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Maternal Value-Based Payment Models and Considerations in Medicaid

Presented by: NORC at the University of Chicago



Table of Contents

Background	1
Episode of Care Models	1
Pregnancy Medical Home Models	2
Other Models Captured	2
Methods	2
Findings: Maternal Health Considerations	4
Substance Use Disorders	4
How SUD/OUD is Addressed in Maternal Episodes of Care	4
Postpartum Depression	6
How PPD is Incorporated into Maternal Episodes of Care	
Postpartum Depression in Medicaid Populations	
Promoting Maternal Depression Screening Under Medicaid	
Social Determinants of Health	
How SDOH/Health Equity is Incorporated into Maternal Episodes of Care	
Postpartum Care	
Postpartum Coverage and Maternity Episodes of Care	
Dyadic Care	
How State Dyadic Care is Incorporated into Maternal Episodes of Care	
Findings: Medicaid Payment Considerations	
References	22

List of Tables

Table 1.	Name and Type of State Medicaid Payment Models for Maternal and Child Health	3
Table 2.	Medicaid Payment Considerations1	3



Background

The maternal mortality rate in the United States has been increasing since 2000 and peaked in 2021 at 32.9 deaths per 100,000 live births.⁷ The maternal mortality rate for Black birthing people (69.9 per 100,000) is more than double the average rate and 2.6 times the rate for non-Hispanic white birthing people.⁷ Medicaid pays for over 40 percent of births and 65 percent of births from Black birthing people.⁸ Given Medicaid's role as the largest funder of United States maternity care, the Centers for Medicare and Medicaid Services (CMS) and state Medicaid programs are in a unique position to improve maternity care quality and how healthcare is delivered to pregnant and postpartum people.⁹ In response to the rising maternal mortality rate and health inequities, in recent years, there have been calls for Medicaid to take action such as expand postpartum coverage beyond 60 days, cover evidence-based models, to develop value-based payment models, bolster maternal mortality and morbidity data collection, and more.

In 2022, NORC at the University of Chicago (NORC) conducted an environmental scan to better understand the needs of pregnant and postpartum people and their babies in the context of valuebased purchasing to inform the development *a potential maternity episode of care to address a broad range of concerns around maternal and infant health outcomes, including maternal mortality and morbidity, and health disparities.*ⁱ To this end, NORC collected information about Medicaid programs' maternity care value-based payment models, with a focus on episode of care and pregnancy medical home models.

Episode of Care Models

Episode-based models designs are traditionally cost-based models that ensure quality maintenance by creating minimum quality thresholds. Quality thresholds are included in these models in two distinct ways: 1) by acting as a quality "floor" (a minimum set of metrics which the provider must meet in order to be eligible for shared savings), or 2) by providing incentive payments for performance on quality metrics. The primary goal of these models is to control costs by increasing preventive services and avoiding expensive adverse outcomes, such as hospital admissions. In these models, the provider or provider team is accountable for the costs associated with providing care and may be eligible for shared savings if their costs are below a certain threshold or may bear financial risk if the total cost of providing care is above a certain threshold. This structure incentivizes an overall reduction in high-cost service utilization, which is useful in the context of maternal and child health care where adverse birth outcomes can be costly. Incentives may be provided for processes or outcomes deemed to be high value through paying for performance on quality metrics.

ⁱ The Washington Health Care Authority contracted with NORC at the University of Chicago to conduct this work from February 2022 to December 2022.



Pregnancy Medical Home Models

Pregnancy medical home models provide resources and incentives for care coordination to take place between groups of providers and to provide incentives for higher touch, more personalized care to the pregnant and postpartum target population. The goal of these models is to identify and treat psychosocial factors, behavioral health risks, and chronic conditions by providing screenings and appropriate referral and follow-up to services. Evaluations of these programs found that they improve outcomes such as: lowering emergency department visits, NICU babies, and caesarean section rates (TX) and reducing rates of poor birth outcomes (preterm birth, stillbirth, low birthweight, neonatal death) (WI).^{10,11}

Medical home models exist in both the fee-for-service and managed care, and the role that the managed care organization (MCO) plays in these programs varies from state to state. For example, in Wisconsin, MCOs oversee obstetric providers, who act as primary care medical homes for the patient and receive incentive payments based on outcomes.¹⁰ Medical home models tend to have limited implementation, with only North Carolina's model being statewide.

Other Models Captured

Sometimes, pregnancy medical home models are built from grant programs or other initiatives, to promote the sustainability of the initiative. In this brief, there is one grant program, the MN Integrated Care for High-Risk Pregnant Women initiative that is focused on addressing health disparities for Black birthing people and other high-risk, underserved groups. The California PRIME program, which is an incentive program designed for California's delivery hospitals to improve performance on certain quality metrics, is also included.¹⁴

Methods

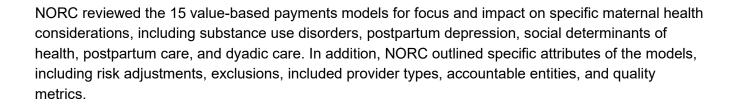
For the environmental scan, NORC focuses on states that have or recently have had an episode of care or pregnancy medical home model for maternal and child health. Models that were identified in MACPAC's *2020 Inventory of State Level Medicaid Policies to Improve Maternity Care and Outcomes* as "models of maternity care, beyond the ways that prenatal care, labor and delivery, and postpartum care are typically provided" were also included.¹⁵ Fifteen (15) programs were identified to include in the analysis (Table 1); seven episode of care models, five medical home models (only one statewide model), a grant program, and an incentive-based program for delivering hospitals.



