The following appendix is part of a Commonwealth Fund blog, Sara Rosenbaum et al., "The Road to Maternal Health Runs Through Medicaid Managed Care," *To the Point* (blog), Commonwealth Fund, May 22, 2023. https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care

Appendix 2

Best Practices in the Coverage and Delivery of Maternal Health: A Review of the Literature

Prepared by George Washington University, Milken Institute School of Public Health

Robust evidence exists to support nearly 60 maternal health "best practices" regarding coverage and performance obligations in Medicaid managed care. The table below presents the most current evidence for these best practices in the form of federal documents, professional guidelines, and other key resources. Additionally, the table provides: 1) definitions of each service/approach (as needed), and 2) an overview of the current Medicaid coverage of each service/approach.

Note on state Medicaid coverage: States have considerable discretion to determine the scope and reimbursement of maternity care benefits. States that have expanded Medicaid must cover the preventive services recommended by the US Preventive Services Task Force (i.e., prenatal screenings, folic acid supplements, and breastfeeding support), but this does not apply to those who qualified for Medicaid via non-expansion pathways. Additionally, while some states/MCOs pay some of the services below on an individual basis, others are paid as part of a global maternity bundle. While states can vary in the benefits they provide to some pregnant individuals depending on their eligibility status, the vast majority of states do provide the same package to all pregnant beneficiaries.

Part 1: Coverage and Performance Obligations Across the Continuum of Maternal Health

1. **Family Planning and Related Services Coverage**
2. **Preconception Service Coverage**
   - Preconception care services
   - Prepregnancy "check-up" visits with counseling and support services for planning pregnancy
   - Fertility assistance
3. **Early Identification of Member Pregnancy**
   - Rapid pregnancy testing, presumptive eligibility, and MCO notification programs
   - Nondirective pregnancy option counseling for confirmed pregnancy
4. **Prenatal Service Coverage**
   - Prenatal care
   - Group prenatal care
   - Prenatal childbirth and infant care classes
   - Ultrasound screening during pregnancy
   - Prenatal vitamins
   - Equipment to monitor gestational diabetes mellitus (GDM)
   - Equipment to monitor for preeclampsia
   - Pregnancy loss counseling and support
5. **Birth Services/Delivery Service Coverage**
   - Hospital births
   - Home births
   - Birth centers
   - Cesarean (C-section) births
   - Reducing early elective deliveries
   - LARC services immediately postpartum
6. **Postpartum Service Coverage**
   - Postpartum visits
   - Enhanced postpartum/interconception care
   - Parent-child "dyadic" interventions

Part 2: Coverage and Performance Obligations Related to Augmentations of Medical Care for Perinatal Persons

7. **Case Management and Care Coordination**
   - Perinatal case management
   - Medicaid maternal health home or pregnancy medical home
   - Coordination and linkage with primary care
   - Evidence-based home visiting programs
8. **Mental and Behavioral Health Service Coverage**
   - Maternal mental health screening and referral
   - All appropriate substance use disorder (SUD) treatment
   - Peer support services

9. **Nutrition Service Coverage**
    - Screenings and referrals to WIC and SNAP
    - Lactation and breastfeeding support
    - Coverage or other support related to infant formula
10. **Oral Health Service Coverage**

Part 3: Coverage and Performance Obligations for Services Related to Social Drivers for Perinatal Persons

11. **Housing Support Coverage**
12. **Transportation Coverage**
13. **Special Support Services for High-Risk Populations**

Part 4: Obligations Related to Access, Networks, Performance, Payment, and Member Rights

14. **Accessibility of Care**
    - Special access rules for persons with access barriers or high medical or social risk
    - Telehealth rules related to prenatal care and postpartum visits
15. **Network Composition and Competencies**
    - In-network hospitals including a range of levels of perinatal care (e.g., regionalized or risk-appropriate perinatal care)
    - In-network hospitals with special capabilities for pregnancy-related care for beneficiaries with high social risk
    - Requirements for anti-bias and Culturally and Linguistically Appropriate Services (CLAS) training
16. **Midwifery Service Coverage**
17. **Doula Service Coverage**
18. **Community Health Worker Coverage**
19. **Maternal Fetal Medicine Coverage**
20. **Quality Improvement and Performance Measurement**
    - Required reporting of CMS perinatal core measures and/or HEDIS measures
    - Required reporting of perinatal performance measures (including by race/ethnicity)
    - Linkage to perinatal quality collaboratives
    - Use of maternal health safety bundles (in-hospital or community)
    - Performance improvement activities/plans related to perinatal care
21. **Payment Reform Initiatives**
22. **Coordination with Key Agencies Serving Members***
    - Schools
    - Child welfare
    - Justice system
23. **Member Rights***
    - Right to select participating provider
    - Ability to obtain care from an out-of-network provider under certain conditions
    - Special protections for members who began care prior to enrollment with an out-of-network provider
    - Special plan safeguards to protect against coverage interruptions during the perinatal period

** These domains are not covered in this literature review.*

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Part 1: COVERAGE AND PERFORMANCE OBLIGATIONS ACROSS THE CONTINUUM OF MATERNAL HEALTH		
1. Family Planning and Related Services Coverage		
Family Planning Services ***Definition:*** Family planning services include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services. (42 CFR Section 59.2) ***Current Medicaid policy and coverage***: Family planning is a required benefit for beneficiaries who qualify through traditional eligibility pathways and ACA expansion eligibility. Under section 1905(a)(4)(C) of the Social Security Act (the Act), family planning services and supplies must be included in the standard Medicaid benefit package and in alternative benefit plans (ABPs). About half of states also have extended family planning only coverage to additional individuals under optional State Plan Amendments (SPAs) or waivers.	• Research shows the role of family planning services in promoting optimal health and pregnancy outcomes. Family planning is considered one of the top ten public health achievements of the 20th century. • The Centers for Disease Control and Prevention (CDC) and Office of Population Affairs (OPA) have issued joint recommendations for quality in providing family planning services, which support delivery of a comprehensive array of methods, counseling, screening, and support services. • The two sets of evidence-based clinical guidelines are the US Medical Eligibility Criteria for Contraceptive Use (US MEC) and US Selected Practice Recommendations for Contraceptive Use. Updated recommendations include newer methods approved by the FDA. • ACOG recommends and supports full coverage of all FDA-approved contraceptives without cost sharing, including coverage for Medicaid beneficiaries. • Healthy People 2030 goals focus on reducing unintended pregnancy by increasing use of birth control and family planning services, particularly by increasing the proportion of women who get needed publicly funded contraceptive services and support. • In Medicaid managed care arrangements, in-network family planning providers appear to be the norm.	**Federal documents and professional guidelines** • Gavin L, Moskosky S, Carter M, et al. (2014). Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs. MMWR. 63(4):1-55. https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf Update: Gavin, L., Pazol, K., & Ahrens, K. (2017). MMWR. 66(50):1383–1385. https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a4.htm • Centers for Disease Control and Prevention. (2016). United States Medical Eligibility Criteria for Contraceptive Use (US MEC). (Updated May 2022). https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html • Centers for Disease Control and Prevention. (2016). US Selected Practice Recommendations for Contraceptives. (Updated May 2022). https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html • American College of Obstetricians and Gynecologists. (2015). Access to Contraception. Committee Opinion No. 615. (Reaffirmed 2022). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception • Centers for Medicare and Medicaid Services (CMS). Medicaid Family Planning Services and Supplies. June 14, 2016. (SHO # 16-008) https://www.hhs.gov/guidance/document/medicaid-family-planning-services-and-supplies • CMS. (2021). Medicaid Covers Family Planning Services. https://www.medicaid.gov/about-us/program-history/medicaid-50th-

[1] Supporting literature is ordered by relevance to the topic.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Federal Medicaid law: • Requires coverage of all FDA-approved birth control methods • Prohibits copayments or any other form of patient cost sharing for family planning services; • Establishes a 90% federal matching rate (FMAP) for the costs of services categorized as family planning; and • Entitles beneficiaries to obtain family planning services from any provider that participates in the Medicaid program, called "freedom of choice" of provider, including for beneficiaries with mandatory enrollment in managed care organizations (MCOs). States' coverage varies within broad federal guidelines. Surveys find that: all states cover all FDA-approved prescription contraception methods, all states covered some form of emergency contraception pill, some states impose limits on LARCS, and most states do not finance over-the-counter methods such as condoms without a prescription.	However, access to out-of-network care remains an extremely important beneficiary guarantee. Education about the freedom of choice of provider for family planning should be required and billing guides should clarify the services covered under this guarantee, including prohibition against use of prior authorization restrictions.	anniversary/entry/47702 • Health Resources and Services Administration. (2021). Women's Preventive Services Guidelines. https://www.hrsa.gov/womens-guidelines/index.html • US Department of Health and Human Services. (2021). *Federal Register, 86*(192) 56144. https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21542.pdf • US Department of Health and Human Services. (Undated). Family Planning. Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning **Other key resources** • Rosenbaum, S., Shin, P., Casoni, M., et al. (2021). Family Planning and Medicaid Managed Care: Improving Access and Quality through Integration. George Washington University. https://publichealth.gwu.edu/sites/default/files/GW-AV%20Family%20Planning%20and%20Medicaid%20Managed%20Care%20Phase%20One%20Report%20Final%20June%202021.pdf • Rosenbaum, S., Murphy, C., Morris, R., Shin, P., Sharac, J. (2022). Family planning and Medicaid manged care integration, Phase Two Report: Insights from the field. George Washington University. https://www.newswise.com/pdf_docs/164795727743481_Family%20Planning%20and%20Medicaid%20Managed%20Care%20Phase%202.pdf • Teal, S., & Edelman, A. (2021). Contraception selection, effectiveness, and adverse effects: A review. *JAMA*, *326*(24), 2507-2518. https://doi.org/10.1001/jama.2021.21392 • Bossick, A. S., Brown, J., Hanna, A., Parrish, C., Williams, E. C., & Katon, J. G. (2021). Impact of State-Level Reproductive Health Legislation on Access to and Use of Reproductive Health Services and Reproductive Health Outcomes: A Systematic Scoping Review in the Affordable Care Act Era. *Women's health issues*, *31*(2), 114–121. https://doi.org/10.1016/j.whi.2020.11.005 • Weisman, CS, Maccannon, DS, Henderson, JT, Shortridge, E, Orso, CL. (2002). Contraceptive counseling in managed care: preventing unintended pregnancy in adults. *Womens Health Issues*; 12:79–95. https://doi.org/10.1016/s1049-

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		3867(01)00147-5 • McCarthy, M. (2021). Contraceptive counseling following in-clinic pregnancy test among women not expecting pregnancy in the next two years: Disparities by service delivery setting and sociodemographic characteristics. *Contraception*, *104*(2), 188–193. https://doi.org/10.1016/j.contraception.2021.02.014 • Dunlop, A. L., Joski, P., Strahan, A. E., Sierra, E., & Adams, E. K. (2020). Postpartum Medicaid Coverage and Contraceptive Use Before and After Ohio's Medicaid Expansion Under the Affordable Care Act. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *30*(6), 426–435. https://doi.org/10.1016/j.whi.2020.08.006 • Curtis, KM, Nguyen, A, Reeves, JA, Clark, EA, Folger, SG, Whiteman, MK. (2021). Update to U.S. Selected Practice Recommendations for Contraceptive Use: Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate. *MMWR Morb Mortal Wkly Rep. 70*(20): 739–743. http://dx.doi.org/10.15585/mmwr.mm7020a2 • Marcella, J. S. (2022). The Title X Program: Setting Standards for Contraceptive and Health Equity. *American Journal of Public Health*. *112*(S5): S511-S514. https://doi.org/10.2105/AJPH.2022.306900
2. Preconception Service Coverage		
Preconception care coverage services ***Definition:*** Preconception care is defined as a set of interventions that aim to identify and modify medical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention, intervention, and care management. ***Current Medicaid policy and coverage***: No specific coverage policy. Many states have had special health department initiatives and some Medicaid	• "Preconception care is recognized as a critical component of health care for women of reproductive age. The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age and to reduce risk factors that might affect future pregnancies. Preconception care is part of a larger health-care model that results in healthier women, infants, and families." - CDC • Preconception care is an essential element of primary and preventive care for women of reproductive age, rather than an isolated visit. It is more than a single visit, less than all well-woman care.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists (2005). ACOG Committee Opinion number 313, September 2005. The importance of preconception care in the continuum of women's health care. *Obstetrics and gynecology*. *106*(3): 665–666. https://doi.org/10.1097/00006250-200509000-00052 • ACOG Committee Opinion No. 762: Prepregnancy Counseling. (2019). *Obstetrics and gynecology. 133*(1): e78–e89. https://doi.org/10.1097/AOG.0000000000003013 • Health Resources and Services Administration. (2021). Women's Preventive Services Guidelines. https://www.hrsa.gov/womens-guidelines/index.html

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
agencies have participated by adding coverage for folic acid vitamins, risk screening, and other elements of preconception care. For purposes of ACA preventive services rules for coverage and cost-sharing, pre-pregnancy visits fall under the category of "well-women visits", which include pre-pregnancy, prenatal, postpartum and interpregnancy visits.	• As part of primary care, well-woman visits, risk assessment, and educational and health promotion counseling is recommended for all women of reproductive age to reduce reproductive risks and improve pregnancy outcomes. Risk assessment and targeted education and counseling should be provided based on a thorough medical history and updated annually. • "The Women's Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure that the recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors." - HRSA • Routine health promotion for all women of reproductive age should include screening for intentions to become or not become pregnant (sometimes called reproductive life plan assessment, also known by model/trademark name "One Key Question").	• Women's Preventive Services Initiative. (2022). https://www.womenspreventivehealth.org/ • Institute of Medicine. (2011). *Clinical Preventive Services for Women: Closing the Gaps*. The National Academies Press. https://doi.org/10.17226/13181 • American Academy of Family Physicians. (2016). Preconception care: Position Paper. https://www.aafp.org/about/policies/all/preconception-care.html • Johnson, K., Posner, S. F., Biermann, J., Cordero, J. F., Atrash, H. K., Parker, C. S., & Curtis, M. G. (2006). Recommendations to improve preconception health and Health Care—United States: Report of the CDC/ATSDR preconception care work group and the select panel on preconception care. *Morbidity and Mortality Weekly Report: Recommendations and Reports*. *55*(RR 6): 1-23. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm **Other key resources** • Atrash, H, Jack, B. (2020). Preconception care to improve pregnancy outcomes: The science. *J Hum Growth Dev.* 30(03):355–362. https://doi.org/10.7322/jhgd.v30.11064 • Jack, B. W., Atrash, H., Coonrod, D. V., Moos, M. K., O'Donnell, J., & Johnson, K. (2008). The clinical content of preconception care: an overview and preparation of this supplement. *American journal of obstetrics and gynecology*. *199*(6): S266-S279. [See full supplement for recommendations.] https:/doi.org/10.1016/j.ajog.2008.07.067 • Frayne, D. J., Verbiest, S., Chelmow, D., Clarke, H., Dunlop, A., Hosmer, J., ... & Zephyrin, L. (2016). Health care system measures to advance preconception wellness: Consensus recommendations of the clinical workgroup of the National Preconception Health and Health Care Initiative. *Obstetrics & Gynecology*. *127*(5): 863-872. https://doi: 10.1097/AOG.0000000000001379 • Dorney, E, Boyle, JA, Walker, R, Hammarberg, K, Musgrave, L, Schoenaker, D, Jack, B, Black, KI. (2022). A Systematic Review of Clinical Guidelines for Preconception Care. *Semin Reprod Med. 40*: 157-169 https://doi.org/10.1055/s-0042-1748190. • Nacev, EC, Greene, MZ, Taboada, MP, Ehrenthal, DB. (2022). Factors Influencing Provider Behavior Around Delivery of Preconception Care. *Matern*

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Child Health J. 26(7):1567-1575. https://doi.org/10.1007/s10995-022-03411-8. • Zaçe, D, Orfino, A, Mariaviteritti, A, Versace, V, Ricciardi, W, DI Pietro, ML. (2022). A comprehensive assessment of preconception health needs and interventions regarding women of childbearing age: a systematic review. *J Prev Med Hyg*. 63(1):E174-E199. https://doi.org/10.15167/2421-4248/jpmh2022.63.1.2391. • Carrandi, A, Bull, C, Callander, E. (2022). Health Economics and Equity in Preconception Health Care: A Systematic Review. *Semin Reprod Med.* https://doi.org/10.1055/s-0042-1749684. • Moos, MK, Dunlop, AL, Jack, BW, Nelson, L, Coonrod, DV, Long, R, Boggess, K, Gardiner, PM. (2008). Healthier women, healthier reproductive outcomes: recommendations for the routine care of all women of reproductive age. *Am J Obstet Gynecol.* 199(Suppl. 2):S280-9. https://doi.org/10.1016/j.ajog.2008.08.06010.1016/j.ajog.2008.08.060
Prepregnancy "check-up" visits with counseling and support services for planning pregnancy ***Definition:*** A single visit for persons planning pregnancy to review risks, discussion prevention (e.g., folic acid, diabetes control, cessation of teratogenic prescription medications, etc.), and specific interventions. ***Current Medicaid policy and coverage***: No specific coverage policy. For purposes of ACA preventive services rules for coverage and cost-sharing, pre-pregnancy visits fall under the category of "well-women visits", which include pre-pregnancy, prenatal, postpartum and interpregnancy visits.	• Prepregnancy "check-up" visits offer an opportunity to screen for and address specific risks to the health of the mother or the child as a result of a pregnancy. • Clinical guidelines for such visits exist via the Women's Preventive Services Initiative (WPSI). • These visits are in the "well-woman" category defined by the NASEM/IOM as part of women's clinical preventive services, and are assumed in this category in the HRSA women's clinical preventive services guidelines. • Pre-pregnancy visits also have been recommended by CDC Select Panel on Preconception Health and Health Care. The CDC recommended payers finance one prepregnancy visit per pregnancy. • The US Public Health Services Exert Panel on Prenatal Care, National Committee on Perinatal Health, and Institute of Medicine Committee on Preventing Low Birthweight also all previously recommended a prepregnancy visit in the months	**Federal documents and professional guidelines** • Health Resources and Services Administration. (2021). Women's Preventive Services Guidelines. https://www.hrsa.gov/womens-guidelines/index.html • Women's Preventive Services Initiative. (2022). https://www.womenspreventivehealth.org/ • Institute of Medicine. (2011). *Clinical Preventive Services for Women: Closing the Gaps*. The National Academies Press. https://doi.org/10.17226/13181 • US Preventive Services Task Force. (2009). Folic acid to prevent neural tube defects. US Department of Health and Human Services, Agency for Healthcare Research and Quality. http://www.uspreventiveservicestaskforce.org/uspstf/uspsnrfol.htm. • US Preventive Services Task Force. (2017). Folic acid for the prevention of neural tube defects: Preventive medication. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication **Other key resources**

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	before conception. • The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	• Raghuraman, N., & Tuuli, M. G. (2021). Preconception Care as an Opportunity to Optimize Pregnancy Outcomes. *JAMA*. *326*(1):79–80. https://doi.org/10.1001/jama.2020.27244 • Hill, B., Hall, J., Skouteris, H., & Currie, S. (2020). Defining preconception: exploring the concept of a preconception population. *BMC pregnancy and childbirth*. *20*(1): 280. https://doi.org/10.1186/s12884-020-02973-1 • Wally, M. K., Huber, L., Issel, L. M., & Thompson, M. E. (2018). The Association Between Preconception Care Receipt and the Timeliness and Adequacy of Prenatal Care: An Examination of Multistate Data from Pregnancy Risk Assessment Monitoring System (PRAMS) 2009-2011. *Maternal and child health journal*. *22*(1): 41–50. https://doi.org/10.1007/s10995-017-2352-6 • Green-Raleigh, K., Lawrence, J. M., Chen, H., Devine, O., & Prue, C. (2005). Pregnancy planning status and health behaviors among nonpregnant women in a California managed health care organization. *Perspectives on sexual and reproductive health*. *37*(4): 179–183. https://doi.org/10.1363/psrh.37.179.05
Fertility assistance ***Definition:*** An array of diagnostic and treatment services that may be necessary to assist in fertility, including diagnostic tests, treatment services, and fertility preservation (e.g., egg/sperm/embryo freezing). ***Current Medicaid policy and coverage:*** The mandatory family planning benefit provides coverage for infertility treatment at the state's option. Surveys indicate that Medicaid covers fertility counseling in 11 states. Some states specifically cover infertility diagnostic services. For example, eight states (GA, HI, MA, MI, MN, NH, NM and NY) offer at least one Medicaid plan with this	• For a variety of reasons, many people require fertility assistance. Those needing these services include: men and women with infertility, as well as LGBTQ and single individuals who seek to have children. An estimated 10% of women report that they or their partners have ever received medical help to become pregnant. • Infertility is most commonly defined as the inability to achieve pregnancy after 1 year of regular, unprotected heterosexual intercourse. Infertility affects an estimated 10-15% of heterosexual couples. • The causes of infertility may be related to a variety of factors such as problems with ovulation or sperm count, the impact of medical treatment (e.g., chemotherapy), or effects of STIs, smoking, or environmental toxins. • Despite the need for such services, fertility care in the U.S. is inaccessible to many due to the high cost. Fertility	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists Committee on Gynecologic Practice and Practice Committee (2014). Female age-related fertility decline. Committee Opinion No. 589. *Fertility and sterility*. *101*(3): 633–634. https://doi.org/10.1016/j.fertnstert.2013.12.032 **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Weigel, G. Ranji, U., Long, M., & Salfanicoff, A. (2020). Coverage and use of fertility services in the U.S. Kaiser Family Foundation. https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
benefit, but the range of diagnostic services covered varies considerably. At the same time, only 4 states (CA, IL, NY, WI) covered fertility medications/treatments in 2021. Notably, some states may require Medicaid to cover treatments for conditions that have impact on fertility. For example, states may cover medications or surgery for fibroids, endometriosis or other gynecologic abnormalities if causing pelvic pain, abnormal bleeding or another medical problem, other than infertility.	services are not covered by most public or private insurance plans. ● Most patients pay out of pocket for fertility treatment, which can amount to well over $10,000 depending on the services received. ● The CDC reports that that use of in vitro fertilization (IVF) has steadily increased since its first successful birth in 1981. According to the most recent data, an estimated 1.8% of U.S. infants are conceived annually using assisted reproductive technology (e.g., IVF and related procedures). ● The lack of coverage for fertility assistance has a disproportionate impact on people of color and low-income individuals. Among reproductive age women, Medicaid covers 30% who identify as Black and 26% who identify as Hispanic, compared to 15% who report being White non-Hispanic. Because eligibility for Medicaid is based on being low-income, people enrolled in the program likely could not afford to pay for fertility services out of pocket.	s/#:~:text=Only%20one%20state%20Medicaid%20program,depending%20on%20the%20services%20received. • Biddle, J. F., Wetherill, L., Geddes, G. C., Quirin, K., Rouse, C. E., & Hines, K. A. (2022). OBGYN providers' lack of knowledge and management of genetic risks due to advanced paternal age underscore the need for updated practice guidance. *Journal of community genetics*. *13*(4): 427–433. https://doi.org/10.1007/s12687-022-00595-y • Drennan C. (2019). Assisted fertility - the legal and ethical issues. *The Medical-legal journal*. *87*(3): 113–120. https://doi.org/10.1177/0025817219860959 • Howell, E. P., Harris, B. S., Kuller, J. A., & Acharya, K. S. (2020). Preconception Evaluation Before In Vitro Fertilization. *Obstetrical & gynecological survey*. *75*(6): 359–368. https://doi.org/10.1097/OGX.0000000000000788 • Boedt, T., Vanhove, A. C., Vercoe, M. A., Matthys, C., Dancet, E., & Lie Fong, S. (2021). Preconception lifestyle advice for people with infertility. *The Cochrane database of systematic reviews*. *4*(4): CD008189. https://doi.org/10.1002/14651858.CD008189.pub3
3. Early Identification of Member Pregnancy		

The following appendix is part of a Commonwealth Fund blog, Sara Rosenbaum et al., "The Road to Maternal Health Runs Through Medicaid Managed Care," *To the Point* (blog), Commonwealth Fund, May 22, 2023. https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]

Rapid pregnancy testing, presumptive eligibility, and MCO notification programs
 	
Current Medicaid policy and coverage: Coverage varies for both Medicaid beneficiaries and those who qualify for Medicaid based on pregnancy.
 	
At their option, state Medicaid agencies can use presumptive eligibility for pregnant women. This option allows authorized providers to begin treating pregnant people when they first seek to confirm a pregnancy and begin prenatal care immediately, rather than weeks later after a determination has been made regarding their Medicaid eligibility. Presumptive eligibility for Medicaid for pregnant women was first offered as a state option in 1986, and presumptive eligibility for children age 1 and older became an option in 1997.
 	
