbursement for all doulas.

→ Examples

MACPAC and **ASPE** released two comprehensive reports on outlining training and payment needs to create an equitable and sustainable doula workforce.

In December 2023, CMS announced the new **Transforming Maternal Health (TMaH) Model** to: 1) increase access to care, infrastructure, and workforce capacity; 2) support quality improvement and safety; and 3) center efforts around whole-person care delivery during the perinatal period.

→ Policy Levers

State Legislature: Direct the State Medicaid Agency to equitably reimburse doulas.

State Medicaid Agency: Create equitable reimbursement rates for doulas.

Medicaid Health Plans: Create equitable reimbursement rates in contracts.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

MACPAC:
Doulas in Medicaid

ASPE:
Doula Care and Maternal Health

Transforming Maternal Health (TMaH) Model:
Model Overview

Big Idea 1
Build, Support, and Sustain the Workforce

Policy Opportunity 2

Increase the number of doulas providing services for those with Medicaid insurance coverage, including financial resources to support comprehensive training.

→ Examples

In **California**, Los Angeles County is preparing to launch the new Doula Hub.

New Jersey's "doula guides" are Medicaid staff who help doulas enroll and obtain an NPI number.

Ohio has created a streamlined application for doulas and home visitors looking to enroll as Medicaid providers using a centralized provider credentialing hub.

MACPAC and **ASPE** released two comprehensive reports on outlining training and payment needs to create an equitable and sustainable doula workforce.

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→ Policy Levers

State Legislature: Direct the State Medicaid Agency to seek a waiver or state plan amendment.

State Medicaid Agency: Provide waiver or state plan amendment.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

California:

LA Expands Doula Access

New Jersey:

NJ Doula Care Benefit

Nurture NJ Project

Community Doula Stakeholder Meeting

Ohio:

Centralized Credentialing

OH Doula Services

Centralized Credentialing Update

MACPAC:

Doulas in Medicaid

ASPE:

Doula Care And Maternal Health

Transforming Maternal Health (TMaH) Model:

Model Overview

Policy Opportunity 3

Increase the number of **certified peer specialists and therapists** to provide behavioral and mental health care.

→ Examples

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→ Policy Levers

State Legislature: Direct the State Medicaid Agency to seek a waiver or state plan amendment.

State Medicaid Agency: Provide a waiver or state plan amendment.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

Transforming Maternal Health (TMaH) Model:
Model Overview

Big Idea 1
Build, Support, and Sustain the Workforce

Policy Opportunity 4

Ensure Medicaid coverage of all licensed/certified midwives.

→ Examples

22 states cover other midwives in addition to certified nurse-midwives.

In addition to certified nurse-midwives:

- **California** covers licensed midwives and certified professional midwives.
- **D.C.** covers certified midwives and certified professional midwives.

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→ Policy Levers

State Legislature: Direct the State Medicaid Agency to reimburse clinicians and providers.

State Medicaid Agency: Add clinicians and providers as reimbursable.

Medicaid Health Plans: Add clinicians and providers to the network.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

California:
Nurse-Midwives: Scope of Practice

District of Columbia:
Reimbursement for Certified Professional Midwives or Certified Midwives

Transforming Maternal Health (TMaH) Model:
Model Overview

Policy Opportunity 5

Ensure equitable and sustainable reimbursement for all licensed/certified midwives.

→ Examples

28 states + D.C. provide reimbursement for certified nurse midwives under Medicaid at 100% of the physician rate.*

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→ Policy Levers

State Legislature: Direct the State Medicaid Agency to equitably reimburse all clinicians and providers.

State Medicaid Agency: Create equitable reimbursement rates for all clinicians and providers.

Medicaid Health Plans: Create equitable reimbursement rates in contracts for all clinicians and providers.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

Connecticut:
Rate Increase for Certified Nurse-Midwife and Podiatrist Services

District of Columbia:
Medicaid Physician and Specialty Services Rate Methodology

New Mexico:
Provider Policies for Health Care Professional Services

Transforming Maternal Health (TMaH) Model:
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*Data are not currently available about the rate of payment for other midwife credentials

Big Idea 1
Build, Support, and Sustain the Workforce

Policy Opportunity 6

Accelerate equitable access to community-based and midwifery-led birth centers.

