INSTITUTE FOR MEDICAID INNOVATION

Maternal Health Equity in Medicaid: Prenatal-to-3

Policy Issues and Opportunities to Inform a National Strategic Plan

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There is growing political interest in preserving, restoring, and extending Medicaid coverage for services and supports for women, gender, and maternal health. As federal and state policymakers consider opportunities to improve outcomes, they have been exploring a myriad of options, including community-based models of care, such as doulas and midwives; extension of 12-month postpartum coverage; and access to sexual and reproductive health services. 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 efforts are underway in almost every state across the United States, a national strategic agenda in maternal health in Medicaid that links all stakeholders and partners together has not been established. The lack of coordination creates inefficiencies in accomplishing shared goals. In response, the Institute for Medicaid Innovation partnered with the Aspen Institute to host a Medicaid policy summit in the fall of 2023. To inform the focus of the summit, a national survey was deployed and a focus group convened 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 the following priority topics: maternal mental health, doulas and perinatal community health workers, midwifery-led models of care, and prenatal-to-3.

The prenatal-to-3 period represents a critical time of development for children, spanning the prenatal period into the first 3 years of a child's life. During this time of rapid development, a child's earliest experiences impact learning, social-emotional and cognitive skills, and physical health.[1, 2] Maternal well-being before, during, and after pregnancy affects the health of a child at birth and their ongoing development.[1, 3] The connection between parent and child health necessitates interventions that consider the interconnectedness of family resources, strengths, barriers, and challenges to good health.[4]

Models of care focused on this period address the health needs of both children and parents and caregivers. Dyadic or two-generation care services such as Head Start, Nurse-Family Partnership®, and HealthySteps provide opportunities to meet the needs of adults and their children together by combining interventions for health and well-being, education, social capital, and economic assets for families to have a greater opportunity to thrive among generations.[5]

Prenatal-to-3 models include evidence-based maternal and child health home visiting programs that support early childhood development and positive perinatal outcomes through regular home visits and have been shown to increase early skill building, access to care, and family engagement.[6] Other models are integrated into outpatient health care delivery such as group care, such as CenteringPregnancy. the Prenatal-to-3 Policy Impact Center cites strong causal studies that show that group prenatal care improves access to needed services, parental health and wellbeing, and optimal child health and development..[7] Mother-Infant Therapy Group, a group therapy treatment for postpartum depression, was found to be effective in increasing depression recovery rates, mother-infant relationship quality, and infant emotion regulation.[8] HealthySteps[9] is the prototype for primary-care-based dyadic care and includes a set of services delivered to "parents or caregivers and children together, targeting family wellbeing as a mechanism to support healthy child development and mental health." [10]

Maternal opioid use disorder presents one of the clearest opportunities to apply the concept of dyadic care, as opioid use directly impacts both physical and psychological factors in the maternal-infant relationship.[11] The Centers for Medicare & Medicaid Services Innovation Center Maternal Opioid Misuse (MOM) model is an example of an approach that fosters "coordinated and integrated care" [12] for pregnant and postpartum people with opioid use disorder and their infants.

This issue brief outlines the policy issues and opportunities related to prenatal-to-3.

Policy Issues

Medicaid, a joint federal-state funded program, is the largest health insurance program in the United States, covering more than 93 million people, of whom more than 42 million are children.[13] Medicaid insurance in the United States is an individual, rather than a family, benefit, resulting in parents, caregivers, and children often having different coverage plans or a parent or caregiver having no insurance. Since the passage of the Patient Protection and Affordable Care Act, the resultant increase in the federal poverty level metric, and the public health emergency, most parents or caregivers have coverage in Medicaid expansion states (N = 41).[14] However, many people lose coverage after pregnancy, and even in states where postpartum coverage extends up to 1 year, the full potential of prenatal-to-3 models is harder to realize if parents or caregivers do not have health care coverage through the first 3 years of young children's lives.
Prenatal-to-3 models are also funded through a myriad of federal and state programs, such as the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs. Philanthropy supplements public funding for the development, implementation, and evaluation of prenatal- to-3 services. [20] The priorities, resourcing, and regulatory levers of these braided funding streams drive four policy areas.

Workforce

Many prenatal-to-3 models demonstrate the effectiveness of community-based workers as the frontline for delivering services. Parents, peers, and preprofessional workers comprise this workforce, many with lived experience as caregivers of children under 3, use of these services, and Medicaid health insurance coverage. The effectiveness and sustainability of staffing these services with community-based workers relies on having culturally congruent training and mentoring as well as fair pay and other supports. Federal and state legislation; funding Medicaid state plan amendments and waivers; and adjacent actions, including requirements in Medicaid managed care contracts, can promote policies to support this workforce.[11] Notably, many barriers faced by prenatal-to-3 community-based workers are similar to the barriers faced by community-based doulas and midwives, which are discussed more specifically in other issue briefs prepared for the Maternal Health Policy Equity Summit.