State	Name of Program	Type of Program	Status
Arkansas	Arkansas Perinatal Episode	Episode	Inactive, ended in 2021 ¹⁶
Arizona	Arizona Global Obstetric Bundle	Episode	Active ¹⁷
California	California PRIME Program	Incentive Payment	Inactive, ended in 2020 ¹⁴
Colorado	Colorado Maternity Bundled Payment Program	Episode	Active ¹⁸
Minnesota	Minnesota Integrated Care for High-Risk Pregnant Women (ICHRP)	Grant	Active ⁸
North Carolina*	North Carolina Pregnancy Medical Home ("Pregnancy Management Program" as of 7/1/2021)	Medical Home	Active, but transitioned into Pregnancy Management Program 7/1/2021 ¹⁹
New Jersey	New Jersey Perinatal Episode of Care Program	Episode	Active (pilot program) ²⁰
Nevada	Nevada Care Management for High-Risk Pregnant Beneficiaries	Medical Home	Inactive, 1115 expired 6/30/2018 ²¹
New York	New York Maternity Care Value Based Payment Arrangement	Episode	Active ⁴
Ohio	Ohio Perinatal Bundled Payment	Medical Home	Active ²²
Pennsylvania	Maternity Care Bundled Payment	Episode	Active ²³
Tennessee	Tennessee Perinatal Episode of Care	Episode	Active ²⁴
Texas	Texas Pregnancy Medical Home Initiative	Medical Home	Active ¹¹
Washington	Maternal Episode of Care Value-Based Payment Model	Episode	Active ²⁵
Wisconsin	Wisconsin OB Medical Home Initiative	Medical Home	Active ²⁶

Table 1. Name and Type of State Medicaid Payment Models for Maternal and Child Health

*North Carolina's Pregnancy Medical Home (PMH) was transitioned into the Pregnancy Management Program (PMP) effective July 1, 2021 to accommodate the state's adoption of managed care. Under PMP, "many of the guidelines [that existed under PMH] remain the same, including the continued use of the pregnancy risk screening tool and referral of high-risk pregnant women for pregnancy care management."¹³ This maintaining of key PMH program features will be prioritized by the state during the first 3 years of managed care (July 2021-June 2024). Therefore, the aforementioned PMH research is still relevant to how the program exists today. However, under the PMP there is no longer an enrollment requirement or process to "opt in" for participation in the program. All providers are considered participating Pregnancy Management Program providers and will receive at a minimum, the same rate for vaginal deliveries as they do for cesarean sections.



Findings: Maternal Health Considerations

Substance Use Disorders

How SUD/OUD is Addressed in Maternal Episodes of Care

Six of the 15 reviewed models included SUD/OUD in some way in their models. Considerations range from required substance use disorder (SUD)/Opioid use disorder (OUD) screening (Arizona's Global Obstetric Bundle) while others include direct interventions such as staffing requirements and mechanisms that reward entities for addressing SUD/OUD in patients. Staffing requirements are included in Pennsylvania's Maternity Care Bundled Payment wherein maternity care teams must include one staff member trained to address behavioral health and SUD needs of patients.²³ Pennsylvania's model also included the "initiation of alcohol and other drug abuse treatment," as a quality measure tied to gainsharing payments. New York's model featured a similar metric (initiation and engagement of substance use disorder treatment) as well as a tobacco screening and cessation quality measure.²⁷ Some models featured SUD/OUD considerations risk-sharing arrangement. For example, under Colorado's risk-sharing arrangement, episodes involving SUD were granted a higher risk-sharing threshold to account for the higher costs associated with treating SUD. New Jersey's model accounts for SUD populations by offering a SUD Participation Incentive payment to providers whose patient profile may include a considerable proportion of patients with SUD diagnoses.³ To gualify for the SUD Participation Incentive, providers must: have at least 15 valid episodes during the performance period and be in the top 20% of all NJ FamilyCare providers serving SUD populations.

SUD prevalence is increasing and they present a substantial challenge for pregnant and postpartum people and their infants. SUD, including OUD, are a major contributing factor to pregnancy-related deaths; OUD prevalence among pregnant people has increased in the past 20 years by 400%.²⁸ Substance use during pregnancy and postpartum can also have serious adverse impacts on the infant. When pregnant people use opioids, their infants may develop neonatal opioid withdrawal syndrome (NOWS), which is linked to higher rates of preterm birth and neonatal intensive care unit (NICU) admissions. The range and severity of the symptoms experienced by the infant depends on a variety of factors, including the type of opioid the infant was exposed to, the timing, the dose/amount and whether the infant was exposed to multiple substances.²⁹ Best practice treatment for infants with NOWS is

primarily non-pharmacological (e.g., Eat, Sleep, Console) with pharmacological treatment to be considered as needed, and evaluated on a case-by-case and infant functioning basis.³⁰

People with OUD often face psychosocial and environmental factors which may complicate their treatment. For example, womenⁱⁱ with OUD often have a history of sexual abuse and/or interpersonal violence (IPV), inadequate social supports, unpredictable parenting models, poor nutrition, unstable housing, and co-occurring psychiatric conditions.²⁹ Research shows that a combination of medication for opioid use disorder (MOUD) – such as buprenorphine or methadone - and behavioral therapy is the most effective way to treat OUD and increases the likelihood of cessation of opioid use in all populations, including postpartum people.³¹ The research points to a strong need for postpartum people with OUD to have access to primary care and behavioral health services, and for those providers to coordinate with each other. Coordination of services is of the utmost importance for pregnant and postpartum people with SUD, as there are several points where a family can be lost to follow up. This makes close communication between the postpartum providers and the pediatric team particularly important. Most experts recommend a family-centered approach that is community-based to increase access and provide follow-up for the birth parent, infant, and family's evolving needs. Postpartum care must also address the birth parent's substance use management and ongoing needs assessments for the infant and their family.³²

After people with SUD/OUD give birth they are at an increased risk of developing PPD. Up to 45% of OUD patients screen positive for PPD, and up to 40% of patients attending an opioid treatment program report having PPD.³³ These rates are compounded by co-occurring mental health disorders found in two-thirds of women with OUD.³⁴ Lack of sleep, stress, and caring for a newborn put this population at risk for PPD and subsequent relapse. Therefore, opportunities to identify PPD become crucial for postpartum people with a history of OUD.