→ Examples

Support initiatives to diversify the midwifery workforce, such as those from the **Burke Foundation** and the **University of Illinois**, as well as the **Midwives for MOMS Act of 2023** (H.R. 3768).

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→ Policy Levers

State Legislature: Direct the State Medicaid Agency to prioritize or incentivize birth centers and licensed/certified midwives.

State Medicaid Agency: Prioritize or incentivize birth centers and licensed/certified midwives.

Medicaid Health Plans: Prioritize or incentivize contracts with birth centers and licensed/certified midwives.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

New Jersey Burke Foundation:
Building a Strong and Diverse Perinatal Workforce for New Jersey

University of Illinois Melanated Midwives:
Melanated Midwives

Midwives for MOMS Act of 2023:
S. 1851: Midwives for MOMS Act of 2023

Transforming Maternal Health (TMaH) Model:
Model Overview

Policy Opportunity 7

Increase **billing and reimbursement capacity** for community-based organizations.

→ Examples

New York's 1115 HEROS waiver which engages with community-based organizations.

Home and community-based services waivers for long-term services and supports allow community-based organizations to provide and be reimbursed for services.

Set up credentialing and billing collectives for doulas, midwives, and community-based organizations who are not affiliated with large health systems.

→ Policy Levers

State Legislature: Direct the State Medicaid Agency to engage with community-based organizations (CBOs).

State Medicaid Agency: Leverage CBOs via waiver or state plan amendment.

Medicaid Health Plans: contract and partner with CBOs.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

New York:
1115 HEROS Waiver

Home and community-based services waivers:
Waiver 1915(c)

Big Idea 1
Build, Support, and Sustain the Workforce

Policy Opportunity 8

Use Medicaid dollars to pay for **more services and extend allowable coverage** in the postpartum period.

→ Examples

Minnesota covers doula services as an extended service for pregnant people under Minnesota's Medicaid program, Medical Assistance in Minnesota. This covers prenatal and postpartum sessions with a doula and support during labor and delivery.

As a Medicaid health plan, AmeriHealth Caritas DC launched an extensive suite of services and supports during the perinatal period including the **Bright Start®** program.

CityBlock Health provides members with a multidisciplinary care team for clinical, social, and behavioral support.

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→ Policy Levers

State Legislature: Direct the State Medicaid Agency to cover more services.

State Medicaid Agency: Cover more services via a waiver or state plan amendment.

Medicaid Health Plans: Contract with clinicians and providers who offer expanded services and provide equitable and sustainable reimbursement.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

Minnesota:
Doula Services

Bright Start®:
Welcome Booklet for Moms

CityBlock Health:
CityBlock Approach

Transforming Maternal Health (TMaH) Model:
Model Overview

Big Idea 2

Integrate Services and Systems Across Settings and Sectors

Policy Opportunity 1

Support the development of infrastructure that strengthens the collaborative, team-based workforce in maternity care – including doulas, midwives, family medicine physicians, pediatricians, and OB-GYNs.

→ Examples

California's 2022-2023 budget includes $1.5 billion in investments over the next three years to strengthen and expand the health care workforce (to include certified nurse midwives and other primary care/ reproductive health workers).

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→ Policy Levers

State Legislature: Provide investments and incentives.

Federal Government: Provide investments and incentives.

→ Links to examples and resources

California:
2022-23 California State Budget Explained

Transforming Maternal Health (TMaH) Model:
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Policy Opportunity 2

Support licensed/certified midwives to practice independently.

→ Examples

A GAO report found that states without collaborative practice agreements have a higher percentage of births attended by midwives.**

Nebraska Legislative Bill 466 provides full practice authority for CNMs and **North Carolina** removes physician supervision requirement for CNMs.