As of January 2020, 30 states reported using presumptive eligibility for pregnant women. Some states have alternative procedures for expedited eligibility and enrollment. The role of MCOs in presumptive eligibility varies.
	• Coverage of pregnancy tests (i.e., urine and blood-based tests), presumptive eligibility, and rapid notification of MCOs are necessary to facilitate early interventions, such as:
	  • 1) early pregnancy counseling (which permits pregnant people to make early informed decisions about their health care),
	  • 2) the option to quickly enter into prenatal care (which is associated with improved maternal and child health outcomes), and
	  • 3) early entry into perinatal case management and administration of risk assessments via an MCO.
	• Presumptive eligibility for pregnant people has been shown to increase use of early prenatal care, particularly for those with less access to care and less than high school education.
		Federal documents and professional guidelines
		• American College of Obstetricians and Gynecologists. (2021). Routine tests during pregnancy. Guidance FAQ No. 133. https://www.acog.org/womens-health/faqs/routine-tests-during-pregnancy
		• CMS. (Undated.) Implementation Guide: Medicaid State Plan Eligibility, Presumptive Eligibility for Pregnant Women. https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-presumptive-eligibility-for-pregnant-women.pdf
		
		Other key resources
		• Kaiser Family Foundation. (2020). Presumptive Eligibility in Medicaid. https://www.kff.org/health-reform/state-indicator/presumptive-eligibility-in-medicaid-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
		• Brooks, T., Roygardner, L., Artiga, S., Pham, O., & Dolan, R. (2020). Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2020: Findings from a 50-state survey. Kaiser Family Foundation and Georgetown Center for Children and Families. https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/
		• Bellerose, M., Rodriguez, M., & Vivier, P. M. (2022). A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. *Health services research*. *57*(4): 775–785. https://doi.org/10.1111/1475-6773.14008
		• Eliason, E. L., Daw, J. R. (2022). Presumptive eligibility for pregnancy Medicaid and timely prenatal care access. *Health Serv Res*. 1-7. doi:10.1111/1475-6773.14035
		• Clark, M. (2020). Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options. Georgetown University Center for Children and Families. https://ccf.georgetown.edu/wp-

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		content/uploads/2020/11/Pregnancy-primary-v6.pdf • Degife, E., Forman, H., & Rosenbaum, S. (2021). Expanding Presumptive Eligibility as a Key Part of Medicaid Reform. *JAMA Health Forum. 2*(2): e210017-e210017. https://doi.org/10.1001/jamahealthforum.2021.0017 • Brooks, T. (2011). Presumptive eligibility: Providing access to health care without delay and connecting children to coverage. Georgetown Cneter for Children and Families. https://ccf.georgetown.edu/wp-content/uploads/2012/03/Presumptive_eligibility_20111.pdf • Broaddus, E. T. (2008). Presumptive eligibility for pregnant women. National Academy for State Health Policy. https://nashp.org/wp-content/uploads/sites/default/files/Presumptive%20Eligibility%20Monitor.pdf • Krukowski, R.A., Jacobson, L.T., John, J. *et al.* Correlates of Early Prenatal Care Access among U.S. Women: Data from the Pregnancy Risk Assessment Monitoring System (PRAMS). *Matern Child Health J.* 26: 328–341 (2022). https://doi.org/10.1007/s10995-021-03232-1 • Shah, J. S., Revere, F. L., & Toy, E. C. (2018). Improving Rates of Early Entry Prenatal Care in an Underserved Population. *Maternal and child health journal*. *22*(12): 1738–1742. https://doi.org/10.1007/s10995-018-2569-z
Nondirective pregnancy option counseling for confirmed pregnancy ***Current Medicaid policy and coverage:*** Coverage is unclear for both Medicaid beneficiaries and those who qualify for Medicaid based on pregnancy. States differ in permitting abortion counseling. Federal rules for family planning require providers to: "offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options: (A) Prenatal care and delivery; (B) Infant care, foster care, or adoption;	• Nondirective pregnancy option counseling (including accurate information about all pregnancy options) is supported by multiple expert bodies to ensure patients can give informed consent to their reproductive health treatment, including: the American Medical Association, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Academy of Physician Assistants, Association of Women's Health, Obstetric and Neonatal Nurses, and others. • Any withholding of information without the patient's knowledge or consent is considered ethically unacceptable by these professional organizations.	**Federal documents and professional guidelines** • American Academy of Pediatrics. (2006). Counseling the adolescent about pregnancy options, *Pediatrics*, 101(5), 938–940. https://publications.aap.org/pediatrics/article-abstract/101/5/938/65321/Counseling-the-Adolescent-About-Pregnancy-Options?redirectedFrom=fulltext • American Medical Association. (2013). Opinion 2.1.3: Withholding information from patients, Code of Medical Ethics. https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf • American College of Obstetricians and Gynecologists. (2014). *Guidelines for Women's Health Care: A Resource Manual*, 4th Edition. https://www.acog.org/clinical/journals-and-publications/ebook

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
and (C) Pregnancy termination. (ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and, referral upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling." - 42 CFR Section 59.5		• Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (2016). AWHONN position statement: Health care decision making for reproductive care, *Journal of Obstetric, Gynecologic & Neonatal Nursing.* 45(5):718. https://doi.org/10.1111/j.1751-486X.2009.01494.x • American Academy of Physician Assistants. (2013). Guidelines for Ethical Conduct for the PA Profession. https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf • US Department of Health and Human Services. (2021). *Federal Register, 86*(192): 56144. https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21542.pdf **Other key resources** • Nobel, K., Ahrens, K., Handler, A., & Holt, K. (2022). Patient-reported experience with discussion of all options during pregnancy options counseling in the US South. *Contraception*. *106*: 68–74. https://doi.org/10.1016/j.contraception.2021.08.010
4. Prenatal Service Coverage		
Prenatal care ***Current Medicaid policy and coverage:*** All states provide coverage for routine prenatal care visits provided by physicians. Coverage of prenatal care for midwives is required but varies. Many states have had Medicaid prenatal care initiatives since 1984, when prenatal eligibility expansions began. These initiatives are sometimes called "enhanced prenatal care" and involve additional case management or social support. (See more on these topics below.)	• Over two-thirds (68%) of women whose births were financed by Medicaid received early prenatal care (beginning during the first trimester) and 76% had adequate prenatal care (received nine or more prenatal care visits over the course of their pregnancy). • Nationally, Medicaid beneficiaries are less likely to begin prenatal care in the first trimester and less likely to receive adequate prenatal care compared to privately insured women. Pregnant people in Medicaid were more likely to experience timely and adequate prenatal care than their uninsured counterparts. • Studies of women in states with Medicaid expansion resulting in more continuous coverage show positive	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care: Eighth Edition. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. • MACPAC. (2020). Medicaid's role in financing Maternity Care. (Factsheet). https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf • MACPAC. (2018). Access in Brief: Pregnancy women in Medicaid. https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf **Other key resources**

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	impact on adequacy of the timing of prenatal care.	• Lockwood, C.J., Berghalla, V., Barss, A.A. (2022). Prenatal care: Initial assessment. *Up-to-Date.* https://www.uptodate.com/contents/prenatal-care-initial-assessment • Issel LM, Forrestal SG, Slaughter J, Wiencrot A, Handler A. (2011). A review of prenatal home-visiting effectiveness for improving birth outcomes. *J Obstet Gynecol Neonatal Nurs*. 40(2), 157-165. • Meghea, C. I., You, Z., Raffo, J., Leach, R. E., & Roman, L. A. (2015). Statewide Medicaid Enhanced Prenatal Care Programs and Infant Mortality. *Pediatrics*. *136*(2): 334–342. https://doi.org/10.1542/peds.2015-0479 • Peahl, A. F., Gourevitch, R. A., Luo, E. M., Fryer, K. E., Moniz, M. H., Dalton, V. K., ... & Shah, N. (2020). Right-sizing prenatal care to meet patients' needs and improve maternity care value. *Obstetrics & Gynecology*, *135*(5), 1027-1037. https://doi.org/10.1097/AOG.0000000000003820 • Kinsler, S. (2014). Supporting high performance in early entry into prenatal care: State and safety net provider policies, programs, and practices. National Academy for Health State Policy. https://nashp.org/wp-content/uploads/sites/default/files/files/OverviewFINAL-prenatal-care_0.pdf • Institute of Medicine (US) Committee to Study Outreach for Prenatal Care, & Brown, S. S. (1988). *Prenatal Care: Reaching Mothers, Reaching Infants*. National Academies Press. https://doi.org/10.17226/731 • Rosen, M. G., Merkatz, I. R., & Hill, J. G. (1991). Caring for our future: a report by the expert panel on the content of prenatal care. *Obstetrics and gynecology*. *77*(5): 782–787. https://pubmed.ncbi.nlm.nih.gov/2014096/ • Baker, M. V., Butler-Tobah, Y. S., Famuyide, A. O., & Theiler, R. N. (2021). Medicaid Cost and Reimbursement for Low-Risk Prenatal Care in the United States. *Journal of midwifery & women's health*. *66*(5): 589–596. https://doi.org/10.1111/jmwh.13271 • Baer, R. J., Altman, M. R., Oltman, S. P., Ryckman, K. K., Chambers, C. D., Rand, L., & Jelliffe-Pawlowski, L. L. (2019). Maternal factors influencing late entry into prenatal care: a stratified analysis by race or ethnicity and insurance status. *The journal of maternal-fetal & neonatal medicine.*

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		32(20): 3336–3342. https://doi.org/10.1080/14767058.2018.1463366 ● Eliason, E. L., Daw, J. R., & Allen, H. L. (2021). Association of Medicaid vs Marketplace Eligibility on Maternal Coverage and Access with Prenatal and Postpartum Care. *JAMA network open*. *4*(12): e2137383. https://doi.org/10.1001/jamanetworkopen.2021.37383
Group prenatal care ***Definition:*** Group prenatal care offers pregnant women the opportunity to receive care in a group setting, meeting together as a cohort to have prenatal care appointments that include additional time for education and support from their providers and other pregnant women. ***Current Medicaid policy and coverage:*** Surveys indicate only 12 states cover group prenatal care. Some states cover this service only for individuals with higher risk pregnancies, and others limit the number of hours that can be received. Most states that cover group prenatal care provide separate Medicaid reimbursement, beyond the rate for the office prenatal care visit. Group prenatal care was one of three innovative approaches to prenatal care included in the CMS Strong Start demonstration project.	● Group prenatal care is supported by recommendations from the American College of Obstetricians and Gynecologists and other professional organizations. ● Group prenatal care models, including the Centering Pregnancy model, have been widely used and evaluated in public, private, and military care settings. ● For pregnant people, receipt of group prenatal care is associated with improved pregnancy-related weight management, an increase in patients presenting in active labor and at greater cervical dilatation, and a decrease in likelihood of requiring cesarean delivery. Receipt of group prenatal care is also associated with improved knowledge and preparation related to pregnancy, birth, family planning, postpartum depression, and care for infants. ● For infants, receipt of group prenatal visits is associated with fewer adverse birth outcomes, including preterm birth, low-birthweight birth, and NICU admissions.	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists. (2018). ACOG Committee Opinion: Group Prenatal Care. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/03/group-prenatal-care.pdf ● Centers for Medicare and Medicaid Services (2018). Strong Start for Mothers and Newborns Evaluation: Year 5 Project Synthesis. https://innovation.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf. **Other key resources** ● Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ ● Ickovics, J. R., Kershaw, T. S., Westdahl, C., Magriples, U., Massey, Z., Reynolds, H., & Rising, S. S. (2007). Group prenatal care and perinatal outcomes: a randomized controlled trial. *Obstetrics and gynecology*. *110*(2 Pt 1): 330–339. https://doi.org/10.1097/01.AOG.0000275284.24298.23 ● Picklesimer, A. H., Billings, D., Hale, N., Blackhurst, D., & Covington-Kolb, S. (2012). The effect of CenteringPregnancy group prenatal care on preterm birth in a low-income population. *American journal of obstetrics and gynecology*. *206*(5): 415.e1–415.e4157.https://doi.org/10.1016/j.ajog.2012.01.040; ● Pekkala, J., Cross-Barnet, C., Kirkegaard, M., Silow-Carroll, S., Courtot, B., &

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Hill, I. (2020). Key Considerations for Implementing Group Prenatal Care: Lessons from 60 Practices. *Journal of midwifery & women's health*. *65*(2): 208–215. https://doi.org/10.1111/jmwh.13047 ● Heberlein, E., Smith, J., Willis, C., Hall, W., Covington-Kolb, S., & Crockett, A. (2020). The effects of Centering Pregnancy group prenatal care on postpartum visit attendance and contraception use. *Contraception*. *102*(1): 46–51. https://doi.org/10.1016/j.contraception.2020.02.010 ● Tanner-Smith, E. E., Steinka-Fry, K. T., & Lipsey, M. W. (2014). The effects of CenteringPregnancy group prenatal care on gestational age, birth weight, and fetal demise. *Maternal and child health journal*, *18*(4), 801–809. https://doi.org/10.1007/s10995-013-1304-z
Prenatal childbirth and infant care classes ***Current Medicaid policy and coverage:*** Surveys indicate that only 14 states cover both childbirth and parenting education during pregnancy. Not all states finance health education classes to support childbirth, infant care, or parents for people under any of the Medicaid eligibility pathways.	● ACOG recommends pregnant people and family members attend childbirth education programs. ● ACOG recommends that though specific course content and techniques for managing pain differ by childbirth preparation program, all should use appropriate literacy and language levels and cultural competence. ● Education might include nutrition, weight gain, exercise, dental care, nausea, vitamin and mineral toxicity, teratogens, and air travel depending on the patient. ● ACOG recommends post-partum education should include patient self-care, parent-infant relationships, and newborn infant care. ● Prenatal childbirth classes have been shown to be most effective for women giving birth for the first time (nulliparous women) and have impact on both maternal and infant health outcomes. ● Attending birthing classes is associated with higher rates of normal vaginal delivery, lower rates of vacuum extraction, fewer cesarean section deliveries, and lower frequency of epidural analgesia.	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care, 8th Edition. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx ● American College of Obstetricians and Gynecologists (2018). Group Prenatal Care. Committee Opinion 731. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care **Other key resources** ● Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. ● Afshar, Y., Wang, E. T., Mei, J., Esakoff, T. F., Pisarska, M. D., & Gregory, K. D. (2017). Childbirth Education Class and Birth Plans Are Associated with a Vaginal Delivery. *Birth, 44*(1), 29–34. https://doi.org/10.1111/birt.12263 ● Chen, I., Opiyo, N., Tavender, E., Mortazhejri, S., Rader, T., Petkovic, J.,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	• Attending birthing classes is also associated with higher likelihood of using breathing and visualization techniques during labor. Mindfulness-based childbirth education is associated with improved psychological functioning and self-efficacy in the birth process, as well as lower postpartum depression symptoms and lower rates of opioid analgesia use in labor.	Yogasingam, S., Taljaard, M., Agarwal, S., Laopaiboon, M., Wasiak, J., Khunpradit, S., Lumbiganon, P., Gruen, R. L., & Betran, A. P. (2018). Non-clinical interventions for reducing unnecessary caesarean section. *The Cochrane database of systematic reviews*. *9*(9): CD005528. https://doi.org/10.1002/14651858.CD005528.pub3 • Duncan, L. G., Cohn, M. A., Chao, M. T., Cook, J. G., Riccobono, J., & Bardacke, N. (2017). Benefits of preparing for childbirth with mindfulness training: a randomized controlled trial with active comparison. *BMC pregnancy and childbirth*. *17*(1): 140. https://doi.org/10.1186/s12884-017-1319-3 • Vanderlaan, J., Sadler, C., & Kjerulff, K. (2021). Association of Delivery Outcomes With the Number of Childbirth Education Sessions. J*ournal of perinatal & neonatal nursing*. *35*(3): 228–236. https://doi.org/10.1097/JPN.0000000000000579 • Gluck, O., Pinchas-Cohen, T., Hiaev, Z., Rubinstein, H., Bar, J. & Kovo, M. (2020), The impact of childbirth education classes on delivery outcome. *Int J Gynecol Obstet. 148:* 300-304. https://doi.org/10.1002/ijgo.13016
Ultrasound screening during pregnancy ***Current Medicaid policy and coverage:*** All states cover prenatal ultrasounds for pregnant women, but some impose limitations on this coverage - such as limits on the number of ultrasounds allowed during the course of a pregnancy and medical necessity requirements.	• A comprehensive first-trimester ultrasound provides valuable clinical information that cannot be detected with noninvasive prenatal testing (NIPT) alone. • Early encountering of life-threatening congenital malformations via ultrasound allows for patients' choice of termination (earlier termination is more commonly available, psychologically easier for the patient, and easier to perform).	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2020). Committee on Practice Bulletins: Obstetrics Committee on Genetics Society for Maternal-Fetal Medicine Screening for Fetal Chromosomal Abnormalities, Obstetrics & Gynecology: 136(4): e48-e69. https://doi.org/10.1097/AOG.0000000000004084 • American Academy of Family Physicians. (2018). Obstetric ultrasound examination: Position paper. https://www.aafp.org/about/policies/all/obstetric-ultrasound.html **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. • Mei, J. Y., Afshar, Y., & Platt, L. D. (2019). First-Trimester Ultrasound. *Obstetrics and gynecology clinics of North America*. *46*(4): 829–852. https://doi.org/10.1016/j.ogc.2019.07.011 • Scibetta, E. W., & Han, C. S. (2019). Ultrasound in Early Pregnancy: Viability, Unknown Locations, and Ectopic Pregnancies. *Obstetrics and gynecology clinics of North America*. *46*(4): 783–795. https://doi.org/10.1016/j.ogc.2019.07.013
Prenatal vitamins ***Current Medicaid policy and coverage:*** States are not required to cover over-the-counter drugs; however, they are required to cover nonprescription prenatal vitamins. In 2021, a majority of states reported that coverage for prenatal vitamins aligned across coverage eligibility groups, with exception of Oklahoma. While states cover prenatal vitamins for pregnant women, some impose limitations such as requiring a prescription for vitamins. States report using utilization controls to manage the benefit for prenatal vitamins, such as days limits, generic requirements, limits on quantity, inclusion on a Preferred Drug List (PDL), and prior authorization.	• Federal and professional recommendations call for the use of prenatal vitamins, particularly intake of folic acid prior to and during early months of pregnancy. • To reduce the incidence of birth defects, national recommendations call specifically for supplementation of folic acid, taken in a daily prenatal vitamin with at least 400 micrograms starting at least 1 month before pregnancy and during the first 12 weeks of pregnancy. • For many pregnant women, dietary intake of food products is often insufficient to meet these needs and can lead to micronutrient deficiencies. • Vitamins, minerals, and omega-3 fatty acids are important in ensuring the appropriate progress of a normal pregnancy, in order to support the mother through the common discomforts of pregnancy and to prevent pregnancy complications.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. Nutrition During Pregnancy. (Undated). https://www.acog.org/womens-health/faqs/nutrition-during-pregnancy • American College of Obstetricians and Gynecologists. (2017). Neural Tube Defects. Practice Bulletin No. 187. *Obstetrics and gynecology*. *130*(6): e279–e290. https://doi.org/10.1097/AOG.0000000000002412 • Centers for Disease Control and Prevention. History of folic acid recommendations in the United States. (Website, undated.) https://www.cdc.gov/ncbddd/folicacid/recommendations.html#:~:text=The%20U.S.%20Public%20Health%20Service,to%20prevent%20neural%20tube%20defects. **Other key resources** • Jouanne, M, Oddoux, S, Noël, A, Voisin-Chiret, AS. (2021). Nutrient Requirements during Pregnancy and Lactation. *Nutrients. 13*(2): 692. https:///doi.org/10.3390/nu13020692 • Santander Ballestín, S., Giménez Campos, M. I., Ballestín Ballestín, J., & Luesma Bartolomé, M. J. (2021). Is Supplementation with Micronutrients Still Necessary during Pregnancy? A Review. *Nutrients*. *13*(9): 3134. https://doi.org/10.3390/nu13093134 • Tsakiridis, I., Kasapidou, E., Dagklis, T., Leonida, I., Leonida, C., Bakaloudi,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		D. R., & Chourdakis, M. (2020). Nutrition in Pregnancy: A Comparative Review of Major Guidelines. *Obstetrical & gynecological survey*. *75*(11): 692–702. https://doi.org/10.1097/OGX.0000000000000836
Equipment to monitor gestational diabetes mellitus (GDM) ***Current Medicaid policy and coverage:*** Most states cover continuous glucose monitors and nutritional counseling to support pregnant people with gestational diabetes. Under the Women's Preventive Services Guidelines, gestational diabetes (GMD) screening for women 24-48 weeks pregnant and those at high risk of developing gestational diabetes is required to be covered without cost sharing.	• Gestational diabetes mellitus (GDM) is diabetes that develops during pregnancy. GDM is one of the most common medical complications of pregnancy. Prevalence is estimated to be 6-9%. • The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after. • ACOG's 2017 Guidelines for Perinatal Care recommend screening for GDM with a laboratory-based screening test using blood glucose levels for all pregnant women at 24-28 weeks gestation. If the pregnancy is determined to be complicated by gestational diabetes, follow-up glucose monitoring and screening is important (ie; until 6-12 months postpartum). • Pregnant persons with GDM are at increased risk for maternal and fetal complications, including preeclampsia and neonatal hypoglycemia. It has also been associated with an increased risk of several long-term health outcomes in pregnant persons and intermediate outcomes in their children. • Surveillance of blood glucose levels is required to assure glycemic control. Effective self-monitoring of blood glucose is used for GDM management. Ability to maintain glucose concentrations within the reference interval (ACOG recommends fasting values below 96 mg/dL) is associated with lower perinatal mortality rates for diabetic pregnancies. • Treatment of GDM to improve glycemic control has been	**Federal documents and professional guidelines** • US Preventive Services Task Force. (2021). Screening for Gestational Diabetes: US Preventive Services Task Force Recommendation Statement. *JAMA, 326*(6): 531–538. https://doi.org:10.1001/jama.2021.11922 • Health Resources and Services Administration. Women's Preventive Services Guidelines. (2021). https://www.hrsa.gov/womens-guidelines/index.html • American College of Obstetricians and Gynecologists. (2018). Gestational Diabetes Mellitus. ACOG Practice Bulletin No. 190. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/02/gestational-diabetes-mellitus **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Coustan D. R. (2013). Gestational diabetes mellitus. *Clinical chemistry*. *59*(9): 1310–1321. https://doi.org/10.1373/clinchem.2013.203331 • Nankervis, A., Price, S., & Conn, J. (2018). Gestational diabetes mellitus: A pragmatic approach to diagnosis and management. *Australian journal of general practice*. *47*(7): 445–449. https://doi.org/10.31128/AJGP-01-18-4479 • Raman, P., Shepherd, E., Dowswell, T., Middleton, P., & Crowther, C. A. (2017). Different methods and settings for glucose monitoring for gestational diabetes during pregnancy. *The Cochrane database of systematic reviews*. *10*(10): CD011069.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	shown to decrease pregnancy-related morbidity, including Cesarean delivery and neonatal hypoglycemia.	https://doi.org/10.1002/14651858.CD011069.pub2 • Tsakiridis, I., Giouleka, S., Mamopoulos, A., Kourtis, A., Athanasiadis, A., Filopoulou, D., & Dagklis, T. (2021). Diagnosis and management of gestational diabetes mellitus: An overview of national and international guidelines. *Obstetrical & gynecological survey*. *76*(6): 367–381. https://doi.org/10.1097/OGX.0000000000000899
Equipment to monitor for preeclampsia ***Definition:*** Preeclampsia is defined as new-onset hypertension after the 20th week of gestation, along with evidence of maternal organ failure. ***Current Medicaid policy and coverage:*** Most states cover low-dose aspirin for pregnant people and blood pressure monitors for home use as a pregnancy-related service in order to prevent and monitor for changes in hypertension and risk of preeclampsia.	• Hypertensive disorders in pregnancy and postpartum are among the leading causes of maternal mortality and morbidity. • Preeclampsia is associated with higher rates of maternal death (most often due to cerebral hemorrhage) and increased risk of adverse maternal health outcomes (e.g., chronic hypertension, heart disease, stroke, and end-stage kidney disease). Having a previous pregnancy with preeclampsia is associated with increased risk of developing preeclampsia in subsequent pregnancies. The rate of preeclampsia has been steadily rising in the US. • Early and continuous prenatal visits that include first-trimester ultrasound examination and laboratory studies are associated with improved pregnancy outcomes in women with previous eclampsia and preeclampsia. • The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy (to guide subsequent treatment). The USPSTF also recommends low-dose aspirin as a preventive medication for pregnant people at risk for preeclampsia. • Black women are at greater risk for developing preeclampsia than other women and experience higher rates of maternal and infant morbidity and perinatal mortality than other racial and ethnic groups. These	**Federal documents and professional guidelines** • US Preventive Services Task Force. (2017). Screening for preeclampsia. *JAMA. 317*(16): 1661-1667. https://doi.org/10.1001/jama.2017.3439. • U.S. Preventive Services Task Force. (2021). Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication#fullrecommendationstart. • American College of Obstetricians and Gynecologists. (2020). Gestational Hypertension and Preeclampsia: ACOG Practice Bulletin Summary, No 222. *Obstetrics and gynecology*. *135*(6): 1492–1495. https://doi.org/10.1097/AOG.0000000000003892 • American College of Obstetricians and Gynecologists, Task Force on Hypertension in Pregnancy. (2013). Hypertension in Pregnancy. *Obstet Gynecol*. 122:1122–31. https://doi.org/10.1097/01.AOG.0000437382.03963.88 **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Bernstein, P. S., Martin, J. N., Jr, Barton, J. R., Shields, L. E., Druzin, M. L., Scavone, B. M., Frost, J., Morton, C. H., Ruhl, C., Slager, J., Tsigas, E. Z.,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	disparities are associated with differences in access to care and unequal treatment. ● Infants born to mothers with preeclampsia are at higher risk of adverse health outcomes as infants (e.g.: low birthweight, intrauterine growth development, fetal death, preterm birth, infant respiratory distress syndrome, sepsis).	Jaffer, S., & Menard, M. K. (2017). National Partnership for Maternal Safety: Consensus bundle on severe hypertension during pregnancy and the postpartum period. *Obstetrics and gynecology*, *130*(2), 347–357. https://doi.org/10.1097/AOG.0000000000002115 • Huai, J., Lin, L., Juan, J., Chen, J., Li, B., Zhu, Y., Yu, M., & Yang, H. (2021). Preventive effect of aspirin on preeclampsia in high-risk pregnant women with stage 1 hypertension. *Journal of clinical hypertension. 23*(5): 1060–1067. https://doi.org/10.1111/jch.14149 • Turbeville, H. R., & Sasser, J. M. (2020). Preeclampsia beyond pregnancy: long-term consequences for mother and child. *American journal of physiology. Renal physiology*. *318*(6): F1315–F1326. https://doi.org/10.1152/ajprenal.00071.2020 • von Ehr, J., von Versen-Höynck, F. (2016). Implications of maternal conditions and pregnancy course on offspring's medical problems in adult life. *Arch Gynecol Obstet.* 294: 673–679. https://doi.org/10.1007/s00404-016-4178-7 • Bokslag, A., van Weissenbruch, M., Mol, B. W., & de Groot, C. J. (2016). Preeclampsia; short and long-term consequences for mother and neonate. *Early human development*. *102*: 47–50. https://doi.org/10.1016/j.earlhumdev.2016.09.007 • MacDonald TM, Walker SP, Hannan NJ, Tong S, Kaitu'u-Lino TJ. (2022). Clinical tools and biomarkers to predict preeclampsia. *EBioMedicine. 75*:103780. https://doi.org/10.1016/j.ebiom.2021.103780 • Barton, J. R., & Sibai, B. M. (2008). Prediction and prevention of recurrent preeclampsia. *Obstetrics and gynecology*. *112*(2 Pt 1): 359–372. https://doi.org/10.1097/AOG.0b013e3181801d56 • Velauthar, L., Plana, M. N., Kalidindi, M., Zamora, J., Thilaganathan, B., Illanes, S. E., Khan, K. S., Aquilina, J., & Thangaratinam, S. (2014). First-trimester uterine artery Doppler and adverse pregnancy outcome: a meta-analysis involving 55,974 women. *Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology*. *43*(5): 500–507. https://doi.org/10.1002/uog.13275 • Reddy, M., Springhall, E. A., Rolnik, D. L., & da Silva Costa, F. (2018). How