Like disparities in the larger health system, there are disparities related to pregnant people and SUD/OUD. There is a stigma attached to people who are pregnant and who use substances, particularly among BIPOC. Further, systemic oppression and structural racism have left these communities without resources that could protect against adverse health outcomes in the context of SUD/OUD. Poverty, housing and food insecurity, and discrimination all contribute as social determinants of health (SDOH) for this population. Lack of access to OUD treatments like MOUD contribute to the risk of illicit drug use, resulting in increased risk of overdose or death. Treatment models for pregnant people with SUD/OUD must account for SDOH such as race and socioeconomic status and strive to reduce disparities in access to and quality of care.³⁵

ⁱⁱ Gender-inclusive language will be used throughout the brief; however, some source materials may refer specifically to individuals who identify as women.



Postpartum Depression

How PPD is Incorporated into Maternal Episodes of Care

A consideration for postpartum depression (PPD) is included in nine out of the 15 models reviewed, most of which require screening for depression. For example, the Arizona Global Obstetric Bundle requires screening during one prenatal and one postpartum visit, and under the Pennsylvania Maternity Care Bundled Payment prenatal and postpartum depression screening and follow-up are quality measures tied to payment.²³ The Colorado Maternity Bundled Payment Program does not require screening on a timeline but does include screening in second year quality measures that are connected to payment. Furthermore, the New York Care Value Based Payment Arrangement reimburses for PPD screening under an infant's Medicaid number up to three times in the infant's first year of life.³⁶ Similarly, the Nevada Care Management for High-Risk Pregnant Beneficiaries model reimburses health risk assessments (which screens for PPD) performed by a licensed medical provider (i.e. physicians, special clinics, advanced practice registered nurses, and physician's assistants) for the birth parent of a covered child up one year of age.³⁷

North Carolina and Wisconsin both take different approaches to maternal mental health. The North Carolina Pregnancy Management Program includes a \$50 incentive payment tied to the completion of a standardized risk screening tool at each initial visit.¹³ Among the items screened for include: mental illness, prenatal depression, and prior incidence of postpartum depression within patient's obstetric history.³⁸ A positive screening for the aforementioned conditions may prompt referral of the patient to the state's "Care Management for High-Risk Pregnancies," program and if the patient has a child, their child will be referred to the state's "Care Management for At-Risk Children," program. ¹³ The Wisconsin OB Medical Home Initiative includes postpartum screening as part of their home visit care coordination.¹⁰

The California PRIME Program does not include PPD in the model; however, licensed medical practitioners are required to "screen prenatal and postpartum patients for maternal mental health conditions."³⁹ Medi-Cal reimburses for these screenings even at well-child visits and reimburses up to 20 individual or group counseling visits for individuals up to 12 months postpartum.

Postpartum Depression in Medicaid Populations

Postpartum depression (PPD) symptoms can occur at any time during the first postpartum year. Risk factors for PPD include a personal history of anxiety or depression, inadequate support caring for the baby, financial stress, marital stress, complications during pregnancy or birth, parents whose infants were in the NICU, and people with diabetes (both gestational and type 1 and 2).⁴⁰ PPD is a known disruptor to the early responsive, nurturing, and stable relationship between parent and baby, and therefore can profoundly affect the infant.

It is estimated that more than half (55 percent) of all infants in families with incomes below the poverty level are being raised by mothers with some form of depression.⁴¹ Depression during pregnancy may contribute to adverse birth conditions such as preterm birth and low birthweight.⁴² Infants being cared for by mothers who are depressed may suffer disruptions in the formation of a strong parent-child relationship, which compromises a child's early brain development.⁴³ Studies show that this kind of disruption can have potentially long-term implications for the child's cognitive, social, and emotional health.⁴⁴ Among a sample of very low income, largely ethnic minority mothers and infants, mothers with higher depressive symptoms at five months postpartum were associated with infants who gained less weight between 5 to 9 months, increased infant physical health concerns, and increased infant nighttime awakenings.⁴⁵ PPD decreases quality of life for mothers and reduces the likelihood of mothers engaging in safe parenting practices, affecting the dyad as a whole.⁴⁶

Additionally, mothers who suffer from PPD are at increased risk of experiencing interpersonal violence (IPV).⁴⁷ Failing to identify and treat or provide support for people with PPD, or who are experiencing IPV, can have long-lasting damaging consequences for mother and child. Research shows that PPD remains an under recognized and undertreated condition for all low-income women, but especially for women of color.⁴⁸

Pregnancy Risk Assessment Monitoring System (PRAMS) data has demonstrated that prevalence of postpartum depressive symptoms (PDS) is higher among Black, American Indian/Alaska Native (AIAN), and Asian/Pacific Islander birth parents and birth parents from BIPOC communities are also less likely to be asked about depression during a postpartum visit.⁴⁹ Black and Latina women and other postpartum patients are less likely to initiate postpartum mental health care and among those who initiate treatment, they are less likely to receive follow-up treatment, continue care, or refill a prescription.⁴⁸ While women of color are more likely to experience PPD, they are less likely to receive treatment. Some studies show that even when screened, Black mothers are less likely to report that they are experiencing PPD because of the fear that child welfare services will take their child or children away from them.⁵⁰ AIAN women have the highest rates of major PPD, compared to other racial/ethnic groups.^{51,49,52} Research has demonstrated that PPD interventions delivered by AIAN paraprofessionals, were more effective at reducing depression, indicating the importance of culturally congruent care.⁵³

Promoting Maternal Depression Screening Under Medicaid

Promising practices to screening for PPD among states include promotion of screening tools, providing Medicaid reimbursable billing codes, and ensuring that providers know how to refer patients who have identified mental health concerns.⁵⁴ The CMCS Informational Bulletin, *Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children*, says that states and managed care plans use a variety of methods to promote maternal depression screening among providers, including:⁵⁵

• Posting information about maternal depression screening on provider websites and publishing information in provider newsletters.