→ Policy Levers

State Legislature: Remove barriers to independent practice or establish licensure programs as independent practice.

Medicaid Health Plans: Remove barriers to independent practice and enroll new clinicians as independent providers.

→ Links to examples and resources

GAO Report:
Information on Births, Workforce, and Midwifery Education

North Carolina:
State Health Policy

Nebraska:
Legislative Bill 466

**15 states require a collaborative practice agreement, which requires certified nurse midwives to have an established supervisory relationship with a physician. This approach increases the physician's exposure and liability for the midwife's practice, which creates a barrier to independent CNM practice.

Big Idea 2
Integrate Services and Systems Across Settings and Sectors

Policy Opportunity 3

Support licensed/certified midwives to practice at the top of their license—in other words, ensure they have the ability to practice to the full extent of their license, with full integration into the health system.

→ Examples

States with high Midwifery Integration Scoring System scores, such as **New Mexico, Oregon,** and **Washington,** have reported better outcomes.

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→ Policy Levers

State Legislature: Expand scope of practice for all licensed/certified midwives or create new licensure programs with full scope of practice.

Medicaid Health Plans: Remove barriers to full scope of practice or align network clinician scope of practice to state maximum.

Federal Government: Provide investments and incentives.

→ Links to examples and resources

New Mexico:
New Mexico Department of Health

Oregon:
Board of Direct Entry Midwifery - Laws and Rules

Washington:
State Laws that Directly Relate to Midwifery

Transforming Maternal Health (TMaH) Model:
Model Overview

Policy Opportunity 4

Leverage Medicaid to **cover early intervention services** provided by all types of clinicians, including family medicine physicians, ob/gyns, and licensed/certified midwives.

→ Examples

A comparative analysis contracted by the state of **Washington** found that due to the state's application of the EPSDT benefit, nearly all early intervention services are allowable as covered services under the state's Medicaid program. Billing mechanisms or guides developed by the state of Washington for providers could increase utilization of Medicaid reimbursement for services.

→ Policy Levers

State Legislature: Direct the State Medicaid Agency to cover all early intervention services.

State Medicaid Agency: Expand coverage to all early intervention services via waiver or state plan amendment.

Medicaid Health Plans: Expand coverage to all early intervention services.

→ Links to examples and resources

Washington:
Early Intervention & Medicaid in Washington

Washington's Early Supports for Infants and Toddlers (ESIT) and Apple Health (Medicaid) Programs

Infant-Early Childhood Mental Health Services

Big Idea 2
Integrate Services and Systems Across Settings and Sectors

Policy Opportunity 5

Expand **practice locations** of the workforce.

→ Examples

California implemented a No Wrong Door for Mental Health policy that allows individuals enrolled in Medicaid to receive mental health care no matter where they originally seek care.

→ Policy Levers

State Legislature: Establish a 'no wrong door' policy.

Federal Government: Provide investments or incentives in services that are not tied to a specific location.

→ Links to examples and resources

California:
Behavioral Health Information Notice No: 22-011

All Plan Letter 22-005: No Wrong Door for Mental Health Services Policy

No Wrong Door Webinar

Policy Opportunity 6

Increase payment integration of **behavioral health and physical health** for all clinicians, including family medicine physicians.

→ Examples

Allow billing for mental health screenings at prenatal visits and well-child visits under the child's Medicaid insurance if the mother is not insured.

→ Policy Levers

State Legislature: Direct the State Medicaid Agency to create billing options, investments, and incentives.

State Medicaid Agency: Create billing options.

→ Links to examples and resources

KFF Report:
Survey of State Medicaid Programs

National Academy for State Health Policy Report:
Medicaid Policies for Caregiver and Maternal Depression Screening during Well-Child Visits, by State

Policy Opportunity 7

Increase access to **same-day, same-setting** physical and behavioral health integration and care and provide **time-sensitive modification codes** to enable clinicians to bill for behavioral and mental health services.