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		to perform first trimester combined screening for pre-eclampsia. *Australasian journal of ultrasound in medicine*. *21*(4): 191–197. https://doi.org/10.1002/ajum.12111
Pregnancy loss counseling and support ***Current Medicaid policy and coverage:*** *Coverage is unclear.*	• The provision of respectful and supportive perinatal bereavement care to parents and families around stillbirth and neonatal death is associated with improved immediate and long-term well-being and with reduced psychosocial impact. • Receipt of cognitive behavioral intervention targeting the psychological results of perinatal bereavement is associated with a decline in reported grief symptoms.	**Other key resources** • Bennett, S. M., Ehrenreich-May, J., Litz, B. T., Boisseau, C. L., & Barlow, D. H. (2012). Development and preliminary evaluation of a cognitive-behavioral intervention for perinatal grief. *Cognitive and Behavioral Practice. 19*(1): 161–173. https://doi.org/10.1016/j.cbpra.2011.01.002 • Loughnan SA, Boyle FM, Ellwood D, Crocker S, Lancaster A, Astell C, Dean J, Horey D, Callander E, Jackson C, Shand A, Flenady V. (2022). Living with Loss: study protocol for a randomized controlled trial evaluating an internet-based perinatal bereavement program for parents following stillbirth and neonatal death. *Trials.* 6(23):464. https://doi.org/10.1186/s13063-022-06363-0 • Boyle, F. M., Horey, D., Dean, J. H., Loughnan, S., Ludski, K., Mead, J., Homer, C. S., de Wilde, D., Morris, J., & Flenady, V. J. (2020). Stillbirth in Australia 5: Making respectful care after stillbirth a reality: The quest for parent-centered care. *Women and birth: journal of the Australian College of Midwives*. *33*(6): 531–536. https://doi.org/10.1016/j.wombi.2020.08.006
5. Birth Services/Delivery Service Coverage[2]		
Hospital births ***Current Medicaid policy and coverage:*** All states are required to cover inpatient hospital care for deliveries for Medicaid enrollees.	• Across race/ethnicity, class, geography, and payer type, hospital births are the norm in the United States. Most states have less than 1% of Medicaid births occurring outside a hospital. • Black and Hispanic very preterm birth infants are more	**Federal documents and professional guidelines** • American Academy of Family Physicians, American College of Obstetricians and Gynecologists. (2022). AAFP-ACOG joint statement on cooperative practice and hospital privileges. https://www.aafp.org/about/policies/all/aafp-acog-joint-statement.html

[2] In some states, pregnant enrollees who are in managed care for their prenatal are "transitioned" to fee-for-service for labor and delivery and then re-enrolled into managed care after hospital discharge.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	likely to be born at hospitals with higher risk-adjusted neonatal morbidity and mortality rates. These differences contribute to excess morbidity and mortality among these populations. ● Research and performance data indicated that the quality of hospital care at the time of birth varies.	● American Academy of Pediatrics Committee on Fetus and Newborn and American College of Obstetricians and Gynecologists Committee on Obstetric Practice. (2017). Guidelines for Perinatal Care, 8th edition. https://publications.aap.org/aapbooks/book/522/Guidelines-for-Perinatal-Care **Other resources** ● Howell, E. A., Egorova, N., Balbierz, A., Zeitlin, J., & Hebert, P. L. (2016). Black-white differences in severe maternal morbidity and site of care. *American journal of obstetrics and gynecology*. *214*(1): 122.e1–122.e1227. https://doi.org/10.1016/j.ajog.2015.08.019 ● Howell, E. A., & Zeitlin, J. (2017). Improving hospital quality to reduce disparities in severe maternal morbidity and mortality. *Seminars in perinatology*. *41*(5): 266–272. https://doi.org/10.1053/j.semperi.2017.04.002 ● Howell, E. A., Brown, H., Brumley, J., Bryant, A. S., Caughey, A. B., Cornell, A. M., Grant, J. H., Gregory, K. D., Gullo, S. M., Kozhimannil, … & Grobman, W. A. (2018). Reduction of peripartum racial and ethnic disparities: A conceptual framework and maternal safety consensus bundle. *Obstetrics and gynecology*. *131*(5): 770–782. https://doi.org/10.1097/AOG.0000000000002475 ● Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *The Cochrane database of systematic reviews*. *7*(7): CD003766. https://doi.org/10.1002/14651858.CD003766.pub6 ● Plough, A., Galvin, G., Li, Z., Lipsitz, S., Alidina, S., Henrich, N., ... Shah, N. Relationship between labor and delivery unit management practices and maternal outcomes. *Obstetrics & Gynecology*. 2017;130(2): 358–365. https://doi.org/10.1097/AOG.0000000000002128
Home births	● The American College of Obstetricians and Gynecologists (ACOG) recommends that women be provided with	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists. (2020). Planned

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Current Medicaid policy and coverage: Coverage is unclear. Surveys indicate that at least half of states provide coverage of home births. Some states require prior authorization and/or set provider requirements for home births.	information about the safety of home births to enable them to make a medically informed decision. ● Planned home births are associated with decreased odds of having a small gestational age and with fewer maternal interventions than planned hospital births.	Home Birth. ACOG Committee Opinion No. 697. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/planned-home-birth ● Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ ● Olsen, O., & Jewell, M. D. (2000). Home versus hospital birth. *The Cochrane database of systematic reviews*. 2:CD000352. https://doi.org/10.1002/14651858.CD000352 ● Hansel, S., Kuyateh, M. H., Bello-Ogunu, F., Stranton, D. T., Hicks, K., & Huber, L. (2022). Associations between Place of Birth, Type of Attendant, and Small for Gestational Age Births among Pregnant non-Hispanic Black Medicaid Recipients. *Journal of midwifery & women's health*. *67*(2): 202–208. https://doi.org/10.1111/jmwh.13312
Birth centers ***Definition:*** A freestanding birth center is a health care facility that uses a midwifery model of care to provide prenatal, birth, and postpartum services. Freestanding birth centers are not connected to or affiliated with hospitals. ***Current Medicaid policy and coverage:*** The ACA requires that Medicaid reimburse for birth center facility fees and the professional fees of the birthing attendant. Coverage of freestanding birth centers under CHIP is not required, but states may cover services in these facilities to the extent that the state licenses or recognizes such providers under	● The evaluation of the CMS Strong Start for Mothers and Newborns initiative found that birth center providers face challenges in their attempts to participate in Medicaid, including barriers to obtaining network contracts from managed care organizations and low payment rates in both fee-for-service and managed care arrangements. ● Medicaid enrollees currently have less access to birth centers than privately insured women. However, access to birth centers can improve access to cultural competence, improve equity, and reduce costs to the Medicaid program - as compared to OB care. ● Birth center care is associated with lower C-section rates and higher rates of vaginal birth after C-section, as compared to women in hospital care. ● Birth center care is associated with lower rates of	**Federal documents and professional guidelines** ● Centers for Medicare and Medicaid Services (2018). Strong Start for Mothers and Newborns Evaluation: Year 5 Project Synthesis. https://innovation.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf. Accessed July 14, 2022. ● US Department of Health and Human Services. (1995). *Federal Register,* Medicaid program: nurse-midwife services HCFA. *60*(230): 61483–61487. https://www.federalregister.gov/documents/1995/11/30/95-29194/medicaid-program-nurse-midwife-services **Other key resources** ● Hill, I., Dubay, L., Courtot, B., Benatar, S., Bowen, G., Blavin, F., … Morgan, J. (2018). Strong Start for mothers and newborns evaluation: Year 5 project synthesis. https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
state law. In 2019, 37 states licensed and covered birth center care under Medicaid.	preterm and low-birth weight infants, and decreased odds of having a small gestational age neonate ● Birth center care is associated with significantly lower rates of GDM.	● Center for State Health Strategies. (2020). State Policies to Improve Maternal Health Outcomes. Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2021-03/State_Policies_Maternal_Health_Outcomes_Comparison_TABLE_030821.pdf ● Howell, E., Palmer, A., Benatar, S., & Garrett, B. (2014). Potential Medicaid cost savings from maternity care based at a freestanding birth center. *Medicare & medicaid research review*. *4*(3): mmrr2014-004-03-a06. https://doi.org/10.5600/mmrr.004.03.a06 ● Jolles, D. R., Langford, R., Stapleton, S., Cesario, S., Koci, A., & Alliman, J. (2017). Outcomes of childbearing Medicaid beneficiaries engaged in care at Strong Start birth center sites between 2012 and 2014. *Birth. 44*(4): 298–305. https://doi.org/10.1111/birt.12302 ● Jolles, D. R., Stapleton, S. R., & Alliman, J. (2019). Strong start for mothers and newborns: Moving birth centers to scale in the United States. *Birth. 46*(2): 207–210. https://doi.org/10.1111/birt.12430 ● Dubay, L., Hill, I., Garrett, B., Blavin, F., Johnston, E., Howell, E., Morgan, J., Courtot, B., Benatar, S., & Cross-Barnet, C. (2020). Improving Birth Outcomes and Lowering Costs For Women On Medicaid: Impacts of Strong Start For Mothers And Newborns. *Health Affairs.* 39(6): 1042–1050. https://doi.org/10.1377/hlthaff.2019.01042Alliman, J., Stapleton, S. R., ● Wright, J., Bauer, K., Slider, K., & Jolles, D. (2019). Strong Start in birth centers: Socio-demographic characteristics, care processes, and outcomes for mothers and newborns. *Birth*. *46*(2): 234–243. https://doi.org/10.1111/birt.12433 ● Alliman, J., & Bauer, K. (2020). Next steps for transforming maternity care: what Strong Start birth center outcomes tell us. *Journal of Midwifery & Women's Health*. *65*(4): 462. ● Courtot, B., Hill, I., Cross-Barnet, C., & Markell, J. (2020). Midwifery and birth centers under state Medicaid programs: Current limits to beneficiary access to a high-value model of care. *Milbank Quarterly.* 98(4):1091-1113. https://doi.org/10.1111/1468-0009.12473 ● Hardeman, R. R., Karbeah, J., Almanza, J., & Kozhimannil, K. B. (2020).

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Roots Community Birth Center: A culturally-centered care model for improving value and equity in childbirth. *Healthcare. 8*(1): 100367. https://doi.org/10.1016/j.hjdsi.2019.100367 • Hansel, S., Kuyateh, M. H., Bello-Ogunu, F., Stranton, D. T., Hicks, K., & Huber, L. (2022). Associations between place of birth, type of attendant, and small for gestational age births among pregnant non-Hispanic Black Medicaid recipients. *Journal of midwifery & women's health*, *67*(2), 202–208. https://doi.org/10.1111/jmwh.13312
Cesarean (C-section) Births ***Definition:*** Cesarean birth is the delivery of a baby through incisions (surgical cuts) made in the belly and uterus rather than via the vagina. In the United States, about 1 in 3 babies is delivered by cesarean birth. ***Current Medicaid policy and coverage:*** Many state Medicaid agencies have had initiatives designed to reduce C-section births, using quality improvement, performance measurement, value-based payment, and other mechanisms. In 2022, CMS convened a Learning Collaborative on Improving Maternal Health by Reducing Low-Risk Cesarean Delivery (LRCD).	• Cesarean deliveries can prevent injury and death among mothers and infants who are at higher risk for unexpected complications. However, recommendations call for not using Cesarean deliveries for low-risk situations. • Increased use of Cesarean deliveries is associated with rising maternal mortality rates. Repeat Cesarean delivery increases maternal risks and perinatal mortality. Medicaid beneficiaries report having less decision-making role regarding Cesarean deliveries, high rates of infection, blood clots, and other severe maternal morbidity. • Pregnant people who have had a previous Cesarean section are candidates for vaginal birth after Cesarean delivery (VBAC). Recommendations call for physicians to provide information for informed decisions and to encourage planning for VBAC unless specific contraindications exist. • Reducing the health and fiscal burden of unnecessary, low-risk Cesarean deliveries is a national priority, including for Medicaid agencies. • Approximately one-third of births financed by Medicaid were via Cesarean delivery, ranging from about 20% in Alaska to about 37% in Mississippi.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal Fetal Medicine (SMFM). (2019). Safe prevention of the primary Cesarean delivery. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery.pdf • American Academy of Family Physicians. (2015). Planning for labor and vaginal birth after Cesarean delivery: Guidelines from the AAFP. *Am Fam Physician. 91(*3): 197-198. https://www.aafp.org/pubs/afp/issues/2015/0201/p197.html • Centers for Medicare and Medicaid. (Undated). Low-risk Cesarean delivery: Improving maternal health by reducing low-risk Cesarean delivery. https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/quality-improvement/Low-Risk-Cesarean-Delivery/index.html • Bigby, J., Anthony, J., Hsu, R., Fiorentini, C., & Rosenbach, M. (2020). Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program. Mathematica for the U.S. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf • US Department of Health and Human Services. (Undated.) Cesarean Births.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	○ CMS has a measure for Low-Risk Cesarean Delivery (LRCD-CH). The Medicaid LRCD rate for the nation was 25.9% in 2020, with substantial disparities by race (30.6% among Black birthing persons and 24.7% among White birthing persons). ○ A measure for low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is also endorsed by the ACOG, The Joint Commission (PC-02), National Quality Forum (#0471), Maternal and Child Health Bureau-HRSA-HHS (NPM 02), and the American Medical Association-Physician Consortium for Patient Improvement (PCPI).	Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06 ● Cunningham, F. G., Bangdiwala, S. I., Brown, S. S., Dean, T. M., Frederiksen, M., Rowland Hogue, C. J., King, T., Spencer Lukacz, E., McCullough, L. B., Nicholson, W., Petit, N. F., Probstfield, J. L., Viguera, A. C., Wong, C. A., & Zimmet, S. C. (2010). NIH consensus development conference draft statement on vaginal birth after cesarean: new insights. *NIH consensus and state-of-the-science statements. 27*(3): 1–42. https://pubmed.ncbi.nlm.nih.gov/20228855/ ● Lagrew, D. C., Low, L. K., Brennan, R., Corry, M. P., Edmonds, J. K., Gilpin, B. G., Frost, J., Pinger, W., Reisner, D. P., & Jaffer, S. (2018). National Partnership for Maternal Safety: Consensus bundle on safe reduction of primary Cesarean births-supporting intended vaginal births. *Obstetrics and gynecology*. *131*(3): 503–513. https://doi.org/10.1097/AOG.0000000000002471 **Other key resources** ● Cunningham, F. G., Bangdiwala, S. I., Brown, S. S., Dean, T. M., Frederiksen, M., Rowland Hogue, C. J., King, T., Spencer Lukacz, E., McCullough, L. B., Nicholson, W., Petit, N. F., Probstfield, J. L., Viguera, A. C., Wong, C. A., & Zimmet, S. C. (2010). NIH consensus development conference draft statement on vaginal birth after cesarean: new insights. *NIH consensus and state-of-the-science statements*. *27*(3): 1–42. https://consensus.nih.gov/2010/vbacstatement.htm ● Puro, N, Kelly, RJ, Bodas, M, Feyereisen, S. (2022). Estimating the differences in Caesarean section (C-section) rates between public and privately insured mothers in Florida: A decomposition approach. *PLoS ONE.* 17(4): e0266666. https://doi.org/10.1371/journal.pone.0266666 ● Rosenstein MG, Chang S-C, Sakowski C, Markow C, Teleki S, Lang L, Logan J, Cape V, & Main EK. (2021). Hospital quality improvement interventions and statewide policy initiatives and rates of nulliparous term singleton vertex Cesarean deliveries in California. *JAMA. 325*(16): 1631-1639.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		https://doi.org/10.1001/jama.2021.3816 • Snowden, J. M., Osmundson, S. S., Kaufman, M., Blauer Peterson, C., & Kozhimannil, K. B. (2020). Cesarean birth and maternal morbidity among Black women and White women after implementation of a blended payment policy. *Health services research*. *55*(5): 729–740. https://doi.org/10.1111/1475-6773.13319 • Kozhimannil, K. B., Graves, A. J., Ecklund, A. M., Shah, N., Aggarwal, R., & Snowden, J. M. (2018). Cesarean delivery rates and costs of childbirth in a state Medicaid program after implementation of a blended payment policy. *Medical care*. *56*(8): 658–664. https://doi.org/10.1097/MLR.0000000000000937 • Quinlan, J. D., & Murphy, N. J. (2015). Cesarean delivery: counseling issues and complication management. *American family physician*. *91*(3): 178–184. https://pubmed.ncbi.nlm.nih.gov/25822271/
Reducing early elective deliveries ***Definition:*** Births via induction or Cesarean section prior to 39 weeks of gestation without a medical indication. ***Current Medicaid policy and coverage:*** CMS has had an initiative-setting priority to reduce early elective deliveries. Multiple states have initiatives, policies, or plan requirements for early elective deliveries. Some states reduce payments or do not cover procedures such as early elective deliveries, elective inductions, and Cesarean sections that are not medically indicated (e.g., Georgia, Indiana, Iowa, Michigan, New Mexico, New York, South Carolina, Texas).	• Organizations such as ACOG and the March of Dimes have been promoting the importance of full-term pregnancies—those naturally reaching at least 39 weeks gestation—yet early elective deliveries still account for 10-15% of all deliveries. • While some conditions required medical intervention early, the risks of late-preterm and early-term births are well established, and the potential neonatal complications associated with elective delivery at less than 39 weeks of gestation are well documented. • Early elective deliveries are associated with increased maternal and neonatal complications for both mothers and newborns, compared to deliveries occurring beyond 39 weeks among people who go into labor without induction. • CMS made reducing early elective deliveries a priority measure in its initial Core Set of Health Care Quality	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2021). Medically indicated late-preterm and early-term deliveries. ACOG Committee Opinion No. 831. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/medically-indicated-late-preterm-and-early-term-deliveries • American College of Obstetricians and Gynecologists. (2021). Avoidance of non-medically indicated early-term deliveries and associated neonatal morbidities. ACOG Committee Opinion No.765. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/02/avoidance-of-nonmedically-indicated-early-term-deliveries-and-associated-neonatal-morbidities • Carlson, N. S., Dunn Amore, A., Ellis, J. A., Page, K., & Schafer, R. (2022). American College of Nurse-Midwives Clinical Bulletin Number 18: Induction of Labor. *Journal of midwifery & women's health*. *67*(1): 140–149. https://doi.org/10.1111/jmwh.13337 • Centers for Medicare and Medicaid. (2012). Reducing Early Elective

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	Measures for adults enrolled in Medicaid. ○ The CMS measure is: Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at < 39 weeks of gestation completed who had elective deliveries by Cesarean section (C-section), or early inductions of labor, without medical indication. ○ A measure for early elective deliveries is also used by The Joint Commission (PC-01).	Deliveries in Medicaid and CHIP. https://www.medicaid.gov/medicaid/quality-of-care/downloads/eed-brief.pdf ● Centers for Medicare and Medicaid. (2021). Strong Start Toolkit. https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/StrongStartToolkit ● Centers for Medicare and Medicaid. (2019) MIPS Clinical Quality Measure: Maternity Care: Elective delivery or early induction without medical indication at less than 39 weeks. Quality ID #335. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_335_MIPSCQM.pdf ● MACPAC. (2019). Medicaid payment initiatives to improve maternal and birth outcomes. https://www.macpac.gov/wp-content/uploads/2019/04/Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf **Other key resources** ● MacDorman, M. F., Thoma, M., Declercq, E., & Howell, E. A. (2022). The relationship between obstetrical interventions and the increase in U.S. preterm births, 2014-2019. *PloS one*. *17*(3): e0265146. https://doi.org/10.1371/journal.pone.0265146 ● Fowler, T.T., Schiff, J., Applegate, M.S., Griffith, K., & Fairbrother, G.L. (2014). Early elective deliveries accounted for nearly 9 percent of births paid for my Medicaid. *Health Affairs. 33*(12): 2170–2178. https://doi.org/10.1377/hlthaff.2014.0534
LARC services immediately postpartum ***Definition:*** Long-acting reversible contraception (LARC) methods—including intrauterine devices (IUDs) and contraceptive implants—are highly effective and can last months or years. LARC require	● About half of birthing people report having unprotected intercourse before the routine 6-week postpartum visit, resulting in a risk of unintended and/or short-interval pregnancy. In the first year postpartum, at least 70% of pregnancies are unintended. ● Widespread adoption of immediate postpartum LARC	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists. (2020). Immediate postpartum long-acting reversible contraception. ACOG Committee Opinion, No. 670. *Obstetrics and gynecology*. *128*: e32–e37. https://doi.org/10.1097/AOG.0000000000001587 ● American College of Obstetricians and Gynecologists' Committee on

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
procedures for insertion of devices. Birthing people may seek to have LARC insertion done immediately following a birth to avoid having to return for such procedures. ***Current Medicaid policy and coverage:*** CMS encourages states to adopt payment approaches to optimize access and use of LARC. In partnership with CDC and ASTHO, the CMS efforts include communication to states, a "learning community" with technical assistance regarding implementation strategies. States' Medicaid reimbursement policies vary substantially. In 2013, Medicaid reimbursed for immediate postpartum LARC in 14 states. By 2021, 38 states had policies on immediate postpartum LARC. As part of a statewide initiative to improve perinatal outcomes, in 2012, South Carolina was the first state to implement a policy change facilitating Medicaid reimbursement for LARC place immediately postpartum.	services has been hampered by the inability to obtain reimbursement for LARC devices and services provided immediately postpartum. ● Policies to reduce barriers to immediate postpartum LARC services include: ○ Ensuring providers offer a full range of FDA-approved contraceptive methods. ○ Reimbursement for LARC in a payment unbundled from other birth/delivery services. ○ Removing administrative barriers (e.g., removing prior authorization requirements, permitting billing on same day) ○ Provide adequate payment rates to providers for LARC services. ● While studies suggest that revised Medicaid policies increase use of LARC, additional efforts are needed to change provider knowledge of the policy and practices in clinical implementation. ● Mothers were more likely to receive LARC immediately postpartum and have longer interpregnancy intervals following a Medicaid policy change in South Carolina.	Health Care for Underserved Women (2021). Access to Postpartum Sterilization: ACOG Committee Opinion, No. 827. *Obstetrics and gynecology*. *137*(6): e169–e176. https://doi.org/10.1097/AOG.0000000000004381 ● Vricella, L. K., Gawron, L. M., & Louis, J. M. (2019). Society for Maternal-Fetal Medicine Consult Series #48: Immediate postpartum long-acting reversible contraception for women at high risk for medical complications. *American journal of obstetrics and gynecology*. *220*(5): B2–B12. https://doi.org/10.1016/j.ajog.2019.02.011 ● Centers for Medicare and Medicaid. (2016). State Medicaid payment approaches to improve access to long-acting reversible contraception. Center for Medicaid and CHIP Services Informational Bulletin. https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf **Other key resources** ● Kroelinger, C. D., Okoroh, E. M., Uesugi, K., Romero, L., Sappenfield, O. R., Howland, J. F., & Cox, S. (2021). Immediate postpartum long-acting reversible contraception: Review of insertion and device reimbursement policies. *Women's health issues*. *31*(6): 523–531. https://doi.org/10.1016/j.whi.2021.09.001 ● Hahn, T. A., McKenzie, F., Hoffman, S. M., Daggy, J., & Tucker Edmonds, B. (2019). A prospective study on the effects of Medicaid regulation and other barriers to obtaining postpartum sterilization. *Journal of midwifery & women's health*. *64*(2): 186–193. https://doi.org/10.1111/jmwh.12909 ● Moniz, M. H., Chang, T., Davis, M. M., Forman, J., Landgraf, J., & Dalton, V. K. (2016). Medicaid administrator experiences with the Implementation of immediate postpartum long-acting reversible contraception. *Women's health issues*. *26*(3): 313–320. https://doi.org/10.1016/j.whi.2016.01.005 ● Fuerst, M. F., George, K. E., & Moore, J. E. (2021). Long-acting reversible contraception in Medicaid: where do we go from here? *Women's Health Issues*. *31*(4): 310-313. (No DOI). ● Oduyebo, T., Zapata, L. B., Boutot, M. E., Tepper, N. K., Curtis, K. M.,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		D'Angelo, D. V., Marchbanks, P. A., & Whiteman, M. K. (2019). Factors associated with postpartum use of long-acting reversible contraception. *American journal of obstetrics and gynecology*. *221*(1): 43.e1–43.e11. https://doi.org/10.1016/j.ajog.2019.03.005 ● Steenland, M. W., Pace, L. E., Sinaiko, A. D., & Cohen, J. L. (2021). Medicaid Payments For Immediate Postpartum Long-Acting Reversible Contraception: Evidence From South Carolina. *Health Affairs*, *40*(2), 334–342. https://doi.org/10.1377/hlthaff.2020.00254 ● Liberty, A., Yee, K., Darney, B. G., Lopez-Defede, A., & Rodriguez, M. I. (2020). Coverage of immediate postpartum long-acting reversible contraception has improved birth intervals for at-risk populations. *American journal of obstetrics and gynecology*. *222*(4S): S886.e1–S886.e9. https://doi.org/10.1016/j.ajog.2019.11.1282 ● DeSisto, C. L., Estrich, C., Kroelinger, C. D., Goodman, D. A., Pliska, E., Mackie, C. N., Waddell, L. F., & Rankin, K. M. (2017). Using a multi-state Learning Community as an implementation strategy for immediate postpartum long-acting reversible contraception. *Implementation science: IS*: *12*(1), 138. https://doi.org/10.1186/s13012-017-0674-9. ● Harney, C., Dude, A., & Haider, S. (2017). Factors associated with short interpregnancy interval in women who plan postpartum LARC: a retrospective study. *Contraception*. *95*(3): 245–250. https://doi.org/10.1016/j.contraception.2016.08.012 ● Wu, M., Eisenberg, R., Negassa, A., & Levi, E. (2020). Associations between immediate postpartum long-acting reversible contraception and short interpregnancy intervals. *Contraception*. *102*(6): 409–413. https://doi.org/10.1016/j.contraception.2020.08.016 ● Goldthwaite, L. M., & Shaw, K. A. (2015). Immediate postpartum provision of long-acting reversible contraception. *Current opinion in obstetrics & gynecology*. *27*(6): 460–464. https://doi.org/10.1097/GCO.0000000000000224 ● Patberg, E., Young, M., Archer, S., Duininck, G., Li, J., Blackwell, C., Lathrop, E., & Haddad, L. (2021). Postpartum contraceptive use and other reproductive health outcomes among CenteringPregnancy Group Prenatal