- Delivering provider trainings to promote the use of maternal depression screening tools and proper billing codes.
- Conducting in-person visits to clinics to train providers on how to implement screenings, help practices modify clinic flow, and discuss referral strategies.
- Offering practitioners continuing medical education (CME) credits for participation.

States that elect to cover postpartum depression screening can include performance standards to ensure that the service is widely performed. Medicaid policies, including investing in data, research, and accountability for maternal health outcomes, can be implemented to continue to improve perinatal and postpartum mental health.⁵⁶ These activities are generally eligible for Medicaid matching funds.

PPD is particularly common among low-income mothers and mothers of color.⁴⁸ While PPD screenings are useful for detecting PPD, they are different from treating maternal depression. Medicaid policies have taken steps to improve PPD and related outcomes, however, there are additional opportunities for Medicaid to address gaps in screenings and care. If left untreated, postpartum depression can further exacerbate health disparities and worsen birthing outcomes for Black and American Indian/Alaska Native women and other postpartum patients.⁵⁷ PPD can result in negative maternal physical and psychological health, worsened quality of life, difficulties in social relationships, and impact mother-infant interaction (as discussed in the "Dyadic Care" section below).⁵⁸ PPD coupled with the disproportionate adverse life experiences women of color experience, and disparities in gaps in screening and treatment for mental health issues among women of different racial and ethnic backgrounds, can result in poor health outcomes for both the birth parent and baby.⁵⁹

There is an Opportunity to Treat more Birth Parents with PPD by Screening and Linking to Services during Well-Child Visits

Linking interventions for the birth parent to pediatric visits provides another touch point to potentially engage birth parents who have depression, especially those who may not be engaging or sharing how they are feeling in other settings. Because some postpartum people may not go to their own postpartum visits but will go to visits for their babies, it makes sense to check-in on the birth parent's health and well-being at the pediatric visit. Well-child visits happen frequently during the postpartum year, providing an opportunity to check in with the birth parent about their health and well-being.

The Bright Futures/American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* is a schedule of screenings and assessments that are recommended at each well-child visit.⁶⁰ Updates to 2020 recommendations include screening for maternal depression at 1-, 2-, 4-, and 6-month well-child visits. This is in accordance with 2016 CMS policy guidance that allows Medicaid agencies to cover maternal depression screening at well-child visits and mandates that states cover medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.⁶¹ As of 2021, 43 states and DC recommend, require, or allowⁱⁱⁱ maternal

iii 8 states require, 27 states recommend, and 9 states allow

depression screening to be provided as part of a well-child visit.⁶² However, payment must be sufficient to reimburse for the time and resources necessary to deliver the service. Additionally, positive and negative screens are distinguished in claims data through a specific code or modifier in 11 states, while performance measures related to maternal or perinatal depression screening are present in at least 4 states.⁶²

Treatment rates also remain low, and the absence of PPD screening and referral to treatment disproportionately impacts racial and ethnic minorities.⁵⁷ The SBIRT model, which is traditionally used to identify substance use risk, is an example of a model that is being used to raise treatment initiation rates (in the state of South Carolina). Other opportunities to reward pediatricians who screen mothers for PPD and provide appropriate interventions or referrals could also be explored.⁵⁷

Social Determinants of Health

How SDOH/Health Equity is Incorporated into Maternal Episodes of Care

Nine of the 15 models reviewed address health equity: Arizona, Minnesota, New Jersey, New York, North Carolina, Pennsylvania, Washington, and Wisconsin. The Arizona Global Obstetric Bundle, New York Care Value Based Payment Arrangement, and New Jersey Perinatal Episode of Care Program stratify data collection, NCQA prenatal and postpartum care measures, and quality metrics by race and ethnicity respectively.^{27 3} The Minnesota Integrated Care for High-Risk Pregnant Woman grant program is specifically aimed at high-risk pregnancies for American Indian/Alaska Native tribes with high rates of maternal SUDs and Black/African communities with high rates of low-birth-weight babies.⁶³ North Carolina addresses health equity outside of the model with the Care Management for High-Risk Pregnancies, which aims care management at pregnant people with risks for adverse birth outcomes by using screenings and care coordination.¹³ Washington, Pennsylvania, New York, and Wisconsin specifically call out social determinants of health in their models. In 2023, New York added a The Washington Maternal Episode of Care Value-Based Payment Model requires a SDOH screening in order to reduce racial disparities in perinatal outcomes.⁶⁴ The Pennsylvania Maternity Care Bundled Payment has a social determinant of health screening measure and a health equity score that are fixed to gainsharing payments.²³ The health equity score is based on five guality measures: Initiative of Alcohol and Other Drug Abuse or Dependence Treatment; Timeliness of Prenatal Care; Postpartum Care; Prenatal Immunization Status; and Well-Child Visits. Additionally, the model requires the inclusion of at least one maternity care team member who is trained to address Social Determinants of Health needs (e.g. doula, community health worker, peer recovery specialist). The Wisconsin OB Medical Home Initiative focuses on minority women and other pregnant patients with chronic conditions who are also experiencing challenges with SDOH.