→ Examples

Mental health screening during prenatal and well-child visits.

→ Policy Levers

State Legislature: Direct the State Medicaid Agency to create time-sensitive modification codes, investments, and incentives.

State Medicaid Agency: Create time-sensitive modification codes.

→ Links to examples and resources

National Academy for State Health Policy Report:
Medicaid Policies for Caregiver and Maternal Depression Screening during Well-Child Visits, by State

Big Idea 2
Integrate Services and Systems Across Settings and Sectors

Policy Opportunity 8

Adjust payments to **incentivize behavioral health screening and services**.

→ Examples

Value-based programs that incentivize behavioral health.

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→ Policy Levers

State Legislature: Direct State Medicaid Agency to incentivize behavioral health screening and services and investments.

State Medicaid Agency: Incentivize screening and services through contracts with MCOs.

Medicaid Health Plans: Incentivize clinicians and provider groups.

Federal Government: Provide investments and incentives.

→ Links to examples and resources

Association of State and Territorial Health Officials Report:
Health Agency Innovations in Financing Maternal Mental Health

Transforming Maternal Health (TMaH) Model:
Model Overview

Big Idea 3

Collect the Right Data and Make It Open Source

Policy Opportunity 1

Include perinatal mental health screening and treatment **quality metrics** in Medicaid health plan contracts, facilitated by adding measures into the HEDIS core set and reporting statewide data publicly.

→ Examples

The **National Committee for Quality Assurance (NCQA)** has developed perinatal mental health measures.

The **Agency for Healthcare Research and Quality (AHRQ)** has developed the behavioral health risk assessment measure.

Specific state examples of integrating perinatal mental health measures in Medicaid contracting can be found in **New Jersey** and **Pennsylvania**.

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→ Policy Levers

State Medicaid Agency: Add metrics for perinatal mental health screening and treatment quality to contracts with Medicaid MCOs.

Medicaid Health Plans: Require metrics from clinicians and providers in network.

Federal Government: Provide investments and incentives.

→ Links to examples and resources

NCQA Measures:
Postpartum Depression Screening and Follow-up (PDS)

Prenatal Depression Screening and Follow-up (PND)

AHRQ Measure:
Behavioral Health Risk Assessment for Pregnant Women

New Jersey:
Postpartum Depression Screening and Follow-Up (PDS-E)

Pennsylvania:
Healthchoices Agreement

Transforming Maternal Health (TMaH) Model:
Model Overview

Policy Opportunity 2

Standardize data collection across the continuum, including all pregnancy outcomes such as behavioral and mental health outcomes.

→ Examples

An example of standardization can be found in the **New Jersey** birth certificate.

→ Policy Levers

State Legislature: Add standardized behavioral and mental health outcomes data to existing data collection tools.

State Medicaid Agency: Add standardized behavioral and mental health outcomes data to existing data collection tools.

Federal Government: Add standardized behavioral and mental health outcomes data to existing data collection tools or invest in and incentivize state-based data collection updates.

→ Links to examples and resources

New Jersey:
Data Sets
(See Variable List under “NJ Birth Data”)

Big Idea 3
Collect the Right Data and Make It Open Source

Policy Opportunity 3

Create innovative methods to **support data collection** in billing and administration.

→ Examples

Virginia provides incentive payments associated with supporting specific HEDIS-aligned measures of the pregnant individual.

→ Policy Levers

State Legislature: Incentivize innovation.

State Medicaid Agency: Incentivize innovation through contracting with MCOs.

Federal Government: Invest in and incentivize innovation.

→ Links to examples and resources

Virginia:
Virginia Medicaid Community Doula Services

State Plan Amendment 21-0013: Doula Services

Big Idea 4

Establish the Foundation for a Family-based Continuum of Care from Preconception-to-age 3

Policy Opportunity 1

Adopt continuous-enrollment policies beyond one year to eliminate gaps in Medicaid coverage.

→ Examples

Washington provides continuous enrollment through age five.