In a national scan of innovative perinatal initiatives, IMI noted lessons learned from the field included that "establishing equitable reimbursement rates and support for community-developed training can be critical factors in growing a culturally congruent workforce," which is essential to scaling capacity to effectively reach and serve the full prenatal-to-3 population with Medicaid coverage.[11] Small business supports, standardization of credentialing, and hubs to coordinate the administrative aspects of serving as a Medicaid provider have been cited as strategies and infrastructure to support the workforce. According to the Institute for Medicaid Innovation's 2022 Annual Medicaid Health Plan Survey, a growing number of Medicaid health plans are providing training in implicit bias and structural, institutional, or interpersonal racism to providers and partners to improve birth equity, which may improve service delivery to families seeking health care and strengthen collaboration among interdisciplinary care teams.[24]

Payment

The two main policy levers for payment are maintaining and expanding coverage of the entire prenatal-to-3 population and advancing reimbursement for two-generation models.

Expanded Medicaid eligibility is a critical lever of payment for health services to scale resources to meet the needs of families. However, changes in administrative processes or eligibility can result in coverage gaps and ultimately affect access to care for parents and children. Federal Medicaid funding under the Families First Coronavirus Response Act ensured continuous enrollment in Medicaid for individuals due to the COVID-19 public health emergency. However, the unwinding of the continuous enrollment policy will lead to an estimated loss of coverage for 5 million children and 7 million adults.[15] Ten states have waived Children's Health Insurance Program (CHIP) premiums to minimize enrollment barriers and providing support to reduce procedural disenrollments could further reduce coverage gaps for children and their families.[16, 25]

Coverage expansion options for postpartum people and children as a result of the 2023 Consolidated Appropriations Act include mandatory provision of 12 months of continuous eligibility for children in Medicaid and the Children's Health Insurance Program and the option to extend Medicaid coverage of pregnant people to 12 months postpartum.[17] As of May 2023, 38 states and Washington, D.C., have or plan to adopt the expansion option through either state plan amendments or 1115 waivers.[18] However, postpartum coverage expansion is not required.

Fee-for-service reimbursement of dyadic care is a first step toward ensuring payment for this two-generation model through Medicaid and can accelerate development of alternative payment models. It is also a significant step toward sustainable, broad-scale investments in the provision of, and increased access to, the prenatal-to-3 model via well-child care as well as integrated models of primary and behavioral health care.[11] Payment models that link federal and state grant-funded prenatal-to-3 services and Medicaid services have the potential to braid funding for efficiency, create economy of scale, and incentivize integration while also supporting community-based models.[11]

Medicaid programs can encourage innovative payment models for social determinants of health resources and community supports that address structural determinants of health while additional policy and regulatory structures are being developed.[11] Grant-style funding and community reinvestment models may help promote codesign by providers and communities piloting or expanding high-value, evidence-based models of care.

Data and Quality

Prenatal-to-3 quality frameworks are evolving beyond a limited set of perinatal and child measures; however, wide-scale innovation in performance improvement programs has lagged. Medicaid managed care organizations (MCOs), state Medicaid programs, and perinatal quality collaboratives may have the flexibility to implement and integrate evidence-based health care interventions from the physical, behavioral, or public health domains into maternal-child home visiting programs, but it is challenging to generate conclusive evidence and scale these programs—and their payment levers— broadly enough to move the needle on population health outcomes.[11] It may not be possible to demonstrate outcomes that garner political will, such as cost savings. Providing ample and integrated two-generation support for at least the first 3 years of life may not save money in the short term but can create healthier families and have long-term benefits that are hard to measure, at least in the short term.

Data systems are needed to connect maternal and infant records both at the point of service and for process and longitudinal quality and outcome measurement. Linkage is also needed between Medicaid MCO quality programs, state-based maternal mortality review committees, and perinatal quality collaboratives.[11] A broader set of quality indicators and outcome measures, such as perceptions and satisfaction around birth experiences, quality of infant early childhood mental health, and drivers of health equity, could enrich quality programs and research on the impact of varied models, particularly on health disparities.[11, 19]

Delivery System

The delivery system mirrors the payment system, which is based on enrolling individuals in health care insurance and reimbursing care rendered to individuals. Care of parents and caregivers is often siloed from that of infants and children, and even health care providers and staff trained to provide services to all members of the family are constrained by separate billable encounters, medical records, and wraparound resources.

Since the COVID-19 pandemic, the necessity of innovating alternatives to standard care delivery and flexibilities in regulations has accelerated the exploration and implementation of telehealth, vaccine programs outside of health care facilities, and novel home- and community-based services. Widespread experience with these flexibilities may render a clearer vision of cohesive and accessible care and provide added impetus to design care models that colocate and integrate resources.