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Care participants. *Journal of women's health (2002)*. *30*(7): 990–996. https://doi.org/10.1089/jwh.2019.8241
6. Postpartum Service Coverage		
Postpartum visits ***Definition:*** ACOG defines a comprehensive postpartum visit as one that includes: "a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance". ACOG also recommends that women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care and management of their conditions. ***Current Medicaid policy and coverage:*** Most states do not limit the number of postpartum visits that can be covered; however, some states do. In a recent survey, 6 states reported limits on the number of covered postpartum visits. It is unclear if any states require MCOs to cover "comprehensive" postpartum visits or specify the	• ACOG recommends that all postpartum persons have contact with their provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks following birth. • Many new mothers do not receive appropriate or adequate postpartum care following childbirth, despite evidence-informed professional guidelines. • The CMS and leading physician organizations call for including and measuring four elements of a postpartum visit, including: breastfeeding education, postpartum depression screening, glucose screening for people with gestational diabetes, and family planning. • A comprehensive postpartum visit includes: assessment of physical, social, and psychological well-being, including but not limited to: contraception, and birth spacing; infant care and feeding; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. However, less than 50% of postpartum visits have been found to lack all of the pieces of a comprehensive visit, and less than 30% of postpartum persons on Medicaid do not receive any postpartum visit (due to a variety of barriers). • Strategies demonstrated to increase use of postpartum visits include: patient education, provider incentives, and quality improvement projects.	**Federal documents and professional guidelines** • CMS Maternal and Infant Health Quality Improvement. (2019) MIPS Clinical Quality Measure No. 336: Maternity Care: Post-Partum Follow-Up and Care Coordination. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_336_MIPSCQM.pdf and https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_1415-p009-3-ef.pdf • American College of Obstetricians and Gynecologists. (2021). Optimizing postpartum care. ACOG Committee Opinion No. 736. *Obstet Gynecol. 131*: e140–50. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care • Morgan, J., Bauer, S., Whitsel, A., Combs, C. A., Society for Maternal-Fetal Medicine (SMFM), & Quality Committee. (2022). Society for Maternal-Fetal Medicine Special Statement: Postpartum visit checklists for normal pregnancy and complicated pregnancy. *American Journal of Obstetrics and Gynecology*. S0002-9378(22): 00453-7. https://doi.org/10.1016/j.ajog.2022.06.007 • Ogunwole, S. M., Chen, X., Mitta, S., Minhas, A., Sharma, G., Zakaria, S., ... & Smith, G. (2021). Interconception care for primary care providers: consensus recommendations on preconception and postpartum management of reproductive-age patients with medical comorbidities. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes*. *5*(5): 872-890. https://doi.org/10.1016/j.mayocpiqo.2021.08.004 • Bigby, J., Anthony, J., Hsu, R., Fiorentini, C., & Rosenbach, M. (2020). Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
content of postpartum visits. Some states provide "enhanced postpartum care" packages for high-risk groups (i.e., those with chronic conditions such as diabetes or those with low-weight/preterm births) - which is essentially additional case management and support to ensure access to postpartum visits. (See more on this topic below.)	• Timely receipt of postpartum visits can reduce postpartum ER visits, increased likelihood of receiving a depression screen, identifying risks for maternal mortality or severe maternal morbidity, and receiving care to manage chronic conditions (e.g., diabetes, hypertension).	Mathematica for the U.S. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf • CMS Maternal and Infant Health Initiative. (2015). Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations. Technical Assistance Resource. https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improvepostpartum-care.pdf **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Stuebe, A. M., Kendig, S., Suplee, P. D., & D'Oria, R. (2021). Consensus bundle on postpartum care basics: from birth to the comprehensive postpartum visit. *Obstetrics & Gynecology*. *137*(1): 33-40. https://doi.org/10.1097/AOG.0000000000004206 • Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: a critical transition period with unmet maternal health needs. *American journal of obstetrics and gynecology*. *217*(1): 37–41. https://doi.org/10.1016/j.ajog.2017.03.032 • Geissler, K., Ranchoff, B. L., Cooper, M. I., & Attanasio, L. B. (2020). Association of Insurance Status With Provision of Recommended Services During Comprehensive Postpartum Visits. *JAMA network open*. *3*(11): e2025095. https://doi.org/10.1001/jamanetworkopen.2020.25095 • Howell, E. et al. (2020). Timely postpartum visits for low-income women: A health system and Medicaid payer partnership. *American Journal of Public Health.* 110(S2): S215-S218. https://doi.org/10.2105/AJPH.2020.305689 • Harrell, T., Howell, E.A., Balbierz, A. et al. (2022). Improving postpartum care: Identifying opportunities to reduce postpartum emergency room visits among publicly-insured women of color. *Matern Child Health J.* 26,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		913–922. https://doi.org/10.1007/s10995-021-03282-5 ● Wang, X., Pengetnze, Y. M., Eckert, E., Keever, G., & Chowdhry, V. (2022). Extending postpartum Medicaid beyond 60 days improves care access and uncovers unmet needs in a Texas Medicaid health maintenance organization. *Frontiers in public health*. *10*: 841832. https://doi.org/10.3389/fpubh.2022.841832 ● DeSisto, C. L., Rohan, A., Handler, A., Awadalla, S. S., Johnson, T., & Rankin, K. (2020). The effect of continuous versus pregnancy-only Medicaid eligibility on routine postpartum care in Wisconsin, 2011-2015. *Maternal and child health journal*. *24*(9): 1138–1150. https://doi.org/10.1007/s10995-020-02924-4 ● Ruderman, R. S., Dahl, E. C., Williams, B. R., Davis, K., Feinglass, J. M., Grobman, W. A., Kominiarek, M. A., & Yee, L. M. (2021). Provider Perspectives on Barriers and Facilitators to Postpartum Care for Low-Income Individuals. *Women's health reports*, *2*(1), 254–262. https://doi.org/10.1089/whr.2021.0009 ● Gordon, S. H., Sommers, B. D., Wilson, I. B., & Trivedi, A. N. (2020). Effects of Medicaid expansion on postpartum coverage and outpatient utilization. *Health affairs (Project Hope)*. *39*(1): 77–84. https://doi.org/10.1377/hlthaff.2019.00547 ● Masho, S. W., Cha, S., Karjane, N., McGee, E., Charles, R., Hines, L., & Kornstein, S. G. (2018). Correlates of postpartum visits among Medicaid recipients: An analysis using claims data from a managed care organization. *Journal of women's health. 27*(6): 836–843. https://doi.org/10.1089/jwh.2016.6137 ● Rankin, K. M., Haider, S., Caskey, R., Chakraborty, A., Roesch, P., & Handler, A. (2016). Healthcare utilization in the postpartum period among Illinois women with Medicaid paid claims for delivery, 2009-2010. *Maternal and child health journal*. *20*(Suppl 1): 144–153. https://doi.org/10.1007/s10995-016-2043-8. ● Reddy, R., James, K. E., Mauney, L. C., Kaimal, A. J., Daw, J. R., & Clapp, M. A. (2022). Postpartum readmission and uninsurance at readmission for Medicaid vs privately insured births. *American journal of obstetrics &*

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		gynecology MFM, *4*(2), 100553. https://doi.org/10.1016/j.ajogmf.2021.100553
Enhanced postpartum/interconception care ***Definition:*** Postpartum or interconception care with enhanced case management, disease management, or other additional benefits for women with identified risks or chronic conditions. (Interconception care refers to services provided following the end of a pregnancy (ie; for 12 months) to women with prior adverse outcomes, pregnancy-related complications, or chronic conditions - to address risks for the woman's health and any future pregnancy she may choose to have. It may be called enhanced postpartum care.) ***Current Medicaid policy and coverage:*** Interconception or enhanced postpartum care initiatives in Medicaid have existed in some states such as Georgia, Louisiana, South Carolina, and others. They might apply specifically to those who had adverse birth outcomes (e.g., very low birthweight or preterm births) or to women with chronic conditions such as diabetes or hypertension. They operate similar to chronic care model or CMMI health home models for those with additional needs for treatment, disease management, and care coordination. Medicaid postpartum coverage extensions give states a way to increase financing for enhanced	• The CDC Recommendations to Improve Preconception Health and Health Care calls for interconception care. At the core of these efforts is a focus on women with prior adverse pregnancy outcomes using approaches similar to those in disease management programs, including intensive care coordination and improved access to effective treatment. • Enhanced postpartum/interconception care initiatives may focus on birthing people with prior preterm births, hypertension, cardiac conditions, gestational diabetes, and other conditions that increase risk of maternal morbidity and mortality in the year postpartum. • Researchers and state teams have explored ways to improve postpartum and interconception care over the past two decades. Several research projects have shown promising results in using interconception care. Projects in Arizona, Georgia, Illinois, Louisiana, and North Carolina had positive findings and pointed to some challenges in reaching and serving women in a timely way. Some studies looked specifically at ways to change clinical and public health practice.	**Federal documents and professional guidelines** • CMS. (2021). Postpartum Care: Improving Postpartum Care Learning Collaborative. https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/quality-improvement/postpartum-care/index.html • CMS. (2019). Improving postpartum care: State projects conducted through the postpartum care action learning series and adult Medicaid quality grant program. (Issue Brief). https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-als-state-projects.pdf • American College of Obstetricians and Gynecologists. (2021). Interpregnancy care. ACOG Committee Opinion No. 8. https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/01/interpregnancy-care • Johnson, K., Posner, S. F., Biermann, J., Cordero, J. F., Atrash, H. K., Parker, C. S., ... & Curtis, M. G. (2006). Recommendations to improve preconception health and Health Care—United States: Report of the CDC/ATSDR preconception care work group and the select panel on preconception care. *Morbidity and Mortality Weekly Report: Recommendations and Reports*. *55*(RR-6): 1-23. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm **Other key resources** • Myerson, R., Crawford, S., & Wherry, L.R. (2020). Medicaid expansion increased preconception health counseling, folic acid intake, and postpartum contraception. *Health Affairs*. 39(11): 1883–1890. https://doi.org/10.1377/hlthaff.2020.00106 • Gregory, E. F., Passarella, M., Levine, L. D., & Lorch, S. A. (2022). Interconception preventive care and recurrence of pregnancy

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
postpartum/interconception care.		complications for Medicaid-insured women. *Journal of Women's Health. 31*(6). https:/doi.org/10.1089/jwh.2021.0355 • Johnson, K., Applegate, M., & Gee, R. E. (2015). Improving Medicaid: Three decades of change to better serve women of childbearing age. *Clinical obstetrics and gynecology*. *58*(2): 336–354. https://doi.org/10.1097/GRF.0000000000000115 • Johnson, K. A., & Gee, R. E. (2015). Interpregnancy care. *Seminars in perinatology*. *39*(4): 310–315. https://doi.org/10.1053/j.semperi.2015.05.011 • Ogunwole, S. M., Chen, X., Mitta, S., Minhas, A., Sharma, G., Zakaria, S., Vaught, A. J., Toth-Manikowski, S. M., & Smith, G. (2021). Interconception care for primary care providers: Consensus recommendations on preconception and postpartum management of reproductive-age patients with Medical comorbidities. *Mayo Clinic proceedings. Innovations, quality & outcomes*. *5*(5): 872–890. https://doi.org/10.1016/j.mayocpiqo.2021.08.004 • Lu MC, Kotelchuck M, Culhane JF, Hobel CJ, Klerman LV, Thorp JM. (2006). The content of internatal care: An approach to preconception care between pregnancies. *Matern Child Health J*. 10(5 Suppl): S107-22. https://doi.org/10.1007/s10995-006-0118-7 • Rosener SE, Barr WB, Frayne DF, Barash JH, Gross ME & Bennett IM. (2016). Interconception care for mothers during well-child visits with family physicians: An IMPLICIT Network study. *Annals of Family Medicine. 14*(4): 350-355. https://doi.org/10.1370/afm.1933 • Frayne, D., Hughes, P., Lugo, B., Foley, K., Rosener, S., Barr, W. B., Davis, S. A., Knoll, H., Krajick, K., & Bennett, I. M. (2021). Interconception Care for Mothers at Well Child Visits After Implementation of the IMPLICIT Model. *Maternal and child health journal*. *25*(8): 1193–1199. https://doi.org/10.1007/s10995-021-03137-z • Handler, A., Rankin, K. M., Peacock, N., Townsell, S., McGlynn, A., & Issel, L. M. (2013). The implementation of interconception care in two community health settings: lessons learned. *American journal of health promotion. 27*(3 Suppl): eS21–eS31. https://doi.org/10.4278/ajhp.120116-QUAN-33

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		• Biermann, J., Dunlop, A. L., Brady, C., Dubin, C., & Brann, A., Jr (2006). Promising practices in preconception care for women at risk for poor health and pregnancy outcomes. *Maternal and child health journal*. *10*(5 Suppl): S21–S28. https://doi.org/10.1007/s10995-006-0097-8
Parent-child "dyadic" interventions ***Definition:*** Services provided primarily to the parent and child together, often to promote optimal child development, to improve parent-child relationships, or to provide simultaneous mental health treatment. ***Current Medicaid policy and coverage:*** While not a specific coverage category, most states are covering some type of parent-child dyadic interventions, typically for mothers with children from birth to three. Examples include approval for financing for maternal depression screening in well-child visits and corresponding dyadic mental health treatment under the child's Medicaid number. Medicaid agencies also are covering models such as Centering Parenting and HealthySteps to promote parenting skills and child development. Postpartum coverage extensions from 60 days to one year provide an opportunity for mothers and infants to both have a full year of continuous coverage under which more parent-child, dyadic interventions can be financed.	• Bright Futures guidelines from the American Academy of Pediatrics and the Maternal and Child Health Bureau, HRSA-HHS, include recommendations for screening of maternal depression in well-child visits, particularly during the first year of infant life. • Reports from the National Academies of Sciences, Engineering, and Medicine (NASEM) have identified a number of evidence-based, parent-child, dyadic interventions that have been shown to be effective in improving child development, health, and mental health. • The American Academy of Pediatrics 2021 statement on preventing childhood toxic stress calls for changes in pediatric primary care to engage families and promote parent-child relationships in the earliest years.	**Federal documents and professional guidelines** • Hagan, J.F., Shaw, J.S., Duncan, P.M. eds. (2017). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th ed*. American Academy of Pediatrics. https://www.aap.org/en/practice-management/bright-futures • American Academy of Pediatrics. (2022). Bright Futures Periodicity Schedule. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.8619253.1561379779.1658342705-794881978.1658342705 • Health Care Resources and Services Administration. (2022). Bright Futures. https://mchb.hrsa.gov/programs-impact/bright-futures • Committee on Psychosocial Aspects of Child and Family Health, Section on Developmental and Behavioral Pediatrics, Council on Early Childhood. (2021). Preventing childhood toxic stress: Partnering with families and communities to promote relational health. *Pediatrics*. *148*(2): e2021052582. https://doi.org/10.1542/peds.2021-052582 **Other key resources** • National Academies of Sciences, Engineering, and Medicine. (2019). *Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity*. The National Academies Press. https://doi.org/10.17226/25466. • Caskey, R. N., Olender, S. E., Zocchi, A., Bergo, C. J., Uesugi, K. H., Haider, S., & Handler, A. S. (2021). Addressing Women's Health Care Needs During Pediatric Care. *Women's health reports 2*(1): 227–234. https://doi.org/10.1089/whr.2021.0016 • Handler, A., Bergo, C., Dominik, B., Bier, E., & Caskey, R. (2021). A two-

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		generation approach to postpartum care: Building on the well-baby visit. *Birth. 48*(3): 347–356. https://doi.org/10.1111/birt.12544 • Haider, S., Stoffel, C., Rankin, K., Uesugi, K., Handler, A., & Caskey, R. (2020). A novel approach to postpartum contraception provision combined with infant care: A randomized, controlled trial. *Women's health issues*. *30*(2): 83–92. https://doi.org/10.1016/j.whi.2019.12.001 • Monk, C., Dimidjian, S., Galinsky, E., Gregory, K. D., Hoffman, M. C., Howell, E. A., Miller, E. S., Osborne, C., Rogers, C. E., Saxbe, D. E., & D'Alton, M. E. (2022). The transition to parenthood in obstetrics: enhancing prenatal care for 2-generation impact. *American journal of obstetrics & gynecology MFM*. *4*(5): 100678. https://doi.org/10.1016/j.ajogmf.2022.100678 • Gregory, E. F., Passarella, M., Levine, L. D., Fiks, A. G., & Lorch, S. A. (2020). Preventive health care utilization among mother-infant dyads with Medicaid insurance in the year following birth. *Medical care*. *58*(6): 519–525. https://doi.org/10.1097/MLR.0000000000001310 • Clark, M. & Burak, E. (2022). Opportunities to support maternal and child health through Medicaid's new postpartum coverage extension. Georgetown University Center for Children and Families. https://ccf.georgetown.edu/2022/07/15/opportunities-to-support-maternal-and-child-health-through-medicaids-new-postpartum-coverage-extension/ • Smith, H., Sheeder, J., Ehmer, A., Hasbrouck, S., Scott, S., & Ashby, B. (2021). Implementing interconception care in a dyadic adolescent mother-child clinic. *Maternal and child health journal*. *25*(11): 1670–1676. https://doi.org/10.1007/s10995-021-03212-5 • Earls, M., M.W. Yogman, G. Mattson, et al. (2019). Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics.* 143(1): 1–9. https://pediatrics.aappublications.org/content/pediatrics/143/1/e20183259.full.pdf • Johnson, K., & Bruner, C. (2018). A Sourcebook on Medicaid's role in early childhood: Advancing high performing medical homes and improving lifelong health. Child and Family Policy Center.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		https://www.inckmarks.org/docs/pdfs_for_Medicaid_and_EPSDT_page/SourcebookMEDICAIDYOUNGCHILDRENALL.pdf • Johnson, K., Rosenbaum, S., & Handley, M. (2020). The next steps to advance maternal and child health in Medicaid: Filling gaps in postpartum coverage and newborn enrollment. *Health Affairs Blog.* https://www.healthaffairs.org/do/10.1377/hblog20191230.967912/full • Johnson, K. (2021). Missing Babies: Best practices for ensuring continuous enrollment in Medicaid and access to EPSDT. Johnson Group Consulting, Inc. https://ccf.georgetown.edu/wp-content/uploads/2021/03/missing_babies_EPSDT_Medicaid_finalJan2021_Johnson_edit061621.pdf
Part 2: COVERAGE AND PERFORMANCE OBLIGATIONS RELATED TO AUGMENTATION OF MEDICAL CARE FOR PERINATAL PERSONS		
7. Case Management and Care Coordination		
Perinatal case management ***Definition:*** Medicaid perinatal case management programs have been variously known as prenatal care coordination, maternity care coordination, enhanced prenatal care, and so forth. (It typically refers to perinatal care with more intensive care coordination/case management.) ***Current Medicaid policy and coverage:*** States differ in their coverage of Medicaid coverage of case management and targeted case management (TCM) for adults, but many make exceptions and offer perinatal coverage. Most perinatal case management has covered prenatal and 60 days postpartum.	• Beginning in the late 1980s with expanded Medicaid maternal and infant care coverage and benefits, a majority of states created perinatal case management programs. In general, the perinatal case management programs took advantage of the Medicaid targeted case management (TCM) benefit option created in 1986 and delivered services to women in their homes or community settings. Many states sustained effective programs (e.g., CA, MI, NC, WA, WI). By 1990, 33 states had such perinatal case management/care coordination programs. • A number of studies documented the effectiveness of perinatal case management, with most finding increased prenatal care utilization and some (but not all) showing significant changes in birth outcomes such as low	**Federal documents and professional guidelines** • 42 CFR Section 440-169. https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol4/pdf/CFR-2012-title42-vol4-sec440-169.pdf • Office of Inspector General. (2019). Medicaid Targeted Case Management. US HHS. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000235.asp • Office of Population Affairs. (2018). Perinatal high-risk case management: Addressing barriers for expectant and parenting teens. https://opa.hhs.gov/grant-programs/pregnancy-assistance-fund-paf/paf-successful-strategies/perinatal-high-risk-case **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-

The following appendix is part of a Commonwealth Fund blog, Sara Rosenbaum et al., "The Road to Maternal Health Runs Through Medicaid Managed Care," *To the Point* (blog), Commonwealth Fund, May 22, 2023. https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
A survey of states, found that of the36 states reporting that they covering case management services for pregnant women in Medicaid, nearly all (34) indicated that coverage was across eligibility groups (e.g., traditional, pregnancy-related eligibility pathways). The states specifically covering perinatal care coordination/case management services typically have used a state plan amendment (SPA) for TCM. In addition, some states have used waiver and contract mechanisms to structure perinatal care coordination/case management under managed care, accountable care, and similar arrangements. Case management is generally understood to consist of services that assist eligible Medicaid beneficiaries in securing medical and other health services necessary to appropriate care and treatment. Case management is not the direct provision of care and services, but instead is a separate and reimbursable class of services under Medicaid that for specific beneficiaries, identifies necessary services, assists in locating the services, identifies providers, and monitors the provision of care. Targeted case management is a separate benefit category.	birthweight. • Dosage and scope of prenatal care case management has been found to make a difference in effectiveness and impact on outcomes. • Most perinatal case management have undergone changes over time, as Medicaid managed care arrangements spread, the proportion of births covered by Medicaid increased, and local health department roles in the health care system evolved. • Receipt of perinatal care coordination is associated with greater likelihood of improved utilization of services and birth outcomes, including: ○ utilization of prenatal and postpartum visits; ○ receipt of maternal depression screenings; ○ reduced risk of adverse pregnancy and birth outcomes (e.g., low birthweight, preterm birth, infant mortality); ○ greater utilization of nutrition services (e.g., WIC); and ○ reduced healthcare utilization and cost for participating pregnant members (e.g., reduced number of ER visits and number of inpatient hospital days).	related-services-findings-from-a-2021-state-survey-report/. • Hillemeier, M. M., Domino, M. E., Wells, R., Goyal, R. K., Kum, H. C., Cilenti, D., Timothy Whitmire, J., & Basu, A. (2015). Effects of maternity care coordination on pregnancy outcomes: propensity-weighted analyses. *Maternal and child health journal*. *19*(1): 121–127. https://doi.org/10.1007/s10995-014-1502-3 • Slaughter, J. C., Issel, L. M., Handler, A. S., Rosenberg, D., Kane, D. J., & Stayner, L. T. (2013). Measuring dosage: a key factor when assessing the relationship between prenatal case management and birth outcomes. *Maternal and child health journal*. *17*(8): 1414–1423. https://doi.org/10.1007/s10995-012-1143-3 • Larson, A., Berger, L. M., Mallinson, D. C., Grodsky, E., & Ehrenthal, D. B. (2019). Variable uptake of Medicaid-covered prenatal care coordination: The relevance of treatment level and service context. *Journal of community health*. *44*(1): 32–43. https://doi.org/10.1007/s10900-018-0550-9 • Meghea, C. I., You, Z., Raffo, J., Leach, R. E., & Roman, L. A. (2015). Statewide Medicaid enhanced prenatal care programs and infant mortality. *Pediatrics*. *136*(2): 334–342. https://doi.org/10.1542/peds.2015-0479 • Van Dijk, J. W., Anderko, L., & Stetzer, F. (2011). The impact of prenatal care coordination on birth outcomes. *Journal of obstetric, gynecologic, and neonatal nursing*. *40*(1): 98–108. https://doi.org/10.1111/j.1552-6909.2010.01206.x • Buescher, P. A., Roth, M. S., Williams, D., & Goforth, C. M. (1991). An evaluation of the impact of maternity care coordination on Medicaid birth outcomes in North Carolina. *American journal of public health*. *81*(12): 1625–1629. https://doi.org/10.2105/ajph.81.12.1625 • Keeton, K., Saunders, S. E., & Koltun, D. (2004). The effect of the Family Case Management Program on 1996 birth outcomes in Illinois. Journal of women's health. 13(2): 207–215. https://doi.org/10.1089/154099904322966191

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		• Nason, C. S., Alexander, G. R., Pass, M. A., & Bolland, J. M. (2003). An evaluation of a Medicaid managed maternity program: the impact of comprehensive care coordination on utilization and pregnancy outcomes. *Journal of health and human services administration*. *26*(2): 239–267. (No DOI). • Kane, D. J., & Issel, L. M. (2005). Estimating Medicaid prenatal case management costs: the provider's perspective. *Nursing economics*, *23*(4), 181–147. (No DOI). • Larson, A., Berger, L. M., Mallinson, D. C., Grodsky, E., & Ehrenthal, D. B. (2019). Variable uptake of Medicaid-covered prenatal care coordination: The relevance of treatment level and service context. *Journal of community health*. *44*(1): 32–43. https://doi.org/10.1007/s10900-018-0550-9.
Medicaid maternal health home or pregnancy medical home ***Definition:*** A term often used to describe a variation of perinatal case management, in other instances used to describe a specific care delivery model with enhanced care coordination. Generally, Medicaid health homes are a delivery system reform model designed to help improve outcomes for people with complex and chronic medical conditions by providing person-centered, team-based care. Like health homes more broadly, the maternal health home model aims to improve health outcomes by improving coordination among primary, specialty, and hospital care as well as other social support services.	• Maternal and child health experts have identified the receipt of *coordinated, collaborative, high-touch care* (facilitated by case management and maternal health homes) for all perinatal persons as essential for equity and care continuity. All perinatal care should ideally take place in a "maternal health home" or "women's health home" and should have a strong linkage to ongoing primary care. • A few states have evaluated this model. Since 2011, North Carolina's Pregnancy Medical Home (PMH) model pays a case management entity a per-member-per-month payment from Medicaid to oversee case management of 90% of pregnant and postpartum Medicaid beneficiaries, in partnership with their providers. Enhanced payments are provided for completed risk screenings and postpartum visits. • The Strong Start for Mothers and Newborns prenatal care	**Federal documents and professional guidelines** • No specific guidelines at this time. **Other key resources** • MACPAC. (2021). North Carolina Pregnancy Medical Home. https://www.macpac.gov/wp-content/uploads/2021/09/North-Carolina-Pregnancy-Medical-Home.pdf • Clark, M, Burak, E. (2021). Maternal Health Home Option in Build Back Better Plan Lays Groundwork for Two-Generation Success. The Georgetown University Health Policy Institute Center for Children and Families. https://ccf.georgetown.edu/2021/11/12/maternal-health-home-option-in-build-back-better-plan-lays-groundwork-for-two-generation-success/ • Zephyrin, L., Seervai, S., Lewis, A., Katon, J. G. (2021). Community-based models to improve maternal health outcomes and promote health equity. (Issue Brief). Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Current Medicaid policy and coverage: Any state could do this at their option, including use of TCM or managed care mechanisms. North Carolina was the first state to use a "pregnancy medical home". Strong Start sites also tested what the demonstration project called a "maternity care home" model, which was also primarily a perinatal case management approach. Federal legislation has been proposed to provide state Medicaid agencies the option to provide coordinated care through "maternal health homes". Under the proposal states would have option to create coordinated "health homes" to deliver comprehensive, individualized care to pregnant and postpartum people. Enhanced federal matching funds and planning grants to states were part of this proposal.	initiative, funded by the CMS Innovation Center (CMMI), was designed to test three outpatient models of enhanced prenatal care: birth centers, group prenatal care, and maternity care homes. The aim was to reduce rates of preterm birth, rates of low birthweight, and costs among women enrolled in Medicaid or the Children's Health Insurance Program (CHIP). The maternity care home approach augmented typical prenatal care with the addition of care managers (e.g., nurses, social workers, and/or community health workers) to a patient-centered medical home. These efforts fit within the parameters of typical perinatal case management but were not consistently implemented across sites. Accordingly, the five-year evaluation showed varied results for perinatal case management (the "maternity care home approach") under this initiative. • While it did not pass, the Build Back Better Act legislation (HR 5376) included a new option for states to use SPA in order to provide coordinated care through "maternal health homes" which would serve as a hub for pregnant and postpartum people to receive care from a team of health, mental health, and other perinatal providers.	briefs/2021/mar/community-models-improve-maternal-outcomes-equity • Berrien, K., Ollendorff, A., & Menard, M. K. (2015). Pregnancy medical home care pathways improve quality of perinatal care and birth outcomes. *North Carolina medical journal*. *76*(4): 263–266. https://doi.org/10.18043/ncm.76.4.263 • Mallampati, D., Jackson, C., & Menard, M. K. (2022). The association between care management and neonatal outcomes: the role of a Medicaid-managed pregnancy medical home in North Carolina. *American journal of obstetrics and gynecology*. *226*(6): 848.e1–848.e9. https://doi.org/10.1016/j.ajog.2022.03.018 • Hill, I., Cross-Barnet, C., Courtot, B., Benatar, S., & Thornburgh, S. (2019). What do women in Medicaid say about enhanced prenatal care? Findings from the national Strong Start evaluation. *Birth*. *46*(2): 244–252. https://doi.org/10.1111/birt.12431 • Hill, I., Dubay, L., Courtot, B., Benatar, S., Bowen, G., Blavin, F., … Morgan, J. (2018). Strong Start for mothers and newborns evaluation: Year 5 project synthesis. (Urban Institute Report No. 5.1). https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf • Suhag, A., Dutta, R., Schwarzwald, H. L., Taylor, T., & Hollier, L. (2017). Pregnancy medical home: Outcomes and costsavings. *American Journal of Obstetrics & Gynecology*. 216(1): S39-S40. https://doi.org/10.1016/j.ajog.2016.11.940. • National Academy for State Health Policy. (2017). Case Study: Wisconsin's Obstetric Medical Home Program Promotes Improved Birth Outcomes. https://www.nichq.org/sites/default/files/inline-files/Wisconsin-Case-Study.pdf. • Masten, Y., Song, H., Esperat, C. R., & McMurry, L. J. (2022). A maternity care home model of enhanced prenatal care to reduce preterm birth rate and NICU use. *Birth*. *49*(1): 107-115. https://doi.org/10.1111/birt.12579 • Tucker, C. M., Berrien, K., Menard, M. K., Herring, A. H., Daniels, J., Rowley,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		D. L., & Halpern, C. T. (2015). Predicting preterm birth among women screened by North Carolina's Pregnancy Medical Home Program. *Maternal and child health journal*. *19*(11): 2438-2452. https://doi.org/10.1007/s10995-015-1763-5
Coordination and linkage with primary care ***Current Medicaid policy and coverage:*** Coverage and approaches are unclear. Generally, women return to their primary care provider either for a postpartum visit or next well or sick visit. Contracts may define these relationships within networks.	• ACOG recommends that basic prenatal care should include care coordination. • ACOG recommends that in the post-partum period, the OBGYN and patient should identify the patient's primary care provider. • ACOG recommends that infant primary care physicians share in responsibility of providing continuity of care with neonatal care centers. • Transitions from obstetric care to primary care can mean a change in provider for many women. Experts and national initiatives call for increased use of patient-centered medical homes and structures that support collaboration. • Fragmentation in women's health care has disproportionate effects on communities of color, due to an increased likelihood of living in an underserved area and facing structural racism and bias in the health care system.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care, 8th Edition. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx • American College of Obstetricians and Gynecologists. (2018). Optimizing Postpartum Care. Committee Opinion Number 736. https://journals.lww.com/greenjournal/Fulltext/2018/05000/ACOG_Committee_Opinion_No__736__Optimizing.42.aspx **Other key resources** • McCloskey, L., Bernstein, J., The Bridging The Chasm Collaborative. (2021). Bridging the chasm between pregnancy and health over the life course: A national agenda for research and action. *Women's Health Issues*. *31*(3): 204–218. https://doi.org/10.1016/j.whi.2021.01.002 • Phillips, R. L., Jr, McCauley, L. A., & Koller, C. F. (2021). Implementing high-quality primary care: A Report from the National Academies of Sciences, Engineering, and Medicine. *JAMA*. *325*(24): 2437–2438. https://doi.org/10.1001/jama.2021.7430 • Zephyrin, L., Suennen, L., Viswanathan, P., Augenstein, J., & Bachrach, D. (2020). *Part 1: A Framework for Addressing Gaps and Barriers*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/fund-reports/2020/jul/transforming-primary-health-care-women-part-1-framework • Wen, T., Krenitsky, N. M., Clapp, M. A., D'Alton, M. E., Wright, J. D.,