→ Policy Levers

State Legislature: Direct State Medicaid Agency to adopt continuous enrollment.

State Medicaid Agency: Establish continuous enrollment policies.

Federal Government: Invest in and incentivize policies that support continuous enrollment.

→ Links to examples and resources

Washington:
Washington State Will Continue Medicaid Waiver for Five More Years

Medicaid Transformation Project Extension

Medicaid Transformation Project Renewal

Policy Opportunity 2

Create federal guidance (pathway) for states to provide at least **3-year postpartum coverage.**

→ Examples

The **American Rescue Plan** Act of 2021 gave states the option to extend Medicaid postpartum coverage to 12 months via a state plan amendment (SPA). The **Consolidated Appropriations Act** of 2023 made the option permanent. **CMS** provided guidance for states to implement the SPA.

American Rescue Plan of 2021 gave states the **option** to extend post-partum coverage from 60 days to one year.

MACPAC provided federal recommendations in support of one year of coverage at 100% FMAP.

→ Policy Levers

State Legislature: Invest and create a pathway.

State Medicaid Agency: Provide state plan amendment that creates
a pathway.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

American Rescue Plan Act of 2021:
H.R.1319 - American Rescue Plan Act of 2021

Consolidated Appropriations Act:
H.R.2617 - Consolidated Appropriations Act, 2023

CMS Guidance:
SHO# 21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program

MACPAC:
Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

Big Idea 4

Establish the Foundation for a Family-based Continuum of Care from Preconception-to-age 3

Policy Opportunity 3

Create federal guidance for states to **provide dyadic (parent/child) care coverage.**

→ Examples

Georgia developed a guide for behavioral health practitioners for billing dyadic models.

California developed a dyadic services benefit for behavioral health services.

→ Policy Levers

State Legislature: Invest and create a pathway.

State Medicaid Agency: Provide state plan amendment to create a pathway.

Medicaid Health Plans: Invest and create a pathway.

Federal Government: Provide guidance, pilot programs, innovation grants, or mandates.

→ Links to examples and resources

Georgia:
Infant and Early Childhood Behavioral Health Services

California:
All Plan Letter 22-029: Dyadic Services and Family Therapy Benefit

Policy Opportunity 4

Provide universal home visiting for individuals prenatal up to two years after pregnancy ends that includes 24/7 behavioral and mental health support, cultural and linguistically appropriate services, and peer support integration.

→ Examples

New Jersey and **Massachusetts** implemented universal home visiting programs. In 2016, **CMS** issued guidance on how home visiting programs could be put in place for individuals with Medicaid insurance. HRSA leads the **Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program**, providing support for long-term home visiting.

→ Policy Levers

State Legislature: Invest and create home visiting programs.

State Medicaid Agency: Add home visiting via state plan amendment or waiver.

→ Links to examples and resources

New Jersey:
Governor Murphy Signs Landmark Legislation to Improve New Jersey's Maternal and Infant Health Outcomes

Massachusetts:
An Act Increasing Access to Maternal Postpartum Home Visiting Services

CMS Guidance:
Coverage of Maternal, Infant, and Early Childhood Home Visiting Services

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program:
Program Overview

Big Idea 4

Establish the Foundation for a Family-based Continuum of Care from Preconception-to-age 3

Policy Opportunity 5

Change the clinical standard of care to support dyadic (parent/child) care to occur simultaneously.

→ **Examples**

California and **New York** dyadic care benefit supports this integrated clinical model.

→ **Policy Levers**

State Legislature: Change the standard of care requirements.

State Medicaid Agency: Create a pathway and provide incentives for dyadic care.

→ **Links to examples and resources**

California:
Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children

New York:
2023 Medicaid Eligibility Changes

Policy Opportunity 6

Direct individuals expressing **behavioral and mental health needs to care, not punishment** (e.g., criminal charges, child welfare).

→ **Examples**

In 2018, **CMS** released information on the **Maternal Opioid Misuse (MOM) model**.