Optimizing health outcomes for pregnant and postpartum people and reducing health disparities also requires careful consideration of how the health care system can best address



social determinants of health (SDOH) to address the health needs of all people, particularly those from marginalized communities.

Addressing the SDOH is essential to improving health outcomes and reducing disparities in health and healthcare. These social determinants include education, socioeconomic status, the built environment such as neighborhoods, and access to health care.⁶⁵ In response to the growing importance of SDOH, there have been increased efforts to fund initiatives to address social needs.⁶⁵ In recent years, health programs such as Medicaid have begun developing strategies to identify and address the social needs of their beneficiaries.

SDOH play a key role in the significant inequities that BIPOC birth parents and infants experience. BIPOC individuals are more likely to experience disproportionately low incomes and have unmet social needs, such as limited access to safe and affordable housing, lower-quality education, unreliable public transportation, and access to nutritious and affordable food, all of which increase the likelihood of inequitable birth outcomes and contribute to severe maternal morbidity and mortality.ⁱ They are also more likely to experience racism, discrimination, and differential treatment in health care settings.

Some states are beginning to explore ways that SDOH can be addressed in the context of their Medicaid program. For example, North Carolina's Healthy Opportunities Pilots program allows for \$650 million in Medicaid funding over the course of five years to support evidence-based non-medical efforts to address SDOH. These needs include services related to housing, transportation, food, and interpersonal safety.⁶⁶ California's Whole Person Care Pilot Program aims to coordinate health, behavioral health, and social services through a patient-centered approach. The program targets Medicaid beneficiaries who are high healthcare users and who continue to have poor health outcomes.⁶⁷ The state invested \$100 million to fund pilot programs that support individuals who are mentally unwell, experiencing homelessness, and have a medical need for housing support services.⁶⁸

Postpartum Care

Postpartum Coverage and Maternity Episodes of Care

The postpartum period is a critical period that can affect the long-term health and well-being of both the birth parent and child.

During this period, new parents must adapt to multiple physical, social, and psychological changes, but for families whose prenatal care is covered by Medicaid, the postpartum period may be more than just a challenging time. Compared with privately insured people, people covered by Medicaid suffer from higher rates of chronic medical conditions before, during, and after pregnancy as well as higher rates of pre-term deliveries and low-birth weight (LBW) infants.⁶⁹ Postpartum depression and other mental health struggles are also a serious risk. Rates of suicidal ideation and intentional self-harm significantly increased for childbearing individuals one year before and after birth between 2006 and 2017,

especially for non-Hispanic Black individuals, low-income populations, and those with comorbid serious mental illnesses.⁷⁰

Expanding postpartum care to 12 months will allow health care providers to help parents better address specific challenges like mental health, domestic violence, substance use, and address unmet social needs. Better access to postpartum care may improve health outcomes for birth parents, especially low-income and Black, Indigenous, and other people of color (BIPOC). This expansion is also important for addressing health equity, because lower-income Hispanic birth parents and American Indian/Alaska Native birth parents are much more likely to lose access to health insurance between the preconception and postpartum period than white non-Hispanic individuals.

The Consolidations Appropriations Act of 2023 makes the state plan option to provide 12 months of postpartum coverage permanent.¹ As of August 2023, 36 states have implemented the 12-month postpartum extension. Ten additional states are planning to implement a 12-month extension. Two states – Utah and Wisconsin – have proposed limited coverage extensions.⁷¹ Expanding postpartum care to 12 months allows healthcare providers to help parents better address specific challenges like mental health, domestic violence, substance use, and unmet social needs.

As of August 2023, states with maternity episodes of care in this brief, except Texas and Wisconsin, have either expanded or plan to expand postpartum Medicaid coverage to 12 months. Despite this it is not yet clear how this will impact the maternity VBP models. In NORC's review, 11 out of 15 states (Arkansas¹⁶, Arizona, Colorado, New Jersey³, New York⁴, North Carolina, Ohio⁵, Tennessee, Texas, Pennsylvania²³, and Washington) had a postpartum component to their models. All these states had postpartum episodes 60 days long. This 60-day period is in line with the mandatory Medicaid postpartum continuous coverage required of all states. However, fails to make states accountable for postpartum care delivered under the new 12-month postpartum coverage extension option.

Dyadic Care

How State Dyadic Care is Incorporated into Maternal Episodes of Care

Only two of the 15 reviewed episode of care models address dyadic care:

The New York Maternity Care Valued Based Payment Arrangement consists of three separate episodes (the Prenatal episode, the Delivery and Postpartum episode).²⁷ The Newborn Episode specifically targets services provided to the newborn including inpatient nursery and/or neonatal intensive care unit stay, up to 30 days after hospital discharge. The state aims to reinforce connections between the episodes through quality metrics, which includes Depression Screening and Follow-Up for Adolescents and Adults and Exclusive Breast Milk Feeding.

In the Pennsylvania Maternity Care Bundled Payment, one of the quality measures by which providers are judged is the percentage of children who receive two or more well-child visits with a primary care physician within 60 days after birth.²³ Another quality measure is prenatal immunization status.

Dyadic care in pregnancy and postpartum means providing or coordinating care for the birth parent and baby at the same time.