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Attenello, F., Mack, W. J., & Friedman, A. M. (2020). Fragmentation of postpartum readmissions in the United States. *American journal of obstetrics and gynecology*, *223*(2), 252.e1–252.e14. https://doi.org/10.1016/j.ajog.2020.01.022
Evidence-based home visiting programs ***Definition:*** Evidence-based home visiting includes more than 20 program models approved by HHS based on the Home Visiting Evidence of Effectiveness' (HomVEE) review of evidence using Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program criteria**.** Models must use home visiting as their primary way to deliver services and that work to improve outcomes in at least one of eight domains: (1) maternal health; (2) child health; (3) positive parenting practices; (4) child development and school readiness; (5) reductions in child maltreatment; (6) family economic self-sufficiency; (7) linkages and referrals to community resources and supports; and (8) reductions in juvenile delinquency, family violence, and crime. ***Current Medicaid policy and coverage:*** More than 22 states have approved Medicaid financing for evidence-based home visiting as of 2021. Coverage is under a variety of benefit categories and mechanisms, with most states using a SPA for the Targeted Case Management (TCM) benefit. Other states cover evidence-based home visiting using waivers.	• Evidence-based home visiting is promoted as a "best practice" by the American Academy of Pediatrics. • In 2016, CMS issued guidance (via a Joint Informational Bulletin with HRSA) on state Medicaid coverage of home visiting programs, such as those endorsed by the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). • Among the 22 evidence-based home visiting models approved by HHS, some have been shown to improve use of prenatal care, postpartum visits, well-child visits, childhood immunizations, postpartum family planning, and birth spacing, as well as improved maternal and child health and developmental outcomes. • Evidence-based home visiting has not been shown to improve *pregnancy* outcomes, with the exception of the Maternal and Infant Health Program (MIHP), which operates as a perinatal case management/enhanced prenatal care program in Michigan Medicaid.	**Federal documents and professional guidelines** • Administration for Children and Families. (2022). Home Visiting Evidence of Effectiveness. https://homvee.acf.hhs.gov/ • Centers for Medicare and Medicaid Services. (2016). Joint Bulletin: Coverage of Maternal, Infant, and Early Childhood Home Visiting Services. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf. • Council on Community Pediatrics, Council on Early Childhood, & Committee on Child Abuse and Neglect. (2017). Early Childhood Home Visiting. *Pediatrics*. *140*(3): e20172150. https://doi.org/10.1542/peds.2017-2150 **Other key resources** • Johnson K. (2019). Medicaid Financing for Home Visiting: State of the States. Johnson Group Consulting, Inc. https://ccf.georgetown.edu/2019/01/24/how-are-states-using-medicaid-to-pay-for-homevisiting-new-paper-offers-more-clarity • Goyal, N. K., Hall, E. S., Meinzen-Derr, J. K., Kahn, R. S., Short, J. A., Van Ginkel, J. B., & Ammerman, R. T. (2013). Dosage effect of prenatal home visiting on pregnancy outcomes in at-risk, first-time mothers. *Pediatrics*, *132 Suppl 2*(Suppl 2), S118–S125. https://doi.org/10.1542/peds.2013-1021J • Roman, L., Raffo, J. E., Zhu, Q., & Meghea, C. I. (2014). A statewide Medicaid enhanced prenatal care program: impact on birth outcomes. *JAMA Pediatrics*. *168*(3): 220–227. https://doi.org/10.1001/jamapediatrics.2013.4347 • Meghea, C. I., You, Z., Raffo, J., Leach, R. E., & Roman, L. A. (2015).

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Statewide Medicaid enhanced prenatal care programs and infant mortality. *Pediatrics*. *136*(2): 334–342. https://doi.org/10.1542/peds.2015-0479
8. Mental and Behavioral Health Service Coverage		
Maternal depression screening and referral ***Definition:*** Perinatal depression refers to a major depressive episode occurring during pregnancy or within four weeks after birth. In addition, many people enter pregnancy with depression and anxiety. ***Current Medicaid policy and coverage:*** CMS encourages states to provide maternal depression screening, including in adult primary care and during pediatric well-child visits. Nearly all states have adopted policies that support financing for maternal/perinatal depression screening of Medicaid beneficiaries during and following pregnancy. Some states place limits and utilization controls on depression screening. In addition, nearly all states provide coverage of postpartum depression treatment, with most using utilization controls.	• The American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Nurse-Midwives, and other professional organizations all recommend universal screening of pregnant and postpartum women for depression as one component of quality obstetric care. • The U.S. Preventive Services Task Force also recommends depression screening for adults, including screening for perinatal depression because it contributes to a significant reduction in overall prevalence of depression and associated morbidities. • The American College of Obstetricians and Gynecologists specifically recommends that obstetrician-gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. • In addition, the American College of Obstetricians and Gynecologists recommends that obstetrician-gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being during the comprehensive postpartum visit — including screening for postpartum depression and anxiety with a validated tool. • The American Academy of Pediatrics Bright Futures: Guidelines (4th Edition) and visit schedule includes a recommendation for pediatric providers to screen for	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists (ACOG). (2018). Screening for perinatal depression. Committee Opinion No. 757. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf . • American Academy of Family Physicians. Clinical preventive service recommendation. (Undated). Depression. https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/depression.html • U.S. Preventive Services Task Force (USPSTF). (2016). Final recommendation statement: Depression in adults: Screening. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening • Centers for Medicare and Medicaid. (2016). Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children. Center for Medicaid and CHIP Services Informational Bulletin. https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf • Committee on Psychosocial Aspects of Child and Family Health. (2019). AAP Policy Statement: Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. *Pediatrics*. *143*(1): e20183259. https://doi.org/10.1542/peds.2018-3259 • Kendig, S., Keats, J. P., Hoffman, M. C., Kay, L. B., Miller, E. S., Moore Simas., T. A., Frieder, A., Hackley, B., Indman, P., Raines, C., Semenuk, K., Wisner, K. L., Lemieux, L. A. (2017). Consensus bundle on maternal mental health: Perinatal depression and anxiety. *Obstetrics & Gynecology.* 129(3):

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	postpartum depression at four well-child visits in the first 6 months of infant life and refer to appropriate evaluation and treatment services for the mother and infant when indicated. • Primary care and obstetric providers should be prepared to make referrals to mental health providers and/or initiate treatment. • Perinatal mood and anxiety disorders are among the most common mental health conditions affecting women of reproductive age. When left untreated, these conditions can have profound adverse effects on women and their children. • Specifically, perinatal depression is the most common obstetric complication in the United States, with prevalence rates of 10% to 25% among new mothers. • Nationwide survey data show that while 13% of surveyed women with a recent live birth reported postpartum depressive symptoms, one in five did not report a health care provider asking about depression during prenatal care and one in eight reported they were not asked about depression during postpartum visits. • Studies also point to disparities with regard to postpartum screening for depression, with Asian, Black, Native American, and multiracial women less likely than White mothers to receive screening. Disparities also have been shown in terms of mental health-related emergency department visits and hospitalizations. • Risk factors associated with perinatal depression include stressful life events, history of depression, limited social support, unintended pregnancies, and current or previous intimate partner violence. • While the effectiveness of screening for postpartum depression is related to the availability of services to	422-430. https://doi.org/10.1097/AOG.0000000000001902 • Agency for Healthcare Research and Quality. (2019). Efficacy and Safety of Screening for Postpartum Depression. AHRQ Publication No. 13-EHC064-EF. https://effectivehealthcare.ahrq.gov/products/depression-postpartum-screening/research **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Benatar, S., Cross-Barnet, C., Johnston, E., & Hill, I. (2020). Prenatal depression: Assessment and outcomes among Medicaid participants. *Journal of Behavioral Health Services & Research*. *47*(3): 409-423. https://doi.org/10.1007/s11414-020-09689-2 • Haight, S. C., Byatt, N., Moore Simas, T. A., Robbins, C. L., Ko, J. Y. Recorded diagnoses of depression during delivery hospitalizations in the United States, 2000–2015. *Obstetrics & Gynecology. 133*(6): 1216-1223. https://doi.org/10.1097/AOG.0000000000003291 • Bauman BL, Ko JY, Cox S, et al. (2020). Postpartum depressive symptoms and provider discussions about perinatal depression — United States, 2018. *MMWR Morb Mortal Wkly Rep. 69*(19): 575–581. http://dx.doi.org/10.15585/mmwr.mm6919a2 • Rhodes, A. M., & Segre, L. S. (2013). Perinatal depression: A review of US legislation and law. *Archives of women's mental health*. *16*(4): 259–270. https://doi.org/10.1007/s00737-013-0359-6 • Sidebottom, A., Vacquier, M., LaRusso, E., Erickson, D., & Hardeman, R. (2021). Perinatal depression screening practices in a large health system: Identifying current state and assessing opportunities to provide more equitable care. *Archives of women's mental health*. *24*(1): 133–144. https://doi.org/10.1007/s00737-020-01035-x • Dagher, R. K., Bruckheim, H. E., Colpe, L. J., Edwards, E., & White, D. B.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	follow-up for women with positive screens, research also shows that depression screening alone can have some positive benefit for people in the perinatal period.	(2021). Perinatal depression: Challenges and opportunities. *Journal of women's health (2002)*. *30*(2): 154–159. https://doi.org/10.1089/jwh.2020.8862 • Xue, W. Q., Cheng, K. K., Xu, D., Jin, X., & Gong, W. J. (2020). Uptake of referrals for women with positive perinatal depression screening results and the effectiveness of interventions to increase uptake: A systematic review and meta-analysis. *Epidemiology and psychiatric sciences*. *29*: e143. https://doi.org/10.1017/S2045796020000554 • Rafferty, J., Mattson, G., Earls, M. F., Yogman, M. W., & COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. (2019). Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics*. *143*(1): e20183260. https://doi.org/10.1542/peds.2018-3260 • Siu AL, Bibbins-Domingo K, Grossman DC, et al; US Preventive Services Task Force (USPSTF). (2016). Screening for depression in adults: US Preventive Services Task Force recommendation statement. *JAMA*. *315*(4): 380–387. https://doi.org/10.1001/jama.2015.18392 • Estriplet, T., Morgan, I., Davis, K., Crear Perry, J., & Matthews, K. (2022). Black Perinatal Mental Health: Prioritizing Maternal Mental Health to Optimize Infant Health and Wellness. *Frontiers in psychiatry*. *13*: 807235. https://doi.org/10.3389/fpsyt.2022.807235 • Institute of Medicine. (2009). *Depression in Parents, Parenting, and Children. Opportunities to Improve Identification, Treatment, and Prevention*. National Academies Press.
All appropriate substance use disorder (SUD) treatment ***Current Medicaid policy and coverage:*** Many states are expanding the continuum of services offered to individuals with SUD, including pregnant women. Under the federal SUPPORT Act, Medicaid must	• Given the importance of SUD treatment during pregnancy, the American Society of Addiction Medicine (ASAM) recommends pregnant women should be given priority access to treatment. • Medicaid agencies, plans, and providers have roles in carrying out other federal obligations in substance use and child welfare systems. • Any pregnant person receiving services under the	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2017). Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. *Obstet Gynecol*. 130: e81–94. https://doi.org/10.1097/AOG.0000000000002235 • MACPAC. (2020). Substance Use Disorder and Maternal and Infant Health Treatment: Chapter 6 Report to Congress. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-6-Substance-Use-Disorder-and-Maternal-and-Infant-Health.pdf

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
cover basic aspects of drug and alcohol dependency recovery for perinatal persons with at least one SUD, including medication assisted treatment (MAT). States determine the extent of the additional SUD services they will provide to perinatal persons, and do not have a separate SUD benefit for pregnancy women. However, the majority of states offer SUD benefits to pregnant people beyond what is required under federal law, and may include a broader continuum of SUD services, outpatient, and or residential SUD services. State SUD benefits typically include detoxification and individual and group therapy. The CMS Maternal Opioid Misuse (MOM) model provides funds to 8 state Medicaid agencies (CO, IN, ME, MD, NH, TN, TX, WV) to improve the coordination of care for pregnant and postpartum beneficiaries with an OUD and their infants (demonstration projects from January 2020-December 2024).	Substance Abuse Prevention and Treatment (SAPT) block grant must be given priority in treatment admissions, and individuals referred to the state for treatment must be placed in a program or have interim arrangements made within 48 hours (42 USC § 300x-27). States are also required to allocate a dedicated portion of the SAPT block grant award to support pregnant and parenting women. • Child welfare programs require "plan of safe care" for families of infants affected by substance use exposure. • The incidence of neonatal abstinence syndrome (NAS) quadrupled between 2004-2016. More than 80% or 13 per 1,000 newborn hospitalizations among NAS-related births were paid for by Medicaid. Pregnant people covered by Medicaid are more likely than their counterparts with other forms of insurance to misuse substances or have SUD. However, they are also more likely to have ever received treatment for their SUD. • SUD among perinatal persons can be treated by appropriate modalities and programs, such as individual and group therapy, medication assisted treatment (MAT), and detoxification. In addition to MAT, a variety of other services to support the treatment and recovery of people with substance use disorder, but states are not required to cover these under Medicaid (i.e., facility-based programs). • Recommendations include approaches for OB-GYNs to incorporate basic addiction management into their practice.	• Centers for Medicare & Medicaid Services (CMS). (2018). Neonatal abstinence syndrome: A critical role for Medicaid in the care of infants. https://www.medicaid.gov/federal-policyguidance/downloads/cib060818.pdf. • Centers for Medicare & Medicaid Services (CMS). (2019). State guidance for the new limited exception to the IMD exclusion for certain pregnant and postpartum women included in Section 1012 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Help for Moms and Babies. https://www.medicaid.gov/ federal-policy-guidance/downloads/cib072619-1012.pdf • American Society of Addiction Medicine. (2022). Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids. https://www.asam.org/docs/default-source/public-policy-statements/substance-use-misuse-and-use-disorders-during-and-following-pregnancy.pdf • Innovation Center (CMMI). (2022). Maternal Opioid Misuse (MOM) Model. Centers for Medicare & Medicaid Services (CMS). https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Krans, E. E., Campopiano, M., Cleveland, L. M., Goodman, D., Kilday, D., Kendig, S., Leffert, L. R., Main, E. K., Mitchell, K. T., O'Gurek, D. T., D'Oria, R., McDaniel, D., & Terplan, M. (2019). National partnership for maternal safety: Consensus bundle on obstetric care for women with opioid use disorder. *Obstetrics and gynecology*. *134*(2): 365–375.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		https://doi.org/10.1097/AOG.0000000000003381 ● Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants. https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-andParenting-Women-With-Opioid-Use-Disorder-and-TheirInfants/SMA18-5054 ● Children's Bureau. (2019). Plans of Safe Care for Infants with Prenatal Substance Exposure and their Families. Administration for Children and Families (ACF). https://www.childwelfare.gov/pubPDFs/safecare.pdf. Also see: https://ncsacw.acf.hhs.gov/topics/plans-of-safe-care.aspx ● U.S. Government Accountability Office (GAO). (2017). Newborn health: Federal action needed to address neonatal abstinence syndrome. Report No. GAO-18-32. https://www.gao.gov/assets/690/687580.pdf. ● Smid, M. C., & Terplan, M. (2022). What obstetrician–gynecologists should know about substance use disorders in the perinatal period. *Obstetrics & Gynecology*. *139*(2): 317-337. https://doi.org/10.1097/AOG.0000000000004657 ● Lennox, R., Patel, T., Marmel, A., & Shaw, E. (2021). Prenatal care outcomes in women with substance use disorders: A retrospective cohort study. *Journal of Obstetrics and Gynaecology Canada*. *43*(7): 850-855. https://doi.org/10.1016/j.jogc.2020.10.021 ● Meinhofer, A., Witman, A., Maclean, J. C., & Bao, Y. (2022). Prenatal substance use policies and newborn health. *Health Economics*. *31*(7): 1452-1467. https://doi.org/10.1002/hec.4518 ● Logue, T. C., Wen, T., & Friedman, A. M. (2022). Dual diagnosis of mental health condition and substance use disorder at delivery and maternal morbidity. *American Journal of Obstetrics & Gynecology*. *226*(1): S263. https://doi.org/10.1016/j.afog.2021.11.447 ● Simmons, E., & Austin, A. E. (2022). Association of prenatal substance use with prenatal and postpartum care: Evidence from the Pregnancy Risk Assessment Monitoring System, 2016–2019. *Preventive Medicine*. *159*: 107065. https://doi.org/10.1016/j.ypmed.2022.107065

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Peer support services ***Definition:*** SAMHSA defines a peer support provider as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience." Generally, peer support providers are known as "peer support specialists" in mental health settings. ***Current Medicaid policy and coverage:*** Federal law permits coverage of peer support as a standalone service for Medicaid beneficiaries with substance use disorders (SUD) as a primary diagnosis. In 2007, CMS clarified that Medicaid reimburses for peer support services delivered directly (and under supervision of mental health professionals) to Medicaid beneficiaries with mental health and/or substance use disorders. In 2018, the GAO found that 37 states allowed Medicaid billing for peer support services as a complement to SUD treatment. States use the state plan coverage for rehabilitative services, waivers, managed care contracts, and other mechanisms to operationalize this service.	• In 2007, HHS recognized peer support services overseen by a peer support provider as an evidence-based mental health model of care. • Peer support may be inaccessible to Medicaid beneficiaries due to lack of peer support specialists and professionals to supervise peer support providers. • Peer support can provide companionship with those grappling with the same perinatal challenges, can provide emotional support to get through hard times (and have been found to be associated with decreased depressive symptoms), and can provide informational support in the form of guidance and suggestions. • Peer support groups show high satisfaction rates among mothers taking part in such groups.	**Federal documents and professional guidelines** • Centers for Medicare and Medicaid Services. (2007). CMS Letter to State Medicaid Directors. Peer Support Services under the Medicaid Program. (SMDL 07-011). https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf • US Government Accountability Office (GAO). (2020). Substance Use Disorder: Medicaid coverage of peer support services for adults. (GAO-20-616). https://www.gao.gov/products/gao-20-616 • US Government Accountability Office. (2018). Mental Health: Leading practices for state programs to certify peer support specialists. (GAO-19-41). https://www.gao.gov/assets/gao-19-41.pdf. **Other key resources** • Open Minds. (2018) State Medicaid Reimbursement for Peer Support Services. https://static1.squarespace.com/static/56d5ca187da24ffed7378b40/t/5e4e2ecc21989a778bc3db5f/1582182093508/OMCircle_ReferenceGuide_PeerSupport.pdf • Prevatt, B. S., Lowder, E. M., & Desmarais, S. L. (2018). Peer-support intervention for postpartum depression: Participant satisfaction and program effectiveness. *Midwifery*. *64*: 38–47. https://doi.org/10.1016/j.midw.2018.05.009 • Dennis C. L. (2003). The effect of peer support on postpartum depression: a pilot randomized controlled trial. *Canadian journal of psychiatry. 48*(2): 115–124. https://doi.org/10.1177/070674370304800209 • Mazzoni, S., Hill, P., Briggs, A., Barbier, K., Cahill, A., Macones, G., Colditz, G., Tuuli, M., & Carter, E. (2020). The effect of group prenatal care for women with diabetes on social support and depressive symptoms: a pilot randomized trial. *Journal of maternal-fetal & neonatal medicine*, *33*(9), 1505–1510. https://doi.org/10.1080/14767058.2018.1520832
9. Nutrition Services		

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Screenings and referrals to WIC and SNAP ***Current Medicaid policy and coverage:*** Current state coverage and approaches are unclear. Some states have included social supports as part of enhanced prenatal care programs/case management. CMS issued guidance in 2021 regarding Medicaid coverage of nutritional-related support services. States could require MCOs to: 1) ensure that all perinatal beneficiaries are connected with state and federal nutritional support programs, and 2) coordinate with community-based organizations (specifically those that serve BIPOC) that specifically provide nutritional supports for perinatal persons.	• Food insecurity is defined as the disruption of food intake or eating patterns because of lack of money and other resources. Food insecurity results in people having reduce quantity, quality, or variety of diet and includes reduced food intake and may result in hunger. • One third of low-income households in the US report food insecurity, and estimates of food insecurity among perinatal women are even higher. • Perinatal food insecurity is associated with increased likelihood and suboptimal control of hypertension and gestational diabetes among perinatal women. • For infants, perinatal food insecurity is associated with low birthweight and increased risk of birth defects.	**Federal documents and professional guidelines** • Centers for Medicare and Medicaid Services. (2021). State Health Official Letter #21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf. • USDA. (Undated). Food security. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/ • US Department of Health and Human Services. (Undated). Food Insecurity. Healthy People 2030. Food Insecurity. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity • Coleman-Jensen A, Rabbitt M, Gregory C, Singh A. (2016). Household food security in the United States in 2014. Economic Research Service, US Department of Agriculture. Economic Research Report No. 194. https://www.ers.usda.gov/publications/pub-details/?pubid=45428 **Other key resources** • Brochier, A., Garg, A., & Peltz, A. (2022). Clinical and public policy interventions to address food insecurity among children. *Current Opinion in Pediatrics*. *34*(1): 2-7. https://doi.org/10.1097/MOP.0000000000001096 • McLeod, M. R., Vasudevan, A., Warnick, S., Jr, & Wolfson, J. A. (2021). Screening for food insecurity in the primary care setting: Type of visit matters. *Journal of general internal medicine*. *36*(12): 3907–3909. https://doi.org/10.1007/s11606-020-06474-x • Laraia BA, Siega-Riz AM, Gundersen C. (2010). Household food insecurity is associated with self-reported pregravid weight status, gestational weight gain, and pregnancy complications. *J Am Diet Assoc.* 110(5): 692–701. https://doi.org/10.1016/j.jada.2010.02.014 • Cheu, L. A., Yee, L. M., & Kominiarek, M. A. (2020). Food insecurity during pregnancy and gestational weight gain. *American journal of obstetrics & gynecology MFM*, *2*(1), 100068. https://doi.org/10.1016/j.ajogmf.2019.100068