→ **Policy Levers**

State Legislature: Change criminal and child welfare laws and create programs to better protect people with behavioral or mental health needs.

State Medicaid Agency: Remove barriers to care and incentivize participation in MOM or other models.

→ **Links to examples and resources**

CMS Maternal Opioid Use (MOM) Model:
Model Overview

Policy Opportunity 7

Reintroduce the expanded child tax credit.

→ **Examples**

The **American Rescue Plan of 2021** temporarily expanded the child tax credit in 2021.

→ **Policy Levers**

State Legislature: Direct the State Medicaid Agency to create time-sensitive modification codes, investments, and incentives.

State Medicaid Agency: Create time-sensitive modification codes.

→ **Links to examples and resources**

American Rescue Plan Act of 2021:
H.R.1319 - American Rescue Plan Act of 2021

Big Idea 5

Learn from and Build on Emerging Ideas at the Community and State Levels

Policy Opportunity 1

Launch public education and awareness campaigns on the benefits of midwifery with **emphasis on community power-building**.

→ Examples

Uplifting unique community needs (rural, tribal, etc.) through leadership development and community power-building was cited in a **GAO** report and can be found in practice across the nation, including **Alaska, Colorado, New Jersey,** and **Washington**.

Other national and international campaigns include **"The Big Push for Midwives"** and the **World Health Organization's** 2020 "Year of the Nurse and the Midwife"

→ Policy Levers

State Legislature: Invest in and incentivize partnerships with community-based organizations.

State Medicaid Agency: Invest in and incentivize community-based organizations and public awareness campaigns.

Medicaid Health Plans: Invest in and incentivize community-based organizations and public awareness campaigns.

→ Links to examples and resources

GAO Report:
Midwives: Information on Births, Workforce, and Midwifery Education

Alaska:
Alaska Native Birthworkers Community Resources

Colorado:
Birth Equity Policy Platform

New Jersey:
Rutgers Expert Advocates for Expanded Access to Midwifery Care

Washington:
Center for Indigenous Midwifery

The Big Push for Midwives:
Campaign Overview

World Health Organization:
2020 International Year of the Nurse and the Midwife Toolkit

Policy Opportunity 2

Value experience and provide opportunities for doula certification that take experience into account.

→ Examples

California offers an experience and a training pathway for doulas to be credentialed and eligible for Medicaid reimbursement.

→ Policy Levers

State Legislature: Establish certification pathways.

State Medicaid Agency: Ensure doulas can be reimbursed regardless of certification pathway.

→ Links to examples and resources

California:
State Plan Amendment 22-0002: Doula Services

Big Idea 5

Learn from and Build on Emerging Ideas at the Community and State Levels

Policy Opportunity 3

Create dependable and sustainable funding to support community-based organizations.

→ Examples

Indiana's Title V Maternal and Child Health Services Block Grant supports the Indiana Safety Protecting Indiana's Newborns Program. This supports community-based organizations that provide doula services to pregnant people enrolled in Medicaid.

→ Policy Levers

State Legislature: Invest in and incentivize community-based organizations.

State Medicaid Agency: Invest in and incentivize community-based organizations.

Medicaid Health Plans: Invest in or incentivize community-based organizations.

→ Links to examples and resources

Indiana:
Title V MCH Block Grant

Policy Opportunity 4

Build a foundation for the postpartum year that includes services and supports from community-based organizations, doulas, and perinatal community health workers.

→ Examples

Oregon's Medicaid program, Oregon Health Plan, covers doula services as a preventive service. Since 2017, the Oregon Health Authority covers prenatal and postpartum sessions and doula support during labor and delivery.

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→ Policy Levers

State Legislature: Invest in and incentivize community-based organizations.

State Medicaid Agency: Invest in and incentivize community-based organizations.