In the field of child psychotherapy, dyadic therapy means treating the infant or young child and the parent together, focusing on the relationship between the infant and the parent, and makes particular sense in the context of a substance use disorder (SUD) or postpartum depression (PPD). Dyadic approaches have demonstrated effectiveness in treating social-emotional and behavioral problems in young children, and in treating birth parents with depression.⁷² To treat the dyad, both parent and baby must receive Medicaid coverage during the postpartum year. Aligning continuous coverage for both the birth parent and newborn can improve continuous and ongoing care, and coverage transitions, for both parent and infant during and following the first year postpartum.⁷³

States may bundle the first year of pediatric care with a year of postpartum care to support better care for parents and babies. This approach rests on the idea that if the postpartum parent is unwell their infant will be affected and vice versa. The primary advantage of this approach is to increase the opportunities in which parents experiencing PPD or a SUD can be identified and connected to the support and treatment they need in settings where they also receive services for their infants (e.g., well-child visits).

Dyadic Care Medicaid Policies

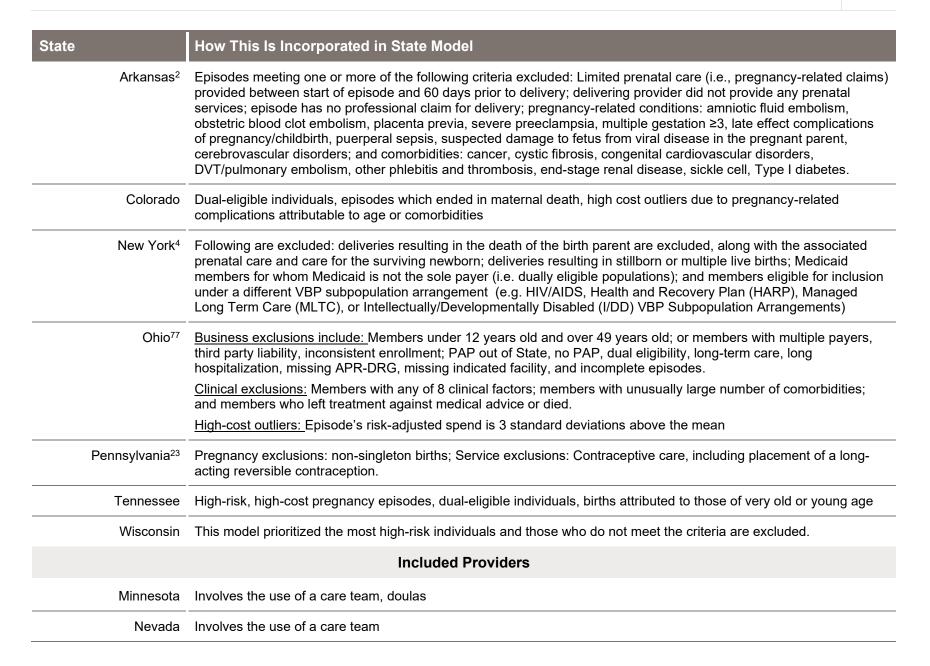
Beyond state episodes, there are other state initiatives related to dyadic care that are worth reviewing. After a successful pilot in San Francisco, effective January 1, 2023, Medi-Cal requires all managed care health plans to provide dyadic behavioral health services. This new policy allows Medi-Cal beneficiaries under age 21 and their caregivers and parents to benefit from Family Therapy without a prerequisite mental health diagnosis, acknowledging the need to support and strengthen the child-parent relationship. The service benefit is intended to address children's development and behavioral health conditions and foster access to preventive care for children, developmentally appropriate parenting, and maternal mental health. These dyadic behavioral health visits are provided for the child or caregiver/ parent at medical visits. The New York State Medicaid program also expanded behavioral health benefits. Effective April 1, 2023, prevention-based individuals, group, and family therapy services can be billed, including psychotherapy without the patient present using ICD-10 code Z65.9. This policy requires all state Medicaid managed care plans to accept the ICD code.⁷⁴

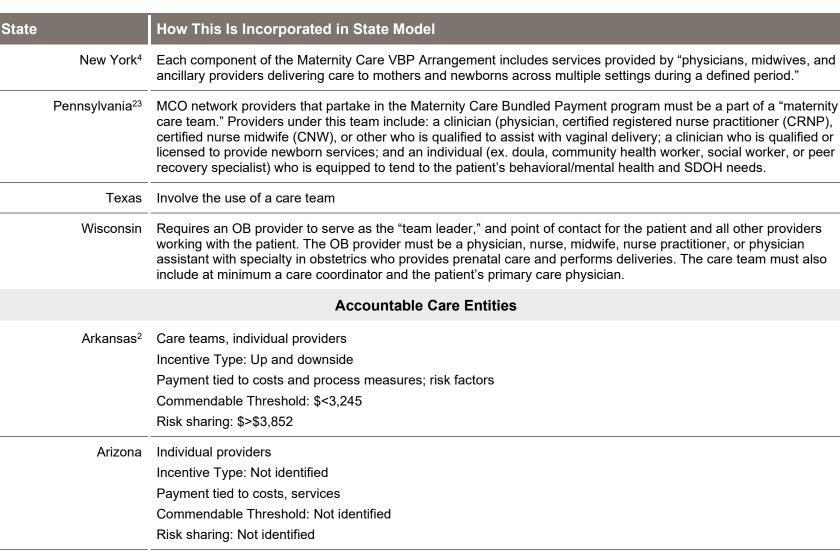
Findings: Medicaid Payment Considerations

The table below (**Table 2**) includes Medicaid payment considerations relevant to maternal episode of care payments including risk adjustment, exclusions, included providers, accountable care entities, and quality metrics.