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		• Bastian, A., Parks, C., Yaroch, A., McKay, F. H., Stern, K., van der Pligt, P., McNaughton, S. A., & Lindberg, R. (2022). Factors Associated with Food Insecurity among Pregnant Women and Caregivers of Children Aged 0-6 Years: A Scoping Review. *Nutrients*, *14*(12), 2407. https://doi.org/10.3390/nu14122407 • Castillo, D. C., Ramsey, N. L., Yu, S. S., Ricks, M., Courville, A. B., & Sumner, A. E. (2012). Inconsistent Access to Food and Cardiometabolic Disease: The Effect of Food Insecurity. *Current cardiovascular risk reports*. *6*(3): 245–250. https://doi.org/10.1007/s12170-012-0236-2 • Carmichael SL, Yang W, Herring A, Abrams B, Shaw GM. Maternal food insecurity is associated with increased risk of certain birth defects. *J Nutr.* 137(9): 2087–92. https://doi.org/10.1093/jn/137.9.2087 • Fitzhugh, C. D., Pearsall, M. S., Tully, K. P., & Stuebe, A. M. (2021). Social determinants of health in maternity care: a quality improvement project for food insecurity screening and health care provider referral. *Health Equity*. *5*(1): 606-611. https://doi.org/10.1089/heq.2020.0120 • Dolin, C. D., Compher, C. C., Oh, J. K., & Durnwald, C. P. (2021). Pregnant and hungry: addressing food insecurity in pregnant women during the COVID-19 pandemic in the United States. *American Journal of Obstetrics & Gynecology MFM*. *3*(4): 100378. https://doi.org/10.1016/j.ajogmf.2021.100378 • Olson C. M. (2010). Food insecurity and maternal health during pregnancy. *Journal of the American Dietetic Association*, *110*(5), 690–691. https://doi.org/10.1016/j.jada.2010.02.001
Lactation & breastfeeding support ***Current Medicaid policy and coverage:*** States are required to cover breastfeeding support (lactation counseling and pumps/supplies) without cost-sharing for the Medicaid expansion population under Women's Preventive Services Guidelines	• Breastfeeding is recommended by the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, US Preventive Services Task Force, and others. For both a mother and a child, breastfeeding is associated with short- and long-term health benefits. • While breastfeeding confers medical, economic, societal, and environmental advantages; however, each woman is	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2018). Optimizing support for breastfeeding as part of obstetric practice. ACOG Committee Opinion No 756. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/10/optimizing-support-for-breastfeeding-as-part-of-obstetric-practice. • Centers for Medicare and Medicaid Services. (2012). Medicaid coverage of

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
under the ACA. Most but not all states cover lactation counseling and breast pumps (electric and manual) for all beneficiaries. Several states set limits on the number of pumps covered. Several states also impose utilization management techniques on lactation counseling, and some only cover lactation consultation services in the hospital (not the outpatient or home setting). For example, surveys found that 30 states do not cover lactation consultation in the home. In addition, some states include lactation consulting as part of the office visits or global maternity feeds, rather than separate reimbursement. Only a small number of states permit lactation consultants to bill independently for their services. CMS encourages states to go beyond the requirement of solely coordinating and referring enrollees to the Special Supplemental Food Program for Women, Infants, and Children (WIC) (established in 42 C.F.R. § 431.635) and include lactation services as separately reimbursed pregnancy-related services.	uniquely qualified to make an informed decision surrounding infant feeding. • National data indicate that ACA coverage policy changes were associated with significant increases in breastfeeding duration. However, multiple studies show lower rates of breastfeeding among low-income and publicly insured women. • Experts have identified insurance coverage of breast pumps (manual and electric) and lactation counseling (in the hospital, outpatient, and home setting) as essential to sustain breastfeeding in the home and workplace. • Receipt of care from lactation consultants is associated with an increased likelihood of breastfeeding uptake and duration.	lactation services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/lactation_services_issuebrief_01102012.pdf • US Department of Health and Human Services. (Undated). Breastfeeding benefits. Healthcare.gov. https://www.healthcare.gov/coverage/breast-feeding-benefits/ • Patnode, C. D., Henninger, M. L., Senger, C. A., Perdue, L. A., & Whitlock, E. P. (2016). Primary Care Interventions to Support Breastfeeding: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA*. *316*(16): 1694–1705. https://doi.org/10.1001/jama.2016.8882 **Other key resources** • National Conference of State Legislatures. (2021). Breastfeeding state laws. https://www.ncsl.org/research/health/breastfeeding-state-laws.aspx • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. • Patel, S., & Patel, S. (2016). The Effectiveness of Lactation Consultants and Lactation Counselors on Breastfeeding Outcomes. *Journal of human lactation*. *32*(3): 530–541. https://doi.org/10.1177/0890334415618668 • Herold, R. A., & Bonuck, K. (2016). Medicaid IBCLC Service Coverage following the Affordable Care Act and the Center for Medicare and Medicaid Services Update. *Journal of human lactation*. *32*(1): 89–94. https://doi.org/10.1177/089033441559v9164 • Wouk, K., Chetwynd, E., Vitaglione, T., & Sullivan, C. (2017). Improving Access to Medical Lactation Support and Counseling: Building the Case for Medicaid Reimbursement. *Maternal and child health journal*. *21*(4): 836–844. https://doi.org/10.1007/s10995-016-2175-x • Mercier, R. J., Burcher, T. A., Horowitz, R., & Wolf, A. (2018). Differences in Breastfeeding Among Medicaid and Commercially Insured Patients: A

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Retrospective Cohort Study. *Breastfeeding medicine*. *13*(4): 286–291. https://doi.org/10.1089/bfm.2017.0228. • Hawkins, S. S., Dow-Fleisner, S., & Noble, A. (2015). Breastfeeding and the Affordable Care Act. *Pediatric clinics of North America*. *62*(5): 1071–1091. https://doi.org/10.1016/j.pcl.2015.05.002 • Hawkins, S. S., Horvath, K., Noble, A., & Baum, C. F. (2022). ACA and Medicaid Expansion Increased Breast Pump Claims and Breastfeeding for Women with Public and Private Insurance. *Women's health issues: official publication of the Jacobs Institute of Women's Health*. *32*(2): 114–121. https://doi.org/10.1016/j.whi.2021.10.005 • Gurley-Calvez, T., Bullinger, L., & Kapinos, K. A. (2018). Effect of the Affordable Care Act on Breastfeeding Outcomes. *American journal of public health*. *108*(2): 277–283. https://doi.org/10.2105/AJPH.2017.304108 • Swerts, M., Westhof, E., Bogaerts, A., & Lemiengre, J. (2016). Supporting breast-feeding women from the perspective of the midwife: A systematic review of the literature. *Midwifery*. *37*: 32–40. https://doi.org/10.1016/j.midw.2016.02.016 • Segura-Pérez, S., Hromi-Fiedler, A., Adnew, M., Nyhan, K., & Pérez-Escamilla, R. (2021). Impact of breastfeeding interventions among United States minority women on breastfeeding outcomes: a systematic review. *International journal for equity in health*. *20*(1): 72. https://doi.org/10.1186/s12939-021-01388-4. • Mercier, R. J., Burcher, T. A., Horowitz, R., & Wolf, A. (2018). Differences in Breastfeeding Among Medicaid and Commercially Insured Patients: A Retrospective Cohort Study. *Breastfeeding medicine*. *13*(4): 286–291. https://doi.org/10.1089/bfm.2017.0228
Coverage or other support related to infant formula ***Current Medicaid policy and coverage:*** CMS has	• For many infants, commercial formula as a central or supplementary part of their diet. This includes those unable to breastfeed for medical or other reasons. • More than one-third of infants covered by Medicaid and	**Federal documents and professional guidelines** • Economic Research Service. (2022). Infants in USDA's WIC Program consumed an estimated 56 percent of U.S. infant formula in 2018. U.S. Department of Agriculture. https://www.ers.usda.gov/data-

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
affirmed the Medicaid role as the primary payer for exempt infant formulas and medical foods issued to Medicaid and WIC participants who have diagnosed medical conditions that precludes or restricts the use of conventional foods. Formula for routine use among infants in good health is not covered by Medicaid. However, as a major source of coverage for infants, Medicaid providers and health plans can be a source of trusted information to families about formula options and switching formula brands. At a minimum, state WIC and Medicaid agencies must coordinate their efforts.	CHIP used formula in their first 12 months of life. More than three-quarters (78%) of newborns in Medicaid or CHIP were fed formula in their first 6 months of life, compared to two-thirds (63%) of their privately insured counterparts in 2020 ● A 1990 study found that every $1 spent on prenatal WIC nutrition supplementation resulted in Medicaid savings of $1.77 to $3.12 for mothers and infants in just the first two months following birth.	products/chart-gallery/gallery/chart-detail/?chartId=103970. ● Food and Nutrition Service. (2015). WIC Policy Memorandum #2015-07. Medicaid Primary Payer for Exempt Infant Formulas and Medical Foods. US Department of Agriculture. https://www.fns.usda.gov/wic/medicaid-primary-payer-exempt-infant-formulas-and-medical-foods **Other key resources** ● Williams, E., & Artiga, S. (2022). Key characteristics of infants and implications of the recent formula shortage. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/key-characteristics-of-infants-and-implications-of-the-recent-formula-shortage/#footnote-556341-3 ● Burak, E.W. (2022). Infants covered by Medicaid and CHIP likely hardest hit by formula shortage, WIC a key resource. Georgetown Center for Children and Families.. https://ccf.georgetown.edu/2022/07/05/infants-covered-by-medicaid-and-chip-likely-hardest-hit-by-formula-shortage-wic-a-key-resource/ ● Neuberger, Z. Bergh, K., & Hall, L. (2022). Infant formula shortage highlights WIC's critical role in feeding babies. Center on Budget and Policy Priorities. https://www.cbpp.org/research/food-assistance/infant-formula-shortage-highlights-wics-critical-role-in-feeding-babies ● Mathematica. (1990). The Savings in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program. Volume 1, https://fns-prod.azureedge.us/sites/default/files/SavVol1-Pt1.pdf ● Kent, G. (2006). WIC's promotion of infant formula in the United States. *International breastfeeding journal*. *1*(1): 8. https://doi.org/10.1186/1746-4358-1-8
10. Oral Health Service Coverage		
Oral health services ***Current Medicaid policy and coverage:*** While state	● National consensus standards call for risk screening, education, and treatment related to oral health and dental disease. In addition, parallel guidelines have been	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists. (2022). Oral health care during pregnancy and across the live span. ACOG Clinical Opinion No.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Medicaid programs must cover dental services for children, federal law does not require states to cover dental benefits for adults, so states may choose to cover dental benefits and have considerable discretion in defining Medicaid adult dental benefits. Typically, a broad definition of pregnancy-related care includes dental care, and a majority of states accept this and provide coverage. As of May 2022, 32 states covered extensive (or comprehensive) dental care, 13 covered limited services (e.g., basic preventive, diagnostics and minor restorative services such as routine cleanings and fillings) and 5 covered emergency extractions or treatment to relieve pain and/or eliminate infections. One state (AL) did not offer Medicaid dental coverage as a pregnancy-related benefit in 2019. Most states (39) extended pregnancy related dental benefits to 60 days postpartum in 2021. However, prior authorization and spending limits are common utilization controls.	issued by the American College of Obstetricians and Gynecologists, American Dental Association, American Academy of Pediatric Dentistry, and other professional organizations. ● Physiologic changes during pregnancy may results in changes in oral health and people are at higher risk for oral health problems (e.g., pregnancy gingivitis, tooth mobility dental caries, and periodontitis). ● Caries, poor dentition, and periodontal disease are associated with an increased risk of preterm delivery and low birth weight. ● Evidence suggests that women with periodontal (gum) disease may be at greater risk for serious health conditions like pre-eclampsia, preterm birth, or having low birthweight birth. Research suggests that gum disease may also be a pathway through which depression impacts a pregnancy. ● Maternal oral health status is linked to her child's future dental health status. Oral care during the perinatal period may decrease the amount of caries-producing oral bacteria transmitted to the infant during common parenting behaviors, such as sharing spoons.	569. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan#:~:text=Pregnancy%20is%20a%20unique%20time,dental%20visits%20twice%20a%20year ● American Academy of Pediatric Dentistry. (2021) Perinatal and Infant Oral Health. The Reference Manual of Pediatric Dentistry. https://www.aapd.org/research/oral-health-policies--recommendations/perinatal-and-infant-oral-health-care/ ● Centers for Disease Control and Prevention. (2022). Oral Health Fast Facts: Pregnancy. https://www.cdc.gov/oralhealth/fast-facts/pregnancy/index.html **Other key resources** ● Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. ● National Academy for State Health Policy. (2022). Medicaid coverage of dental services for general adult and pregnant populations. https://www.nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/. ● Oral Health Care During Pregnancy Expert Workgroup. (2012). Oral health care during pregnancy: A national consensus statement. National Maternal and Child Oral Health Resource Center, Georgetown University. http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf. ● Barzel, R., Holt, K., eds. (2020). Oral Health During Pregnancy: A Resource Guide (3rd ed.) National Maternal and Child Oral Health Resource Center. https://www.mchoralhealth.org/PDFs/oralhealthpregnancyresguide.pdf. ● Eke, C., Mask, A., Reusch, C., Vishnevsky, D., & Quinonez, R.B. (2019). Coverage Brief: Improving Access to Oral Health Care in Pregnancy. Children's Dental Health Project.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		https://www.cdhp.org/resources/384-coverage-brief-improving-access-to-oral-health-care-in-pregnancy . • Vamos, C. A., Thompson, E. L., Avendano, M., Daley, E. M., Quinonez, R. B., & Boggess, K. (2015). Oral health promotion interventions during pregnancy: a systematic review. *Community dentistry and oral epidemiology*, *43*(5), 385–396. https://doi.org/10.1111/cdoe.12167 • Silk, H., Douglass, A. B., Douglass, J. M., & Silk, L. (2008). Oral health during pregnancy. *American family physician*. *77*(8): 1139–1144. (No DOI). • Polyzos N.P., Polyzos, I.P. Zavos A., Valichis, A. Mauri, D. Papanikolaou E.G., et al. (2010). Obstetric outcomes after treatment of perindontal disease during pregnancy: Systematic review and meta-analysis. *BMJ.* 341: c7017. https://doi.org/10.1136/bmj.c7017 • Dye, B. A., Vargas, C. M., Lee, J. J., Magder, L., & Tinanoff, N. (2011). Assessing the relationship between children's oral health status and that of their mothers. *Journal of the American Dental Association. 142*(2): 173–183. https://doi.org/10.14219/jada.archive.2011.0061
Part 3: COVERAGE AND PERFORMANCE OBLIGATIONS FOR SERVICES RELATED TO SOCIAL DRIVERS FOR PERINATAL PERSONS		
11. Housing Support Coverage		
Housing support services ***Definition:*** Homeless is defined as the state of "an individual or family who lacks a fixed, regular, and adequate nighttime residence" (42 U.S.C. § 11302). Chronic homelessness is defined by the U.S. Department of Housing and Urban Development as the state of "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or who has had at least four episodes of homelessness in	• ACOG guidance documents the detrimental impact of housing instability on perinatal health, and recommends increased support and case management for all perinatal persons with housing instability. • Women and families with children are the fastest growing segment of the homeless population, with 34% of the total homeless population composed of families. Factors include poverty, domestic violence, home conflicts for adolescents, mental health, and others. • A majority of low-income families are forced to spend over half of their household income on housing, which	**Federal documents and professional guidelines** • Centers for Medicare and Medicaid Services. (2021). State Health Official Letter #21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf. • American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women. (2021). Health Care for Homeless Women. ACOG Committee Opinion No. 576. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/10/health-care-for-homeless-women

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
the past three years". ***Current Medicaid policy and coverage:*** Coverage and approaches are unclear. Some states use MCO contracts to encourage SDOH screening (to identify housing-related risks) and care coordination related to housing needs. A few states' contracts require MCOs to include FQHCs that specialize in care of the homeless population in their networks. Some states have included linkages to concrete and social supports as part of enhanced prenatal care programs/case management. States also encourage "warm hand-offs" under MCO contracts. CMS issued guidance in 2021 regarding Medicaid coverage of housing-related supports. States can require MCOs to: 1) ensure that all perinatal beneficiaries are connected with states and federal housing assistance, as only 25% of eligible individuals receive it, and 2) coordinate with community-based organizations (specifically those that serve BIPOC) that support safe and accessible housing for perinatal persons.	can put families at serious risk of eviction and homelessness. ● Housing insecurity and homelessness during the perinatal period is associated with reduced likelihood of prenatal care visits and increased likelihood of preterm birth, low birth weight, and extended hospital stays.	**Other key resources** ● Levisohn, A. (2021). How states improve housing stability through Medicaid managed care contracts. National Academy for State Health Policy. https://www.nashp.org/how-states-improve-housing-stability-through-medicaid-managed-care-contracts/ ● Atkeson, A., Levisohn, A., & Rosenthal, J. (2020). Five states break down interagency silos to strengthen their health and housing initiatives. National Academy for State Health Policy. https://www.nashp.org/five-states-break-down-interagency-silos-to-strengthen-their-health-and-housing-initiatives/#toggle-id-2 ● Reece J. (2021). More than shelter: Housing for urban maternal and infant health. *International journal of environmental research and public health*. *18*(7): 3331. https://doi.org/10.3390/ijerph18073331 ● DiTosto, J. D., Holder, K., Soyemi, E., Beestrum, M., & Yee, L. M. (2021). Housing instability and adverse perinatal outcomes: a systematic review. *American journal of obstetrics & gynecology MFM*. *3*(6): 100477. ● Bess, K. D., Miller, A. L., & Mehdipanah, R. (2022). The effects of housing insecurity on children's health: a scoping review. *Health promotion international*, daac006. https://doi.org/10.1093/heapro/daac006 ● Ubri, P. S., Swietek, K., Sawyer, J., Pyatt, T., & Stead, M. (2022). Use of ICD-10-CM Z Codes in 2018 Medicaid Claims and Encounter Data. NORC. https://www.norc.org/PDFs/Documentation%20of%20Social%20Needs%20in%202018%20Medicaid%20Data/Documentation%20of%20SDOH%20in%20Medicaid%20Claims_032422.pdf ● Cross-Barnet, C., Benatar, S., Courtot, B., & Hill, I. (2022). Limits of Prenatal Care Coordination for Improving Birth Outcomes Among Medicaid Participants. *SSRN Pre-print.* http://dx.doi.org/10.2139/ssrn.4136524 ● Kleinman, R., Kehn, M., Wishon Siegwarth, A., & Brown, J. (2017). State strategies for coordinating Medicaid and housing services. *Psychiatric rehabilitation journal*. *40*(2): 225–232. https://doi.org/10.1037/prj0000238
12. Transportation Coverage		

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Transportation services ***Current Medicaid policy and coverage:*** Transportation across state lines to receive reproductive and maternity care services has been affirmed as a right by the US Department of Health and Human Services and Department of Justice. Per 42 C.F.R. §431.53, Medicaid's non-emergency medical transportation (NEMT) benefit facilitates access to care for beneficiaries who may not have a means of getting to healthcare appointments. Transportation services such as taxicabs, public transit buses and subways, and van programs are eligible for federal Medicaid matching funds. All states cover non-emergency transportation (NEMT) per federal regulations. Four states set limits by eligibility pathway, and some others limit distance or require prior authorization. It is unclear how many states require MCOs to be responsible for, arrange for, or provide network coverage for perinatal transport around the time of birth.	• ACOG's 2017 Guidelines for Perinatal Care include recommendations for (1) maternal transport, (2) neonatal transport, and (3) return transport • Lack of maternal transport reimbursement and neonatal back-transport is associated with negative impacts on achievement of risk-appropriate care and perinatal outcomes.	**Federal documents and professional guidelines** • American Academy of Pediatrics Committee on Fetus and Newborn and American College of Obstetricians and Gynecologists Committee on Obstetric Practice. (2017). Guidelines for Perinatal Care, 8th edition. https://publications.aap.org/aapbooks/book/522/Guidelines-for-Perinatal-Care • US. Department of Health and Human Services. Reproductive Rights. (Website, 2022). https://reproductiverights.gov/ • White House Executive Order. July 8, 2022 https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/08/fact-sheet-president-biden-to-sign-executive-order-protecting-access-to-reproductive-health-care-services/ **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Okoroh, E.M., Kroelinger, C.D., Lasswell, S.M., Goodman, D.A. ,Williams, A.M., & Barfield, W.D. (2016). United States and Territorial Policies Supporting Maternal and Neonatal Transfer: Review of Transport and Reimbursement. *Journal of Perinatology. 36*:30. https://doi.org/10.1038/jp2015.109
13. Special Support Services for High-Risk Populations		

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Special support services for certain high-risk populations[3] ***Current Medicaid policy and coverage:*** It is unclear the extent to which special support services are covered for high-risk populations, particularly those who have been historically underserved. With increasing knowledge of the role of social drivers or determinants of health, CMS, state Medicaid agencies, and MCOs are exploring the potential to better address social needs of Medicaid beneficiaries. Some states have defined health and social support services in Medicaid as part of perinatal case management or enhanced prenatal care packages or programs (e.g., the long-standing California Perinatal Services Program (CPSP) continues as a duty for MCOs). (Also see perinatal case management and maternal health homes topics above.)	• Clinical guidelines from the American College of Obstetricians and Gynecologists and American Academy of Pediatrics call for having all perinatal persons and those with infants be screened for "social determinants of health" to identify populations that require additional supports (i.e., domestic violence victims and homeless individuals). • Healthcare providers are advised to simplify medical regimens and address barriers (i.e. transportation) for follow-up visits for perinatal persons found to screen for housing instability and domestic violence. (20–50% of all homeless women and children become homeless as a direct result of fleeing domestic violence, which suggests the need for additional, intensive wrap-around supports for this population.) • Recent studies point to the importance of linking perinatal people served in clinical/medical care to community-based organizations that can provide culturally and linguistically appropriate social support services. • An emerging body of literature points to opportunities to address structural racism, bias, and unequal treatment in health care services and systems.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2021). Health Care for Homeless Women. Committee Opinion 576. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/10/health-care-for-homeless-women. • American Academy of Pediatrics Committee on Fetus and Newborn and American College of Obstetricians and Gynecologists Committee on Obstetric Practice. (2017). Guidelines for Perinatal Care, 8th edition. https://publications.aap.org/aapbooks/book/522/Guidelines-for-Perinatal-Care • Society for Maternal Fetal Medicine, MB Greenberg, M Gandhi, C Davidson, &EB Carter. (2022). Society for maternal-Fetal medicine Consult Services #62. Best practices in equitable care delivery-Address systemic racism and other social determinants of health as causes of obstetrical disparities. *American Journal of Obstetrics & Gynecology. 227*(2): PB44-B59. https://doi.org/10.1016/j.ajog.2022.04.001 • Centers for Medicare and Medicaid Services. (2021). State Health Official Letter #21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf. **Other key resources** • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. • Opoku, S. T., Apenteng, B. A., Kimsey, L., Peden, A., & Owens, C. (2022). COVID-19 and social determinants of health: Medicaid managed care organizations' experiences with addressing member social needs. *Plos one*.

[3] Could include people affected by homelessness, domestic violence, racial/ethnic discrimination, and could include teens, adolescents in foster care, justice-involved adolescents, immigrants, people with disabilities and LGBTQ individuals, etc.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		17(3): e0264940. https://doi.org/10.1371/journal.pone.0264940 • Wang, E., Glazer, K. B., Howell, E. A., & Janevic, T. M. (2020). Social Determinants of Pregnancy-Related Mortality and Morbidity in the United States: A Systematic Review. *Obstetrics and gynecology*. *135*(4): 896–915. https://doi.org/10.1097/AOG.0000000000003762
Part 4: OBLIGATIONS RELATED TO ACCESS, NETWORKS, PERFORMANCE, PAYMENT AND MEMBER RIGHTS		
14. Accessibility of Care		
Special access rules for persons with access barriers or high medical or social risk ***Current Medicaid policy and coverage:*** The CMS 2020 final rule regarding network adequacy removes the requirement that states use time and distance standards to ensure provider network adequacy and instead lets states choose any quantitative standard. The previous rule - established in 2016 by 42 CFR § 422.11 - required a travel time of no more than 45 minutes or 30 miles or 90 minutes or 75 miles in rural areas to reach an OB-GYN. It is unclear how many states continue to require this standard of perinatal network adequacy. Additionally, it is unclear if states require MCOs to enact special access rules specifically for beneficiaries with high medical or social risk.	• The American College of Obstetricians and Gynecologists American and the Academy of Pediatrics recommend the following access rules for high-risk perinatal persons: ○ Healthcare providers are advised to simplify medical regimens and address barriers (i.e. transportation) for follow-up visits for perinatal persons found to screen for housing instability and domestic violence. ○ Women with disabilities may need extra time allotted for their appointment. During appointment scheduling, the need for extra time or services should be done in a non-judgmental way in order to accommodate the patient. ○ Incarcerated women should have access to unscheduled or emergency obstetric visits on a 24-hour basis. While in labor, correctional staff should respect women's privacy and delivery should occur in a licensed hospital and separation of the mother and infant should be avoided. • In rural areas, lack of access to high quality maternal health services is the result of hospital and obstetric department closures, workforce shortages, lack of wrap-around social services, and social determinants of health	**Federal documents and professional guidelines** • The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). (2017). Guide for Perinatal Care, 8th Edition. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx • Centers for Medicare and Medicaid Services. (2019). Improving Access to Maternal Health Care in Rural Communities. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf **Other key resources** • Hostetter, M. & Klein, S. (2021). Restoring Access to Maternity Care in Rural America. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america • Clark, M. (2020). Rural Disparities, Racial Disparities, and Maternal Health Crisis Call Out for Solutions. The Georgetown University Health Policy Institute Center for Children and Families. https://ccf.georgetown.edu/2020/06/12/rural-disparities-racial-disparities-and-maternal-health-crisis-call-out-for-solutions/

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	challenges facing rural residents (i.e., lack of access to transportation or insurance). ○ Nearly half of all rural counties in the US do not have a hospital with obstetric services (known as "maternity care deserts"). As a result, fewer than 50% of rural women have access to perinatal service within a 30-mile drive from their home, and 10% of rural women drive 100 miles or more for these services. ○ In the past decade, rural counties with a higher proportion of Black women were more likely to lose obstetric services than other rural counties. ○ Rural residents – and specifically, rural residents of color – are less likely to have access to appropriate prenatal care and birth facilities and are more likely to have poor birth outcomes, including premature birth, low-birth weight, maternal mortality and severe maternal morbidity, and increased risk of postpartum depression. • Maternity care deserts can also exist in urban centers: 1 in 3 women in an urban area live in an OB desert. • Opportunities exist to increase accessibility to services in maternity care deserts, including: ○ Reducing policy barriers to midwifery and birth center practices; expanding the scope of work for cadres such as nurse midwives ○ Increasing incentives to providers practicing in care deserts ○ Expanding "perinatal regionalization of care" as a strategy ○ Leveraging "community navigators" to support access to wrap-around community services ○ Applying "hub and spoke" models (wherein urban	