Specific resources, shown individually to overcome barriers to care, can be explored in combination to magnify assets and promote the sustainability of effective programs; examples include dyadic care models, group health care or group support services, use of transportation and childcare benefits, and maternal and child health home visiting programs.[11] Expanding the care team to include midwives, doulas, and community health workers—especially those with lived experience as prenatal-to-3 service recipients—may not only increase access, availability, and cultural congruence but also accelerate delivery system design innovation.[11]

However, the need for coordination is increasingly urgent as new services proliferate superimposed upon a longstanding divide among home visiting services, ambulatory care, and social and nutrition services (e.g., the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)). The policies supporting these services may be levers for coordination. The majority of children or pregnant individuals in home visiting programs are enrolled in Medicaid.[26] Although state Medicaid programs may use federal Medicaid dollars to support financing home visiting services, variation in home visiting systems, administrative burdens, and reporting requirements can hamper the delivery system.[21, 22] As states continue to explore opportunities within their Medicaid programs to address the unique needs of children and their families through home visiting services, state Medicaid programs will want to consider, in conjunction with their MIECHV partners, how Medicaid policy levers (e.g., benefit categories and reimbursement) can be operationalized to complement the broader home visiting landscape.[21] Furthermore, Medicaid programs may identify internal efficiencies that reduce barriers for other programs to effectively integrate with them.

Policy Opportunities

Clinical, research, and policy opportunities are identified 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. There are 12 Medicaid policy opportunities specific to prenatal- to-3 within the areas of workforce, payment, data and quality, and delivery systems.

Workforce

Policy changes can ensure a stable workforce as well as create equitable reimbursement for both their services and community-based providers. Policy opportunities that would support the workforce include:

- Explore the use of **1115 demonstration waivers and state plan amendments** to develop **Medicaid reimbursement for services that expand the community workforce**, including doulas, community health workers, and certified professional midwives.
- Support infrastructure e.g, affordable training programs, hub models, etc., designed to:
  - grow a **culturally congruent workforce**;
  - **assist new Medicaid service providers** with enrolling in the Medicaid program; and
  - support the retention and stability of this workforce through offering **equitable, sustainable reimbursement** and streamlining Medicaid billing and reimbursement.
- **Include community-based workers** in interdisciplinary care teams.
- Evaluate **the impact of implicit bias and antiracist training** investments for care team members.

Payment

Expansion of Medicaid income eligibility can improve access to prenatal-to-3 care and reduce financial burden for health care providers and families. This can be accomplished by:[23]

- **Implement continuation of Medicaid benefits through the full first year postpartum**, which can align systems and reimbursement mechanisms while supporting access to care. This is particularly important for health issues contributing to postpartum morbidity and mortality (e.g., perinatal depression, substance use disorder, hypertension).
- Implement mechanisms to **minimize Medicaid coverage gaps for children and adults of reproductive age**, especially during the unwinding of the COVID-19 continuous coverage policy
- **Explore grant-style funding by Medicaid MCOs**, while developing direct Medicaid reimbursement or braided payment for two-generation models, to foster community- driven innovation

Data and Quality

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

- **Conduct studies on community-based perinatal and child program and care models** in Medicaid and support implementation science for integrating evidence-based health care interventions across physical, behavioral, public health care, and maternal-child home visiting programs.
- **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.
- Explore ways to best **integrate Medicaid MCOs** into state-based maternal mortality review committees, perinatal quality collaboratives, state-based maternal health task forces, legislative committees, or community-based advocacy groups.
- **Identify and remove barriers in data systems** and invest in information technology.

Delivery System

Policy opportunities are grounded in reimagining traditional individual-based approaches, recognizing the parent-child dyad, leveraging community-based people and resources, and engaging the whole family as a focus for centered health care service delivery in various settings with an expanded care team. Opportunities to support this approach include:

- **Design care models that colocate and integrate resources**—including community- based workers, such as those based in maternal and child health home visiting programs—**with clinical and social services.**
- Explore ways to **allow the use of transportation and child care 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
- **Explore the use of Medicaid policy levers** (e.g., benefit categories and reimbursement) **by state Medicaid programs,** in conjunction with their MIECHV partners, to complement the broader home visiting landscape,[21] e.g., through reimbursement of certified professional midwives providing home-visiting services and through midwife-led birth centers and social service agencies that can be hubs for wraparound services.

Looking Ahead: Prioritizing Prenatal-to-3

This issue brief provides an overview of salient policy issues and opportunities specific to prenatal-to-3. It provides essential background information to support the establishment of a national 5-year policy strategic plan informed by all Medicaid partners and stakeholders to support increased access and coverage to evidence-based maternal health services and supports that reduces inequities, respects the preferences of individuals with Medicaid insurance, centers care in the community, and strengthens the safety net for families. The Medicaid partners and stakeholders participating in the development of a national 5-year strategic plan will lead, colead, and/or support the commitments that are developed to chart a path forward.

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