State	How This Is Incorporated in State Model	
	Risk Adjustment	
Arkansas ⁷⁵	Arkansas ⁷⁵ The Arkansas Perinatal Episode calculates risk-adjusted costs for services provided across the episode and set thresholds based on average across providers each year using 21 risk factors, that provide meaningful explanato power for predicting cost per episode. Adjustments were made based on diabetes, hemorrhage, twin pregnancy, prolonged labor.	
Colorado The Colorado Maternity Bundled Payment Program calculates separate cost thresholds for patients with SUD.		
New Jersey ³ In the New Jersey Perinatal Episode of Care Program, a risk score is used to calculate the risk-adjusted epis The risk score is based on clinical risk factors such as OUD, premature separation of the placenta, or prior hi pre-term labor.		
Ohio ⁷⁶ In the Ohio Perinatal Bundled Payment seventy-seven factors are used in risk adjustment including but not li obesity, previous caesarean section, sexually transmitted infections, and anemia.		
	Exclusions	
Arizona	The first three antepartum E/M visits, laboratory tests, maternal or fetal echography procedures, amnioinfusion, amniocentesis (any method), chronic villus sampling, fetal contraction stress test, fetal non-stress test, external cephalic version, insertion of cervical dilator more than 24 hour before delivery, E/M services unrelated to the pregnancy during antepartum or postpartum care or for complications or high risk monitoring exceeding 13 visits, inpatient E/M services provided more than 24 hours before delivery, and management of surgical problems arising during pregnancy and non-global OB care or partial services	

Table 2. Medicaid Payment Considerations

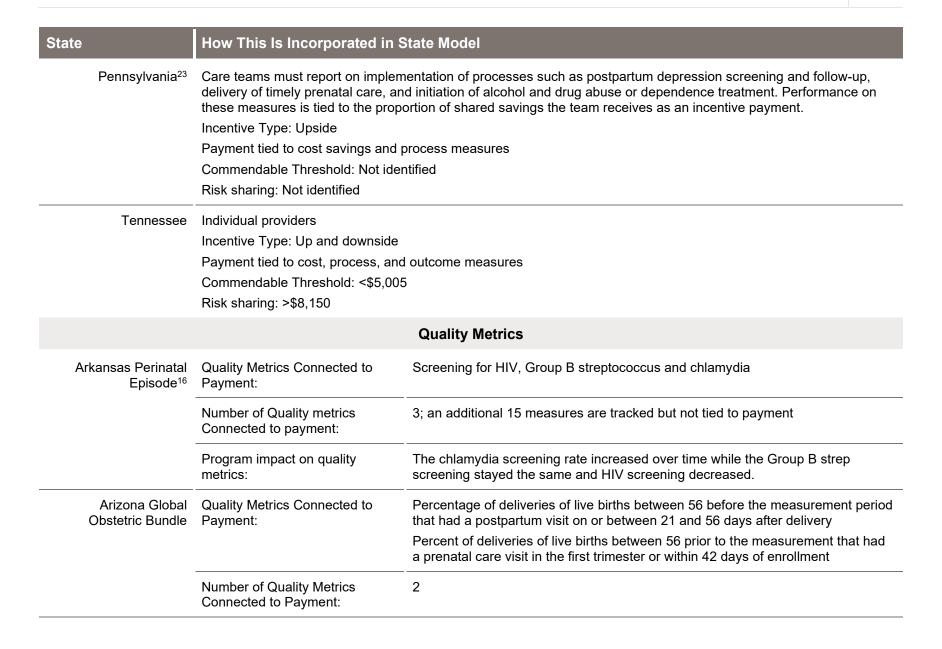




California⁷⁸ Public hospitals

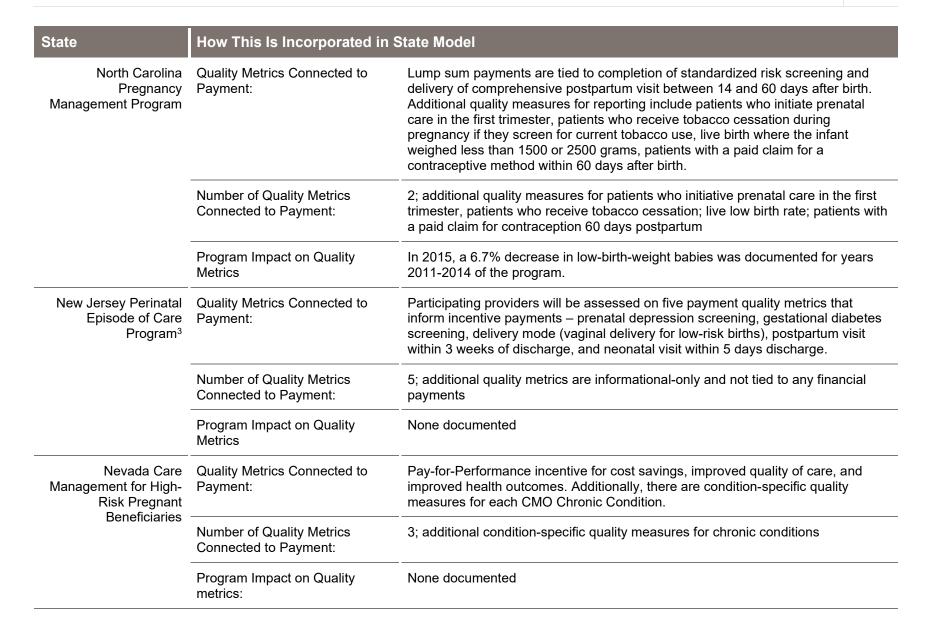


State	How This Is Incorporated in State Model	
Colorado	Individual providers, the proportion of elective deliveries and cesarean-section births is tied to payment	
	Incentive Type: Up ad downside	
	Payment tied to costs, process, outcomes and structural measures	
	Commendable Threshold: <\$7,438.79 (<\$7,791.41 SUD)	
	Risk sharing: >\$7,652.03 (>\$8,131.20 SUD)	
Minnesota	Individual providers	
Nevada	Care teams	
New Jersey ³	Group practices, individual providers	
	Incentive Type: Upside only	
	Payment tied to costs, processes and outcome measures	
	Commendable Threshold: Those who reduce their average risk-adjusted spend by >3% relative to their baseline threshold	
	Risk sharing: Currently the program does not include downside risk	
New York ²⁷	Individual providers	
	Incentive Type: Not identified	
	Payment tied to: Not identified	
	Commendable Threshold: Not identified	
	Risk sharing: Not identified	
North Carolina	blina Individual providers	
Ohio ⁷⁹	Group practices, individual providers	
	Incentive Type: Up and downside	
	Payment tied to costs, process, and outcome measures	
	Commendable Threshold: <\$3,364	
	Risk sharing: >\$4,731	