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	health care organizations provide education and support to rural maternity providers), and ○ Expanding telehealth services, including "remote monitoring" systems that keep a closer eye on high-risk persons between visits.	
Telehealth rules related to prenatal care and postpartum visits ***Definition:*** CMS states that for purposes of Medicaid, telemedicine seeks to improve health by permitting two-way, real time interactive communication between a patient and a provider at a remote site. This approach uses interactive telecommunications equipment that includes audio and video equipment (e.g., telephone, computer). ***Current Medicaid policy and coverage:*** States have the option to finance telehealth/telemedicine. States may decide where, how, and which providers are covered, as well as reimbursement levels. If states decide to reimburse with the same method and amount that they pay for face-to-face services, visits, and consultations, they are not required to submit a SPA for telemedicine services. In 2021, all state Medicaid agencies reimbursed for telehealth in some form. Remote patient monitoring was reimbursable in 39 states. Only 30 state Medicaid programs reimbursed for telephone or audio-only telehealth services. Some states had telehealth policies and coverage in place prior to the	● Telehealth approaches (via telephone, apps, websites, or smartphone text messaging) can address maternal health provider shortages and travel time issues. A range of maternal health services are being delivered using telehealth, both for people with lower and higher risks. ○ In the prenatal period, approaches include: videoconferences to replace some in-person prenatal visits and consultation with remote specialists, including maternal fetal medicine doctors. ○ In the postpartum period, approaches include: videoconferences for early postpartum visits, at-home monitoring, and lactation support. ○ Across the perinatal period, telehealth can support at-home monitoring of weight, blood pressure, diabetes, and other factors. ○ Telemedicine can provide connection to maternal mental health care. ● Rural communities, particularly people of color living in rural areas, have less access to health care providers. The provider shortage is projected to increase. Lack of access to providers in rural areas is associated with worse outcomes. • Telehealth interventions are associated with higher rates of breastfeeding, smoking cessation, and schedule optimization for high-risk pregnancies. Telehealth has	**Federal documents and professional guidelines** ● CMS. Telemedicine. (Undated). https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html ● CMS. (2020). Medicaid state plan fee-for-service payments for services delivered via telehealth. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf ● US Department of Health and Human Services. (2022). State Medicaid telehealth coverage. https://telehealth.hhs.gov/providers/billing-and-reimbursement/state-medicaid-telehealth-coverage/ ● National Telehealth Policy Resource Center. (2022). State telehealth laws and reimbursement policies. Center for Connected Health Policy. https://telehealth.hhs.gov/providers/billing-and-reimbursement/state-medicaid-telehealth-coverage/ ● American College of Obstetricians and Gynecologists. (2020). Implementing Telehealth in Practice. Committee Opinion No. 798. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/implementing-telehealth-in-practice ● American College of Obstetricians and Gynecologists. (2014). Health Disparities in Rural Women. Committee Opinion No. 586. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women?utm_source=redirect&utm_medium=web&utm_campaign=otn ● American Telemedicine Association. (2014). State Medicaid Best Practice Telehealth for High-Risk Pregnancy. http://www.adph.org/ALPHTN/assets/StateMedicaidBestPracticeforHighRi

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
COVID-19 Public Health Emergency, but most states modified their state plans or sought additional authority in the past two years. A few state Medicaid programs have specific efforts related to telehealth and maternity care.	also been found to be cost-effective for managing conditions such as hypertension.	skPregnancy.pdf **Other key resources** ● Kaiser Family Foundation. (2020). Telemedicine and Pregnancy Care. Accessed July 20, 2022. https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/ ● Kozhimannil, K. B., Hung, P., Henning-Smith, C., Casey, M. M., & Prasad, S. (2018). Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. *JAMA*,*319*(12), 1239-1247. https://jamanetwork.com/journals/jama/fullarticle/2674780 ● Clark, M. (2020). Rural Disparities, Racial Disparities, and Maternal Health Crisis Call Out for Solutions. The Georgetown University Health Policy Institute Center for Children and Families. https://ccf.georgetown.edu/2020/06/12/rural-disparities-racial-disparities-and-maternal-health-crisis-call-out-for-solutions/ ● DeNicola, N., Grossman, D.; Marko, K., Sonalkar, S., Butler T., Yvonne S., Ganju, N., Witkop, C. T., Henderson, J. T., Butler, J. L., Lowery, C. (2020). Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes, Obstetrics & Gynecology, 135(2), 371-382. https://doi.org/10.1097/AOG.0000000000003646 ● Magann, E. F., Bronstein, J., McKelvey, S. S., Wendel, P., Smith, D. M., & Lowery, C. L. (2012). Evolving trends in maternal fetal medicine referrals in a rural state using telemedicine. *Archives of gynecology and obstetrics*, *286*(6), 1383-1392. https://link.springer.com/article/10.1007/s00404-012-2465-5 ● Niu, B., Mukhtarova, N., Alagoz, O., & Hoppe, K. (2021). Cost-effectiveness of telehealth with remote patient monitoring for postpartum hypertension. *The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians*, 1–7. https://doi.org/10.1080/14767058.2021.1956456

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
15. Network Composition and Competencies		
In-network hospitals including a range of levels of perinatal care (e.g., regionalized or risk-appropriate perinatal care) ***Definition:*** A classification system was created to distinguish a birth facility's level of risk-appropriate maternal care: basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV). This is also referred to as "regionalization" of perinatal care. ***Current Medicaid policy and coverage:*** In 2019, 31 states had designated policies regarding perinatal levels of care. It is unclear the extent to which Medicaid beneficiaries have access to the range of levels of risk-appropriate perinatal care. Medicaid coverage of maternal and/or neonatal transportation is a critical component of timely provision of perinatal care, specifically for high-risk mothers and infants, and a core element of a comprehensive perinatal regionalization system. As of 2015, 31 states had policies to address neonatal transportation for risk-appropriate care, and 19 states had a Medicaid payment option for transportation reimbursement.	• The American College of Obstetricians and Gynecologists states that the goal of perinatal "levels of care" is to reduce maternal morbidity and mortality, including disparities, by encouraging perinatal systems that can provide risk-appropriate care specific to maternal health needs. • Developed jointly by the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM), the consensus statement on perinatal levels of cares is supported by the American Academy of Family Physicians (AAPF), American Association of Birth Centers (AABC); American College of Nurse-Midwives (ACNM), American Hospital Association (AHA), Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), Commission for the Accreditation of Birth Centers; and others. • Assuring that births occur in a risk-appropriate setting is a priority among federal agencies and professional associations. • Birthing people with complex high-risk conditions can benefit from receipt of care in hospitals that offer a broad array of specialty and subspecialty services. The appropriate care level for patients should be driven by their medical need and not limited to or governed by financial constraints such as health coverage type. Accredited birth centers (freestanding facilities that are not hospitals) are an integral part of many regionalized care systems. • Regional perinatal care systems and the provider relationships within them enhance the ability of women	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2019). Levels of Maternal Care. *Obstetrics & Gynecology.* 134(2): e41-e55. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care.pdf • American Association of Birth Centers; Association of Women's Health, Obstetric and Neonatal Nurses; American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, Kilpatrick, S. J., Menard, M. K., Zahn, C. M., Centers for Disease Control and Prevention's, & Callaghan, W. M. (2019). Obstetric Care Consensus #9: Levels of Maternal Care. *American journal of obstetrics and gynecology*. *221*(6): B19–B30. https://doi.org/10.1016/j.ajog.2019.05.046 **Other key resources** • Vladutiu, C. J., Minnaert, J. J., Sosa, S., & Menard, M. K. (2020). Levels of Maternal Care in the United States: An Assessment of Publicly Available State Guidelines. *Journal of women's health*. *29*(3): 353–361. https://doi.org/10.1089/jwh.2019.7743 • King, A. (2016). Medicaid funding opportunities in support of perinatal regionalization systems. National Academy for State Health Policy and National Institute for Children's Health Quality. https://nashp.org/wp-content/uploads/2017/01/Perinatal.pdf • Kroelinger, C. D., Okoroh, E. M., Goodman, D. A., Lasswell, S. M., & Barfield, W. D. (2020). Designation of neonatal levels of care: a review of state regulatory and monitoring policies. *Journal of perinatology*. *40*(3): 369–376. https://doi.org/10.1038/s41372-019-0500-0 • Kroelinger, C. D., & Goodman, D. A. (2020). Levels of Risk-Appropriate Care: Ensuring Women Deliver at the Right Place at the Right Time. *Journal of women's health*. *29*(3): 281–282.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	to give birth safely in their communities while providing support for circumstances when higher level resources are needed. • State and regional authorities should work together with the multiple providers and organizations to structure a coordinated system of care, designate levels of care, and implement policies and payment structures that support a regionalized system of care. • The CDC developed the Levels of Care Assessment Tool (LOCATe) which provides states, health plans, and providers a simple, web-based tool that standardizes the assessment of maternal and neonatal care capabilities of facilities based on guidelines.	https://doi.org/10.1089/jwh.2019.8179 • Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. • Okoroh, E.M., Kroelinger, C.D., Lasswell, S.M., Goodman, D.A. ,Williams, A.M., & Barfield, W.D. "United States and Territorial Policies Supporting Maternal and Neonatal Transfer: Review of Transport and Reimbursement. *Journal of Perinatology 36* (2016):30, https://doi.org/10.1038/jp2015.109 • Johnson, K., Bruner, C. (2019). Using Medicaid to improve the health and well-being of women and infants: Opportunities in the InCK model in the perinatal period. InCK Marks. https://www.inckmarks.org/docs/Inck_marks_prenatal_brief_050319_finalpdf.pdf • Correa-de-Araujo, R., & Yoon, S. S. (2021). Clinical outcomes in high-risk pregnancies due to advanced maternal age. *Journal of Women's Health*. *30*(2): 160-167. https://doi.org/10.1089/jwh.2020.8860

In-network hospitals with special capabilities for pregnancy-related care for beneficiaries with high social risk[4]
 	
Current Medicaid policy and coverage: It is unclear the extent to which MCOs require in-network hospitals to demonstrate special capabilities to care for perinatal beneficiaries with high social risk.
	• It is widely recognized that vulnerable and socially high-risk populations require higher levels of perinatal care (such as people affected by homelessness, domestic violence, discrimination based on race, ethnicity, sexuality, etc.).
	  ○ Black and Indigenous people are more likely to experience maternal and infant mortality and morbidity, at 2-3 times the rate of White people.
	  ○ Housing insecurity during the perinatal period is associated with increased likelihood of preterm
		Federal documents and professional guidelines
		• American College of Obstetricians and Gynecologists. (2018). Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care. Committee Opinion No. 729. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/01/importance-of-social-determinants-of-health-and-cultural-awareness-in-the-delivery-of-reproductive-health-care
		• Centers for Medicare and Medicaid Services. (2021). State Health Official Letter #21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). https://www.medicaid.gov/federal-policy-

[4] Could include people affected by racial/ethnic discrimination, domestic violence victims, teens, adolescents in foster care, justice-involved adolescents, homeless people, immigrants, people with disabilities; LGBTQ people, etc.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	birth, low birth weight, and extended hospital stays. ● ACOG recommends that hospitals ensure special capabilities to care for beneficiaries with high social risk, including strengthening: screening processes, interpreters, wrap-around and culturally appropriate capabilities to serve and support vulnerable populations, and effective referral pathways. ● Special capabilities can also include safety bundles and processes to prevent morbidity and mortality among individuals with high social risk. The American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine recommend that birth facilities have a screening process in place to detect cases with the possibility of severe maternal morbidity. Those identified through screening should have an assessment to determine if severe maternal morbidity is present or avoidable.	guidance/downloads/sho21001.pdf. ● U.S. Department of Health and Human Services. (2022). CMS Proposes Policies to Advance Health Equity and Maternal Health, Support Hospitals. https://www.cms.gov/newsroom/press-releases/cms-proposes-policies-advance-health-equity-and-maternal-health-support-hospitals ● U.S. Department of Health and Human Services. (2020). Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care. https://thinkculturalhealth.hhs.gov/education/maternal-health-care ● American College of Obstetricians and Gynecologists. (2021). Obstetric Care Consensus No. 5: Severe Maternal Morbidity: Screening and Review. *Obstetrics and gynecology*. *128*(3): e54–e60. https://doi.org/10.1097/AOG.0000000000001642 ● American College of Obstetricians and Gynecologists, Association of Women's Health, Obstetric and Neonatal Nurses, The Joint Commission, Society for Maternal-Fetal Medicine. (2015). Severe maternal morbidity: clarification of the new Joint Commission sentinel event policy. http://www.acog.org/About-ACOG/News-Room/Statements/2015/Severe-Maternal-Morbidity-Clarification-of-the-New-Joint-Commission-Sentinel-Event-Policy **Other key resources** ● Clark, M. (2020). Rural Disparities, Racial Disparities, and Maternal Health Crisis Call Out for Solutions. The Georgetown University Health Policy Institute Center for Children and Families. https://ccf.georgetown.edu/2020/06/12/rural-disparities-racial-disparities-and-maternal-health-crisis-call-out-for-solutions/ ● Howell, E. A., Janevic, T., Hebert, P. L., Egorova, N. N., Balbierz, A., & Zeitlin, J. (2018). Differences in Morbidity and Mortality Rates in Black, White, and Hispanic Very Preterm Infants Among New York City Hospitals. JAMA pediatrics. 172(3): 269–277. https://doi.org/10.1001/jamapediatrics.2017.4402

The following appendix is part of a Commonwealth Fund blog, Sara Rosenbaum et al., "The Road to Maternal Health Runs Through Medicaid Managed Care," *To the Point* (blog), Commonwealth Fund, May 22, 2023. https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Requirements for anti-bias and Culturally and Linguistically Appropriate Services (CLAS) training ***Current Medicaid policy and coverage:*** While the US Department of Health and Human Services (HHS) has policies to support culturally and linguistically appropriate maternal health care, Medicaid policy is unclear. Some MCOs have adopted policies in support of anti-bias, diversity, equity, and inclusion (DEI), Culturally and Linguistically Appropriate Services (CLAS), and other trainings related to cultural competency.	• The American College of Obstetricians and Gynecologists recommends that OB/GYN physicians "recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors." • Implicit bias and unequal treatment in Black maternal health has been widely documented. For example, Black birthing people are less likely to be involved in decision-making during labor and delivery. • The most common DEI educational approaches include cultural humility, bias training, and improving mentoring to diversify the workforce. DEI education can achieve maximal success and long-term impact when implemented as institutional-wide interventions and when not seen as an isolated or independent curriculum. • Cultural competency and anti-bias trainings have been proposed as a way to improve patient outcomes. While research is limited, some studies show a positive relationship between cultural competency training and improved patient outcomes. Likewise, a limited number of evaluations of implicit bias trainings for healthcare professionals and those in residency training programs suggest that these trainings can change knowledge and attitudes about racism and reduce implicit bias. • US HHS is offering a continuing education class on "Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care" for nurses, nurse practitioners, physicians, and physician assistants. • In a systematic review, 10 of 15 studies found that interventions designed to provide more culturally-	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2018). Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care. Committee Opinion No. 729. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/01/importance-of-social-determinants-of-health-and-cultural-awareness-in-the-delivery-of-reproductive-health-care • Office of Minority Health. Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care. (2022). U.S. Department of Health and Human Services. https://thinkculturalhealth.hhs.gov/education/maternal-health-care **Other key resources** • Attanasio, L. B., Kozhimannil, K. B., & Kjerulff, K. H. (2018). Factors influencing women's perceptions of shared decision-making during labor and delivery: Results from a large-scale cohort study of first childbirth. *Patient education and counseling*. *101*(6): 1130–1136. https://doi.org/10.1016/j.pec.2018.01.002 • Corsino, L., & Fuller, A. T. (2021). Educating for diversity, equity, and inclusion: A review of commonly used educational approaches. *Journal of clinical and translational science*. *5*(1): e169. https://doi.org/10.1017/cts.2021.834 • Attanasio, L., & Kozhimannil, K. B. (2015). Patient-reported Communication Quality and Perceived Discrimination in Maternity Care. *Medical care*. *53*(10): 863–871. https://doi.org/10.1097/MLR.0000000000000411 • Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *American journal of public health*. *105*(12): e60–e76. https://doi.org/10.2105/AJPH.2015.302 • Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H. (2011). Does cultural competency training of health professionals improve patient

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	appropriate maternal health services had positive effects on care-seeking behaviors.	outcomes? A systematic review and proposed algorithm for future research. *Journal of general internal medicine*. *26*(3): 317–325. https://doi.org/10.1007/s11606-010-1529-0 • Chambers, B. D., Taylor, B., Nelson, T., Harrison, J., Bell, A., O'Leary, A., Arega, H. A., Hashemi, S., McKenzie-Sampson, S., Scott, K. A., Raine-Bennett, T., Jackson, A. V., Kuppermann, M., & McLemore, M. R. (2022). Clinicians' Perspectives on Racism and Black Women's Maternal Health. *Women's health reports. 3*(1): 476–482. https://doi.org/10.1089/whr.2021.0148 • White-Davis, T., Edgoose, J., Brown. Speights, J. S., Fraser, K., Ring, J. M., Guh, J., & Saba, G. W. (2018). Addressing Racism in Medical Education An Interactive Training Module. *Family medicine*. *50*(5): 364–368. https://doi.org/10.22454/FamMed.2018.875510 • Jones, E., Lattof, S.R. & Coast, E. (2017)Interventions to provide culturally-appropriate maternity care services: factors affecting implementation. *BMC Pregnancy Childbirth*. 17: 267. https://doi.org/10.1186/s12884-017-1449-7 • Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals. *The Cochrane database of systematic reviews*. 5:CD009405. https://doi.org/10.1002/14651858.CD009405.pub2
16. Midwifery Service Coverage		
Midwife services ***Definition:*** A midwife is a trained certified birth attendant who provides a comprehensive range of service related to reproductive health, pregnancy, and birth. Certified nurse-midwives are those with a nursing degree. Terminology for midwives without a nursing degree varies across states (e.g., licensed midwives, direct entry midwives, certified	• Midwifery services for prenatal, birth, and postpartum care, particularly when offered through birth centers, has shown promise in both improving pregnancy outcomes and containing costs. (The national evaluation of Strong Start for Mothers and Newborns - a CMS initiative that tested enhanced prenatal care models for Medicaid beneficiaries - found that women receiving prenatal care at birth centers with midwives experienced better birth outcomes compared to their counterparts in typical	**Federal documents and professional guidelines** • American College of Nurse-Midwives (2016). Midwifery Provision of Home Birth Services: American College of Nurse-Midwives. *Journal of midwifery & women's health*. *61*(1): 127–133. https://doi.org/10.1111/jmwh.12431 • American College of Obstetricians and Gynecologists. (2019). ACOG Committee Opinion No. 766: Approaches to Limit Intervention During Labor and Birth. *Obstetrics and gynecology*. *133*(2): e164–e173. https://doi.org/10.1097/AOG.0000000000003074 • Center for Medicare and Medicaid Innovation and Center for Medicaid and

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
professional midwives, and more). ***Current Medicaid policy and coverage:*** All states are required to cover nurse midwife services as a mandatory Medicaid benefit (42 CFR 440.165). As of 2022, survey data indicate that 33 states provide Medicaid reimbursement only for certified nurse-midwives, and not for other cadres of midwives. In 18 states, both certified nurse-midwives and other midwives are reimbursed under Medicaid. Most states set rules related to midwifery scope of practice and licensing, as well as on certification and training. A majority of states (33) permit certified nurse midwifes to serve as primary care providers under Medicaid, including within managed care programs. At state option, licensed and other midwives may be a covered benefit based upon Medicaid regulations for Other Licensed Practitioner Services at 42 CFR 440.60. Some states may require supervision or association with a physician or other health provider. (However, federal Medicaid regulations at 42 CFR 441.21 require that nurse-midwifes are permitted enter into an independent provider agreement without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.) Payment approaches and levels vary. Payments for certified nurse midwifes is typically between 75% and 100% of physician rates. Some states include	Medicaid prenatal care.) ● For low-risk pregnancies, the combination of the following are associated with reduced perinatal mortality rates and achieving favorable home birth outcomes: 1) availability of a certified nurse-midwife, certified midwife, or midwife whose education and licensure meet International Confederation of Midwives' Global Standard for Midwifery Education; 2) physicians practicing obstetrics integrated with midwifery; 3) ready access to specialty consultation; and 4) access to safe and timely transport to a risk-appropriate hospital setting.	CHIP Services. (2018). Strong Start for Mothers and Newborns initiative. Joint Informational Bulletin. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf **Other key resources** • National Academy for State Health Policy. (2022). Midwife Medicaid reimbursement policies by state. https://www.nashp.org/midwife-medicaid-reimbursement-policies-by-state/ • Courtot, B., Hill, I., Cross-Barnet, C., & Markell, J. (2020). Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care. *The Milbank quarterly*. *98*(4): 1091–1113. https://doi.org/10.1111/1468-0009.12473 • Moore, J. E., George, K. E., Bakst, C., Shea, K. (2020). Improving maternal Health Access, Coverage, and Outcomes in Medicaid: A resource for state Medicaid agencies and Medicaid managed care organizations. Institute for Medicaid Innovation. https://www.medicaidinnovation.org/_images/content/2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report.pdf • Carlson, N. S., Neal, J. L., Tilden, E. L., Smith, D. C., Breman, R. B., Lowe, N. K., Dietrich, M. S., & Phillippi, J. C. (2019). Influence of midwifery presence in United States centers on labor care and outcomes of low-risk parous women: A Consortium on Safe Labor study. *Birth. 46*(3): 487–499. https://doi.org/10.1111/birt.12405 • Sperlich, M., Gabriel, C., & St Vil, N. M. (2019). Preference, knowledge and utilization of midwives, childbirth education classes and doulas among U.S. black and white women: implications for pregnancy and childbirth outcomes. *Social work in health care*. *58*(10): 988–1001. https://doi.org/10.1080/00981389.2019.1686679 • Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2013). Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane database of systematic reviews*. 8:CD004667. https://doi.org/10.1002/14651858.CD004667.pub3

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
certified nurse midwife services as part of global maternity payments		• Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ • Souter, V., Nethery, E., Kopas, M. L., Wurz, H., Sitcov, K., & Caughey, A. B. (2019). Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births. *Obstetrics and gynecology*. *134*(5): 1056–1065. https://doi.org/10.1097/AOG.0000000000003521 • Hangsleben, K., Jones, M., Lia-Hoagberg, B., Skovholt, C., & Wingeier, R. (1995). Medicaid and non-Medicaid prenatal care by nurse-midwives. Comparison of risk, time, care coordination, and reimbursement. *Journal of nurse-midwifery*. *40*(4): 320–327. https://doi.org/10.1016/0091-2182(95)00036-j • Butler, M. M., Sheehy, L., Kington, M. M., Walsh, M. C., Brosnan, M. C., Murphy, M., Naughton, C., Drennan, J., & Barry, T. (2015). Evaluating midwife-led antenatal care: choice, experience, effectiveness, and preparation for pregnancy. *Midwifery*. *31*(4): 418–425. https://doi.org/10.1016/j.midw.2014.12.002
17. Doula Service Coverage		
Doula services **Definition:** The Doula Organization of North America (DONA), the largest organization of certified doulas, defines a birth doula as a person trained and experienced in childbirth who provides continuous physical, emotional, and informational support to the mother before, during and just after birth. Doula services may be limited to the time of birth (labor and delivery period) or be delivered along the	• Use of doula services is a recommended strategy to improve equity in maternal health outcomes. By supporting mothers to advocate for their personal care preferences, doulas can help combat bias and unequal treatment in maternal health care. • Doula care is associated with lower rates of preterm and low-birthweight births, with greater initiation and duration of breastfeeding, and with lower rates of unnecessary emergency Cesarean-sections and obstetric interventions.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2019). Approaches to Limit Intervention During Labor and Birth. ACOG Committee Opinion No. 766: *Obstetrics and gynecology*. *133*(2): e164–e173. https://doi.org/10.1097/AOG.0000000000003074 **Other key resources** • National Health Law Program. Doula Medicaid Project. (2022). https://healthlaw.org/doulamedicaidproject/ • Hasan, A. (2022). State approaches to doula service benefits. National

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
continuum of prenatal, birth, and postpartum care. ***Current Medicaid policy and coverage:*** States have several options for covering doula services. Under the ACA, states have the option to use a SPA to include non-licensed health workers to provide preventive services; states also can use waivers or include coverage in their MCO contracts. Most Medicaid maternity care/pregnancy-related benefit packages do not yet include doula services. As of April 2022, 6 states (FL, MD, MN, NJ, OR, RI) were actively financing Medicaid doula coverage. Another 8 (CA, DC, IL, IN, MI, NV, OH, VA) states have policies in-place and are in the process of implementing doula service coverage. States are using different approaches for reimbursing doulas, including direct and indirect billing arrangements. For example, doulas in some states have been reimbursed by Medicaid programs for childbirth-related education (e.g., breastfeeding support), but are not reimbursed for support during labor and delivery, a core function of their training and profession.		Academy for State Health Policy. https://www.nashp.org/state-medicaid-approaches-to-doula-service-benefits/ • Safon, C. B., McCloskey, L., Ezekwesili, C., Feyman, Y., Gordon, S. H. (2021). Doula care saves lives, improves equity, and empowers mothers. State Medicaid programs should pay for it. *Health Affairs Blog*. https://doi.og/10.1377/hblog20210525.295915 • Zephyrin, L., Seervai, S., Lewis, A., Katon, J. G. (2021). Community-based models to improve maternal health outcomes and promote health equity. (Issue Brief). Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity • Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. *Birth*. *43*(1): 20–27. https://doi.org/10.1111/birt.12218 • Hans, S. L., Edwards, R. C., & Zhang, Y. (2018). Randomized Controlled Trial of Doula-Home-Visiting Services: Impact on Maternal and Infant Health. *Maternal and child health journal*. *22*(Suppl 1): 105–113. https://doi.org/10.1007/s10995-018-2537-7 • Kozhimannil, K. B., Attanasio, L. B., Hardeman, R. R., & O'Brien, M. (2013). Doula care supports near-universal breastfeeding initiation among diverse, low-income women. *Journal of midwifery & women's health*. *58*(4): 378–382. https://doi.org/10.1111/jmwh.12065 • Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C., & O'Brien, M. (2013). Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American journal of public health*. *103*(4): e113–e121. https://doi.org/10.2105/AJPH.2012.301201 • Strauss, N., Sakala, C., & Corry, M. P. (2016). Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. *The Journal of perinatal education*. *25*(3): 145–149. https://doi.org/10.1891/1058-1243.25.3.145 • Mallick, L. M., Thoma, M. E., & Shenassa, E. D. (2022). The role of doulas in

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		respectful care for communities of color and Medicaid recipients. *Birth*. https://doi.org/10.1111/birt.12655 • Steel, A., Frawley, J., Adams, J., & Diezel, H. (2015). Trained or professional doulas in the support and care of pregnant and birthing women: a critical integrative review. *Health & social care in the community*. *23*(3): 225–241. https://doi.org/10.1111/hsc.12112 Bey et al. (2019). Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. Ancient Song Doulas Services, Village Birth International, and Every Mother Counts. https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf
18. Community Health Worker Coverage		
Community health worker services **Definition:** Community health workers (CHWs) are defined as frontline public health workers (typically without health professional credentials or licenses) who are trusted members of the community served and/or share the racial, cultural, economic, linguistic, and experiential backgrounds of residents in those communities. ***Current Medicaid policy and coverage:*** The ACA explicitly included CHWs as contributing health professionals, and provided a new option for use of non-licensed health workers to provide preventive services. Prior to the ACA, CHW programs were mostly grant-funded programs. The potential for Medicaid financing provided momentum to incorporate CHWs into large health systems and	• The National Committee for Quality Assurance (NCQA) and the Penn Center for Community Health Workers have identified nine critical inputs for effective community health worker programs: recruitment and hiring, training, supervision, support, scope of work, workforce development, health and social care team integration, organizational data systems, and program stability. Another factor in the effectiveness of CHWs is their knowledge of and connection to the communities in which their families live, which often requires time communicating and working with community partners as well as families. • CHW services often include health promotion and education, patient outreach and follow-up on referrals, assistance in navigating the health care system, translation and interpretation services, client advocacy, arranging for services or transportation, and other elements of care coordination and case management.	**Federal documents and professional guidelines** • American Public Health Association. (Undated). Community Health Workers. https://www.apha.org/apha-communities/member-sections/community-health-workers • National Committee for Quality Assurance (NCQA) and Penn Center for Community Health Workers. (2021). Critical inputs for successful community health worker programs. https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs-White-Paper-November2021.pdf **Other key resources** • MACPAC. (2022). Medicaid coverage of community health worker services. Issue Brief. https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf • National Academy for State Health Policy (NASHP). (2019). State community health worker models. Issue Brief. https://nashp.org/state-community-health-workermodels