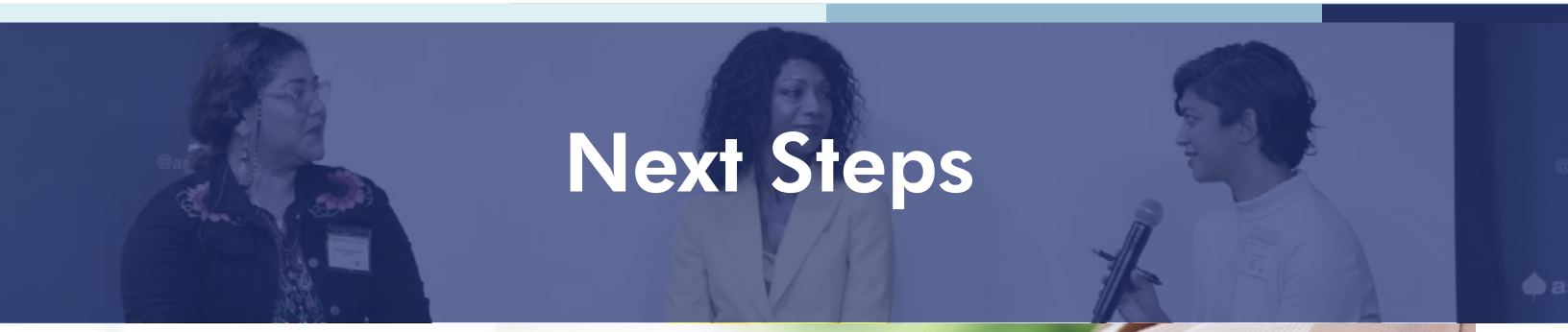
Medicaid Health Plans: Invest in and incentivize community-based organizations.

Federal Government: Invest in and incentivize community-based organizations.

→ Links to examples and resources

Oregon:
Doula Services for Oregon Health Plan Members

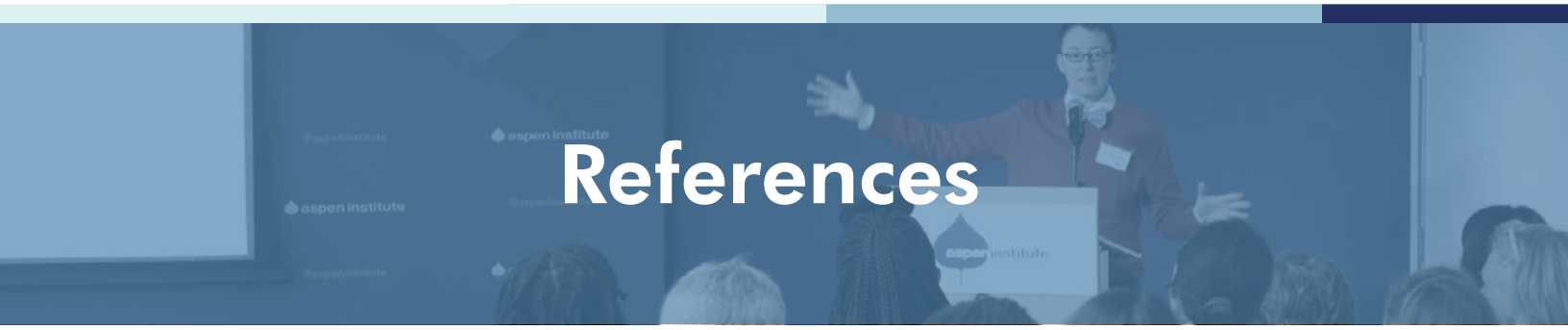
Transforming Maternal Health (TMaH) Model:
Model Overview



Next Steps

The rates of maternal mortality and morbidity in this country are astounding and deeply disturbing. Much work—and an unqualified commitment to get the job done—are needed not only to meet the challenge of reversing these trends, but also to ensure that the goals of health equity and accountability are paramount throughout.

This **Blueprint** puts forth **Five Big Ideas**—a framework—for building out a national strategic plan designed to get that job done within the context of Medicaid—a vital step in the process of improving maternal health policy. That won't be easy, and it won't be quick. But the nation cannot wait to take on this challenge full throttle. The time is now.



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