State	How This Is Incorporated in State Model	
	Program Impact on Quality Metrics	None documented
California PRIME Program ^{14 78}	Quality Metrics Connected to Payment:	Prenatal and postpartum care, C-section rates, Exclusive in-hospital breastfeeding rates, Breast Friendly Certification
	Number of Quality Metrics Connected to Payment:	4
	Program Impact on Quality Metrics	Data from the first three years of the PRIME program showed that prenatal and postpartum care improved along with c-section rates and breastfeeding rates. Mixed results were seen for hemorrhage and unexpected newborn complications.
Colorado Maternity Bundled Payment	Quality Metrics Connected to Payment:	Prenatal behavioral risk assessment, PPD screening, caesarean birth, postpartum contraceptive care and elective delivery
Program	Number of Quality Metrics Connected to Payment:	6
	Program Impact on Quality Metrics	None documented
Minnesota Integrated Care for High-Risk	Quality Metrics Connected to Payment:	N/A
Pregnant Women	Number of Quality Metrics Connected to Payment:	0
	Program Impact on Quality Metrics	The program successfully improved early identification of women with psychosocial and behavioral health risks, reduced the number of newborns testing positive for exposure to illicit substances, improved effectiveness of interventions to reduce risk factors related to low birth weight and increased use of community health workers, doulas, care navigators and peer support specialists in connections to supports and services.



State	How This Is Incorporated in State Model	
New York ²⁷	Quality Metrics Connected to Payment:	1. Contraceptive Care – Postpartum (P4R), 2. C-Section for Nulliparous Singleton Term Vertex (PFR), 3. Depression Screening and Follow-Up for Adolescents and Adults (PFR), 4. Exclusive Breast Milk Feeding (PFR), 5. Incidence of Episiotomy (PFR), 6. Initiation and Engagement of Substance Use Disorder Treatment (PFP), 7. Low Birth Weight, 8. Percentage of Preterm Births (PFR), 9. Prenatal and Postpartum Care (PFP) 10. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (PFR)
	Number of Quality Metrics Connected to Payment:	10; Pay for Performance (PFP) metrics based on the strength contractor's of outcomes while Pay for Reporting (PFR) based upon the timeliness, accuracy, and completeness of the reporting on the metric.
	Program Impact on Quality metrics:	None documented
North Carolina Pregnancy Medical Home	Program Impact on Quality metrics:	From 2011-2015 found a 6.7 percent decrease in the rate of low birthweight babies in the Medicaid population, however, it should be noted that this reduction was for all Medicaid-covered births and cannot specifically be attributed to the pregnancy medical home entirely. ¹²
Ohio Perinatal Bundled Payment ⁷⁶	Quality Metrics Connected to Payment:	Prenatal HIV screening rate, Prenatal GBS screening rate, C-section rate, Percent of episodes with follow-up visit within 60 days
	Number of Quality Metrics Connected to Payment:	4
	Program Impact on Quality metrics:	None documented
Pennsylvania Maternity Bundle Payment ²³	Quality metrics connected to payment:	Social Determinants of Health Screening, Initiation of Alcohol or Other Drug Abuse or Dependence Treatment, Timeliness of Prenatal Care, Postpartum care, Prenatal Depression Screening, Prenatal Depression Screening Follow-Up, Postpartum Depression Screening, Postpartum Depression Screening Follow-Up, Prenatal Immunization Status, Well-Child Visits
	Number of Quality Metrics Connected to Payment:	10; additional quality measures are reported by MCO and Joint Commission Accredited Hospitals for informational purposes but are not tied to payment

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State	How This Is Incorporated in State Model		
	Program Impact on Quality metrics:	None documented	
Tennessee Perinatal Episode of Care	Quality metrics connected to payment:	Screening for HIV, Screening for Group B streptococcus, C-section	
	Number of Quality Metrics Connected to Payment:	3; additional quality measures collected for informational purposes but not tied to payment	
	Program Impact on Quality metrics:		
Wisconsin OB Medical Home Initiative ⁸⁰	Quality metrics connected to payment:	The Department of Health Services will pay an additional \$1,000 to the HMO for each positive birth outcome. While the Department of Health Services does not define a positive birth outcome in the contract language, they define a poor outcome as	
		Preterm birth, Low birth weight, Neonatal death, or stillbirth	
	Number of Quality Metrics Connected to Payment:	7	
	Program Impact on Quality metrics:	The rate for poor birth outcomes decreased from 18% in 2011 to 13% in 2012. The rate was unchanged from 2012 to 2013. The model also caused an increased in postpartum care visits.	

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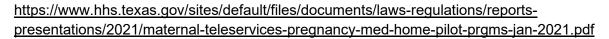
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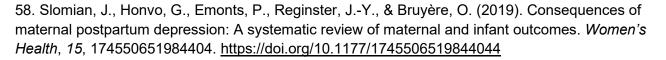
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