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
under managed care plans over the past decade. States have several options for covering CHW services. CHW Medicaid payments can be authorized or encouraged by state Medicaid agencies by: • Adopting an optional SPA for a specific set of preventive health services provided by CHWs under the supervision of, or recommended by, a physician or other licensed provider. • Using Section 1115 waivers or other delivery system reform opportunities from CMS. • Including specific requirements related to CHWs in their contracts with MCOs. • Incentivizing primary care providers to use CHW in care coordination and case management. • Using a SPA for the Medicaid health home option to require or encourage use of CHW in programs for people with chronic or complex conditions. A review in 2021 identified at least 21 states that authorize Medicaid payment for certain CHW services in their state plan or under managed care arrangements. In most states, coverage is for a limited range of services or limited populations.	• For perinatal services, CHW provide support in primary care, through community-based organizations, and in prenatal care clinics. Some studies show improved use of prenatal care, better birth outcomes, shorter NICUs stays for infants, and greater engagement and satisfaction with care. • Studies of some states' Medicaid CHW efforts (e.g., Arizona, New Mexico, Ohio, Oregon,) found increases in use of services and resources, and reductions in costs. Specifically, studies have shown that due to addressing social needs, every dollar invested in CHWs returns $2.47 to an average Medicaid payer within the fiscal year. • In 2020, an estimated 60,000 CHWs were employed in the United States. CHWs reflect the diversity of their communities: 65 percent are Black or Latinx, 23 percent are White, and 10 percent are Native American. Many have lived experiences of racism and financial hardship, making them uniquely positioned to provide navigation and to advocate for structural transformation. In response to the COVID-19 Public Health Emergency, Congress authorized hundreds of millions of dollars to increase the workforce of CHWs.	• Cunningham, S. D., Riis, V., Line, L., Patti, M., Bucher, M., Durnwald, C., & Srinivas, S. K. (2020). Safe Start community health worker program: A multisector partnership to improve perinatal outcomes among low-income pregnant women with chronic health conditions. *American journal of public health*. *110*(6): 836–839. https://doi.org/10.2105/AJPH.2020.305630 • Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. *Health Affairs. 39*(2): 207–213. https://doi.org/10.1377/hlthaff.2019.00981 • Garfield, C and Kangovi, S (2019). Integrating community health workers into health care teams without coopting them. *Health Affairs Blog.* https://www.healthaffairs.org/do/10.1377/forefront.20190507.746358 • Thomas, K., Wilson, J. L., Bedell, P., & Morse, D. S. (2019). "They didn't give up on me": a women's transitions clinic from the perspective of re-entering women. *Addiction science & clinical practice*. *14*(1): 12. https://doi.org/10.1186/s13722-019-0142-8 • George, R., Gunn, R., Wiggins, N., Rowland, R., Davis, M. M., Maes, K., Kuzma, A., & McConnell, K. J. (2020). Early Lessons and Strategies from Statewide Efforts to Integrate Community Health Workers into Medicaid. *Journal of health care for the poor and underserved*. *31*(2): 845–858. https://doi.org/10.1353/hpu.2020.0064 • McAlearney, A. S., Menser, T., Sieck, C. J., Sova, L. N., & Huerta, T. R. (2020). Opportunities for Community Health Worker Training to Improve Access to Health Care for Medicaid Enrollees. *Population health management*. *23*(1): 38–46. https://doi.org/10.1089/pop.2018.0117 • Johnson, D., Saavedra, P., Sun, E., Stageman, A., Grovet, D., Alfero, C., Maynes, C., Skipper, B., Powell, W., & Kaufman, A. (2012). Community health workers and medicaid managed care in New Mexico. *Journal of community health*. *37*(3): 563–571. https://doi.org/10.1007/s10900-011-9484-1 • Sabo, S., Wightman, P., McCue, K., Butler, M., Pilling, V., Jimenez, D. J., Celaya, M., & Rumann, S. (2021). Addressing maternal and child health

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		equity through a community health worker home visiting intervention to reduce low birth weight: retrospective quasi-experimental study of the Arizona Health Start Programme. *BMJ. 11*(6): e045014. https://doi.org/10.1136/bmjopen-2020-045014 • Lockhart, E., Turner, D., Martinez-Tyson, D., Baldwin, J. A., & Marhefka, S. L. (2021). Opportunities for and perceptions of integrating community health workers via the Affordable Care Act: Medicaid health homes. *Journal of public health management and practice*. *27*(2): 193–200. https://doi.org/10.1097/PHH.0000000000001118 • Kangovi S, Mitra N, Norton L, Harte R, Zhao X, Carter T, Grande D, Long JA. (2018). Effect of community health worker support on clinical outcomes of low-income patients across primary care facilities: a randomized clinical trial. *JAMA Internal Medicine*. *178*(12): 1635-43. https://doi.org/10.1001/jamainternmed.2018.4630 • Pinto, D., Carroll-Scott, A., Christmas, T., Heidig, M. & Turchi, R. (2020). Community health workers: Improving population health through integration into healthcare systems. *Current Opinion in Pediatrics*. *2*(5): 674-682. https://doi.org/10.1097/MOP.0000000000000940 • Covert, H., Sherman, M., Miner, K. and Lichtveld, M. (2019). Core competencies and a workforce framework for community health workers: a model for advancing the profession. *American Journal of Public Health. 109*(2): 320-327. https://doi.org/10.2105/ajph.2018.304737 • Meghea, C.I., Li, B., Zhu, Q., Raffo, J.E., Lindsay, J.K., Moore, J.S., Roman, L.A. (2013). Infant health effects of a nurse-community health worker home visitation programme: a randomized controlled trial. *Child Care Health and Development*. 39(1):27-35. https://doi.org/10.1111/j.1365-2214.2012.01370.x • Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., & Perry, H. B. (2018). What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human resources for health*. *16*(1): 39. https://doi.org/10.1186/s12960-018-0304-x. • Hartzler, A.L., Tuzzio, L., Hsu, C. & Wagner, E.H. (2018). Roles and functions

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		of community health workers in primary care. *Annals of Family Medicine.* 16(3):240-245. https://doi.org/10.1370/afm.2208 • Rush, C., Smith, D. O., Allen, C., Mavhungu, B. (2020). Sustainable financing for community health worker employment. National Association of Community Health Workers. https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportOctober2020.pdf
19. Maternal Fetal Medicine Coverage		
Maternal-fetal medicine services **Definition:** Maternal-fetal medicine subspecialists are obstetricians with additional training and board certification in maternal-fetal medicine, making them highly qualified in the care of complicated or high-risk pregnancies. ***Current Medicaid policy and coverage:*** Maternal-fetal medicine physicians are a specialty of obstetrics and can be enrolled as Medicaid providers for perinatal populations.	• Many clinical guidelines identify where co-management/consultation with a maternal-fetal medicine (MFM) specialist is recommended. Examples include prior preterm birth, carrying twins, detection of congenital condition in fetus, etc. • Maternal-fetal medicine subspecialists should be involved in provision of perinatal services for people with complex or high-risk medical needs. • The density of MFM specialists has been significantly and inversely associated with maternal mortality ratios. • Birthing people of color are less likely to have access to maternal-fetal medicine direct or consultative services. • Telehealth virtual consultations allow local providers to work with maternal-fetal medicine specialists, through consultations.	**Federal documents and professional guidelines** • American College of Obstetricians and Gynecologists. (2020). Maternal-fetal intervention and fetal care centers. ACOG Committee Opinion No. 501. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/maternal-fetal-intervention-and-fetal-care-centers • American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine, Kilpatrick, S. K., & Ecker, J. L. (2016). Severe maternal morbidity: screening and review. *American journal of obstetrics and gynecology*, *215*(3), B17–B22. https://doi.org/10.1016/j.ajog.2016.07.050 • Centers for Medicare and Medicaid. (2019). Improving Access to Maternal Health Care in Rural Communities. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf • Blackwell S, Louis JM, Norton ME, Lappen JR, Pettker CM, Kaimal A, Landy U, Edelman A, Teal S, Landis R. (2020). Reproductive services for women at high risk for maternal mortality: A report of the workshop of the Society for Maternal-Fetal Medicine, the American College of Obstetricians and Gynecologists, the Fellowship in Family Planning, and Society of Family Planning. *Am J Obstet Gynecol*. *222*(4): B2. https://doi.org/10.1016/j.ajog.2019.12.008

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Other key resources • Weigel, G., Frederikson, B., and Ranji, U. (2020). Telemedicine and Pregnancy Care. Kaiser Family Foundation. https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/ • Jain, J. A., Temming, L. A., D'Alton, M. E., Gyamfi-Bannerman, C., Tuuli, M., Louis, J. M., Srinivas, S. K., Caughey, A. B., Grobman, W. A., Hehir, M., Howell, E., Saade, G. R., Tita, A., & Riley, L. E. (2018). SMFM Special Report: Putting the "M" back in MFM: Reducing racial and ethnic disparities in maternal morbidity and mortality: A call to action. *American journal of obstetrics and gynecology*. *218*(2): B9–B17. https://doi.org/10.1016/j.ajog.2017.11.591 • Magann, E. F., Bronstein, J., McKelvey, S. S., Wendel, P., Smith, D. M., & Lowery, C. L. (2012). Evolving trends in maternal fetal medicine referrals in a rural state using telemedicine. *Archives of gynecology and obstetrics.* 286(6): 1383-1392. https://link.springer.com/article/10.1007/s00404-012-2465-5.
20. Quality Improvement and Performance Measurement		
Required reporting of CMS perinatal core measures and/or HEDIS measures ***Required reporting of perinatal performance measures (including by race/ethnicity)*** ***Current Medicaid policy and coverage:*** Currently, CMS identified a core set of 9 measures for voluntary reporting by state Medicaid and CHIP agencies, to measure and evaluate progress toward improvement of maternal and perinatal health in Medicaid and CHIP. This set consists of 6 measures from CMS's Child Core Set and 3 measures from the	• In addition to standard CMS measures, HEDIS includes several standard maternal health measures. These measures include: timeliness of prenatal care, timeliness of postpartum care, receipt of postpartum depression screen, and follow-up on postpartum depression screen. • There are multiple initiatives to standardize the collection of perinatal measures in electronic health records. However, more work is needed to ensure the input of standardized codes (i.e., depression screen administered) into standardized fields so that these measures can be reported. There have been numerous calls to disaggregate perinatal measures by race and ethnicity • The White House Blueprint for the Maternal Health Crisis	**Federal documents and professional guidelines** • Centers for Medicare and Medicaid. (2022). 2022 Core Set of Maternal and Perinatal Measures (Maternity Health Core Set). https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-maternity-core-set.pdf • White House. (2022). White House Blueprint for Addressing the Maternal Health Crisis. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf • National Committee for Quality Assurance. (2020). Prenatal and Postpartum Care. https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/ • National Committee for Quality Assurance. (2020). Postpartum Depression Screening and Follow-up.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Adult Core Set. Starting in 2024, six of the CMS Maternal and Perinatal Health Core Set measures will be mandatory (i.e., low birth weight, timely well visits, timely prenatal visits, contraceptive service for youth and postpartum youth, low-risk C-sections.) Three CMS maternity core set measures will not be mandatory (i.e., two adult contraceptive measures and the "timeliness of postpartum care" measure). CMS does not require race-stratified data; however, 37 states require the collection of race-stratified data. It is currently unclear how many states are collecting and reporting on standard perinatal measures by race/ethnicity. Surveys indicate that 32 states' MCO contracts include requirements to enhance maternal health data collection.	announced a Maternal Morbidity and Mortality Data and Analysis Initiative at HHS that will collect inpatient data from 220 hospitals from every state to identify drivers of poor maternal health outcomes. The data will be nationally representative, standardized, and disaggregated by race and ethnicity.	https://www.ncqa.org/hedis/measures/postpartum-depression-screening-and-follow-up/ **Other key resources** • Mathematica. (2021). Quality of maternal and perinatal health care in Medicaid. Prepared for CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-maternity-chart-pack.pdf • Center for State Health Strategies. (2020). State Policies to Improve Maternal Health Outcomes. Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2021-03/State_Policies_Maternal_Health_Outcomes_Comparison_TABLE_030821.pdf • National Academy for State Health Policy (2019). State Medicaid Quality Measurement Activities for Women's Health. (Website, updated October 2019). https://www.nashp.org/state-medicaid-quality-measurement-activities-for-womens-health/ • Morden, E., Byron, S., Roth, L., Olin, S. S., Shenkman, E., Kelley, D., & Scholle, S. H. (2022). Health Plans Struggle to Report on Depression Quality Measures That Require Clinical Data. *Academic pediatrics*, *22*(3S), S133–S139. https://doi.org/10.1016/j.acap.2021.09.022 • Bingham, D., Jones, D. K., & Howell, E. A. (2019). Quality Improvement Approach to Eliminate Disparities in Perinatal Morbidity and Mortality. *Obstetrics and gynecology clinics of North America*. *46*(2): 227–238. https://doi.org/10.1016/j.ogc.2019.01.006 • Howell E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clinical obstetrics and gynecology*. *61*(2): 387–399. https://doi.org/10.1097/GRF.0000000000000349
Linkage to perinatal quality collaboratives ***Definition:*** Perinatal quality collaboratives are state or multistate networks of teams working to improve	• Perinatal quality collaboratives are a key strategy being used to disseminate best practices and drive quality improvement in order to improve health outcomes for pregnant women and newborns.	**Federal documents and professional guidelines** • Centers for Disease Control. (2022). Perinatal Quality Collaboratives. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion.

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
the quality of care for mothers and babies. They aim to improve care across a population, not just within one facility. Many perinatal quality collaboratives use quality improvement methods for rapid-cycle change. ***Current Medicaid policy and coverage:*** Nearly every state has a perinatal quality collaborative. However, it is unclear how many states require MCOs to take part in perinatal quality collaboratives. Recent CMS rules require hospitals to participate in a state perinatal quality collaborative to receive designation as a "Birth Friendly Hospital". States can require MCOs to ensure in-network inclusion of hospitals with this designation.	• The CDC and the March of Dimes jointly launched the National Network of Perinatal Quality Collaboratives (NNPQC) to support state-based perinatal quality collaboratives. The CDC supports 13 state-based collaboratives, and others are supported with private or state dollars. • Perinatal quality collaboratives engage multiple stakeholders, including hospitals, community health centers, state health departments, patients, insurers, and nonprofit organizations. Members identify health care processes and practices that need improvement and use the best available methods to make changes as quickly as possible. • State's efforts include focus on reducing preterm births, severe pregnancy complications related to hypertension or hemorrhage, Cesarean births among low-risk women, mental health, and racial/ethnic disparities in perinatal outcomes.	https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm • Centers for Disease Control. (2016). Developing and sustaining perinatal quality collaboratives: A resource guide for states. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pdf/Best-Practices-for-Developing-and-Sustaining-Perinatal-Quality-Collaboratives_tagged508.pdf • White House. (2022). White House Blueprint for Addressing the Maternal Health Crisis. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf • American College of Obstetricians and Gynecologists. (2020). Safe motherhood initiative. https://www.acog.org/community/districts-and-sections/district-ii/programs-and-resources/safe-motherhood-initiative • Centers for Medicare and Medicaid. (2021). Evidence-based practices for hospitals in managing obstetric emergencies and other key contributors to maternal health disparities. https://www.cms.gov/files/document/qso-22-05-hospitals.pdf • Centers for Medicare and Medicaid. (2022). FY 2023 Hospital Inpatient Prospective Payment System and Long Term Care Hospitals Proposed Rule - CMS-1771-P (Maternal Health). Factsheet. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps-0 • Centers for Medicare and Medicaid. (2022). Maternal morbidity structural measure. FAQ. https://www.cms.gov/files/document/maternal-morbidity-structural-measure-specifications.pdf **Other key resources** • Henderson, Z. T., Ernst, K., Simpson, K. R., Berns, S. D., Suchdev, D. B., Main, E., McCaffrey, M., Lee, K., Rouse, T. B., & Olson, C. K. (2018). The National Network of State Perinatal Quality Collaboratives: A Growing Movement to Improve Maternal and Infant Health. *Journal of women's health. 27*(2): 123–127. https://doi.org/10.1089/jwh.2017.6844 • Simpson, K.R. (2022). Quality Improvement and Participation in Perinatal Quality Collaboratives Promote Patient Safety. *American Journal of*

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Maternal/Child Nursing. 47(3): 175. https://doi.org/10.1097/NMC.0000000000000820 ● Lee King, P. A., Henderson, Z. T., & Borders, A. (2020). Advances in Maternal Fetal Medicine: Perinatal Quality Collaboratives Working Together to Improve Maternal Outcomes. *Clinics in perinatology*. *47*(4): 779–797. https://doi.org/10.1016/j.clp.2020.08.009 ● Markow, C., & Main, E. K. (2019). Creating Change at Scale: Quality Improvement Strategies used by the California Maternal Quality Care Collaborative. *Obstetrics and gynecology clinics of North America*. *46*(2): 317–328. https://doi.org/10.1016/j.ogc.2019.01.014 ● Main E. K. (2018). Reducing Maternal Mortality and Severe Maternal Morbidity Through State-based Quality Improvement Initiatives. *Clinical obstetrics and gynecology*. *61*(2): 319–331. https://doi.org/10.1097/GRF.0000000000000361 ● National Institute for Children's Health Quality. (Undated). National Network of Perinatal Quality Collaboratives. https://www.nichq.org/project/national-network-perinatal-quality-collaboratives
Use of maternal health safety bundles (in-hospital or community) ***Definition:*** Patient safety bundles are a structured way of improving care processes and patient outcomes. They are condition-specific and follow an evidence-based, "5R" structure (readiness, recognition and prevention, response, reporting, respectful, equitable, supportive care). When performed collectively and reliably, these bundles have been proven to improve patient outcomes. A bundle includes actionable steps that can be adapted to a variety of facilities and resource levels.	● The Health Resources and Services Administration (HRSA) provided funding to the American College of Obstetricians and Gynecologists to support the Alliance for Innovation on Maternal Health (AIM) program. ● AIM has developed several of maternal safety bundles for emergencies such as obstetric hemorrhage, severe hypertension, venous thromboembolism, maternal sepsis, Cesarean births, substance use disorder, cardiac conditions, and maternal early warning systems in pregnancy. The goal of these bundles is to promote best practices that make birth safer, increase equity, improve maternal health outcomes, and save lives. ● HRSA also provided funding to the National Healthy Start	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists. (2022). Alliance for Innovation on Maternal Health (AIM) Program. https://saferbirth.org/ ● American College of Obstetricians and Gynecologists. (2022). Alliance for Innovation on Maternal Health (AIM). Practice Management Sheet. https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim ● Health Resources and Services Administration. (2022). Alliance for Innovation on Maternal Health (AIM) and AIM Community Care Initiative (AIM CCI). https://mchb.hrsa.gov/programs-impact/programs/alliance-innovation-maternal-health-aim-community-care-aim-cci ● Centers for Medicare and Medicaid. (2022). FY 2023 Hospital Inpatient Prospective Payment System and Long Term Care Hospitals Proposed Rule

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
Current Medicaid policy and coverage: In December 2021, CMS encouraged hospitals to implement evidence-based best practices for the management of obstetric emergencies. In 2022, CMS created a rule that requires hospitals to implement maternal safety bundles to receive designation as a "Birth Friendly Hospital". Currently, 44 states and DC are utilizing maternal safety bundles, engaging 1,766 birthing facilities. It is unclear how many states currently require MCOs to: 1) incentivize the use of maternal safety bundles or 2) ensure in-network hospitals are applying safety bundles. States can also require MCOs to ensure in-network inclusion of hospitals with the "Birth Friendly Hospital" designation.	Association to leads the AIM Community Care Initiative (AIM CCI) to support the development and implementation of non-hospital focused maternal safety bundles in community-based organizations and outpatient clinical settings in states and communities that experience high incidence and prevalence of maternal morbidity and mortality. ● The Agency for Healthcare Research and Quality (AHRQ) funds additional efforts to support teamwork and communication related to safety bundles. ● The National Birth Equity Collaborative is developing a community-informed model to facilitate opportunities for Black mothers' experiences to inform the care process and quality improvement.	- CMS-1771-P (Maternal Health). Factsheet. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps-0 ● Centers for Medicare and Medicaid. (2022). Maternal morbidity structural measure. FAQ. https://www.cms.gov/files/document/maternal-morbidity-structural-measure-specifications.pdf **Other key resources** ● Morton, C. H., Hall, M. F., Shaefer, S. J., Karsnitz, D., Pratt, S. D., Klassen, M., ... & Chazotte, C. (2021). National Partnership for Maternal Safety: Consensus Bundle on support after a severe maternal event. *Journal of Obstetric, Gynecologic & Neonatal Nursing*. 50(1): 88-101. https://doi.org/10.1016/j.jogn.2020.09.160 ● Walker, D. M., DePuccio, M. J., Huerta, T. R., & McAlearney, A. S. (2020). Designing quality improvement collaboratives for dissemination: lessons from a multiple case study of the implementation of obstetric emergency safety bundles. *The Joint Commission Journal on Quality and Patient Safety*. 46(3): 136-145. https://doi.org/10.1016/j.jcjq.2019.11.002 ● D'Alton, M. E., Main, E. K., Menard, M. K., & Levy, B. S. (2014). The national partnership for maternal safety. *Obstetrics & Gynecology.* 123(5): 973-977. ● Main, E. K., Goffman, D., Scavone, B. M., Low, L. K., Bingham, D., Fontaine, P. L., Gorlin, J. B., Lagrew, D. C., Levy, B. S., National Partnership for Maternal Safety, & Council on Patient Safety in Women's Health Care (2015). National Partnership for Maternal Safety: Consensus Bundle on Obstetric Hemorrhage. *Obstetrics and gynecology*, *126*(1), 155–162. https://doi.org/10.1097/AOG.0000000000000869 ● Lu, M. C., Highsmith, K., de la Cruz, D., & Atrash, H. K. (2015). Putting the "M" back in the Maternal and Child Health Bureau: Reducing maternal mortality and morbidity. *Maternal and Child Health Journal.* 19(7): 1435-1439. https://doi.org/10.1007/s10995-015-1665-6
Performance improvement activities/plans		**Federal documents and professional guidelines**

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]

related to perinatal care
 	
Definition: Perinatal performance improvement activities are frequently developed in the form of a performance improvement plan (PIP). These plans may establish incentives or penalties based on MCO and/or provider performance on key maternal and infant health indicators. Incentives for MCOs can come in the form of quality ratings and/or auto-enrollment tied to their performance; incentives for providers can include increased reimbursement. Penalties may include withholds of funds for failing to meet performance objectives.
 	
Current Medicaid policy and coverage: As per 42 CFR 438.330, all states with Medicaid managed care plans must ensure that their health plans conduct PIPs. Projects must be designed to achieve - through ongoing measurements and interventions - significant improvement, sustained over time, in clinical and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. MCOs must report out yearly on the progress and results of their PIPs.
 	
The scope of states that have used PIPs to improve perinatal care is unclear. A 2017 analysis found that only 16 states were taking part in a maternal health performance improvement project.
	• In 2012, CMS developed a tool to assist MCOs with the mandatory implementation of their PIPs, known as the *Validation of PIP Protocols*. The tool assists in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.
	• Typically, External Quality Review Organizations (EQROs) are contracted to provide technical assistance to MCOs in the process of developing, administering, and reporting on their PIP.
	• PIP topics may be selected by the state, or in cooperation with the MCO. CMS suggests that topics should address "a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction", as well as "reflect high-volume or high-risk conditions of the population served". Specifically, CMS suggests that PIPs address national health priority topics identified by CMS.
	• Some Medicaid state agencies have built a requirement into their RFPs that MCOs create a PIP focused on reducing maternal health disparities.
	• A 2017 analysis of state Medicaid programs found that the majority of maternal health PIPs focused on increasing the frequency and timeliness of prenatal and postpartum visits. For example:
	  ○ CA: In 2015, nine health plans conducted PIPs on the topic of timely postpartum visit care, which included the provision of a $25 incentive gift card to postpartum persons for completing the visit.
	  ○ FL: As of 2017, FL health plans were required to report on the timeliness of prenatal and
		• 42 CFR Section 438-330. https://www.govinfo.gov/content/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec438-330.pdf
		• The Centers for Medicare and Medicaid Services (CMS). (2012). Validation of Performance Improvement Projects (PIPs). https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf.
		
		Other key resources
		• National Academy for State Health Policy (NASHP). (2017). State Medicaid/CHIP Quality Metrics and Performance-Based Incentives for Women's Health Services to Improve Birth Outcomes – 50 State Environmental Scan. http://www.nashp.org/wp-content/uploads/2017/06/NASHP-Womens-Health-Environmental-Scan-updated-11.03.17.pdf
		• National Academy for State Health Policy (2019). State Medicaid Quality Measurement Activities for Women's Health. (Website, updated October 2019). https://www.nashp.org/state-medicaid-quality-measurement-activities-for-womens-health/

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
	postpartum care and implement validated PIPs on these topics. ○ MI: As of 2014, several Michigan Health Plans implemented PIPs to improve prenatal and postpartum care. To improve performance on HEDIS measures, Meridian Health Plan offers financial incentives to providers for completed prenatal and postpartum visits. ○ WI: In 2016, five health plans conducted PIPs on prenatal and postpartum care, using interventions such as provider education sessions and incentive programs for postpartum visits.	
21. Payment Reform Initiatives		
Perinatal payment reform initiatives ***Definition:*** Unlike fee-for-service (FFS) payment approaches that are based on the volume of care provided, value-based payment (VBP) models reward providers for the achievement of quality goals, and/or in some cases, cost savings. Other alternative payment models are designed to emphasize particular clinical practices or benefits. Both seek to drive change in provider action and health outcomes. **Current Medicaid policy and coverage:** Medicaid provide states with multiple tools to promote the use of VBP and other alternative payment approaches through managed care arrangements, particularly through contractual requirements.	● States design their value-based payment (VBP) and alternative payment models primarily to incentivize targeted quality improvements and, in some cases, to reduce costs. Recent efforts have not been designed to fundamentally alter how maternity care is delivered, building instead on existing delivery and payment systems. ● VBP models include payment by episode of care, pay-for-performance, and distinct payments for pregnancy medical homes. Each approach has been implemented in various ways. ● Both incentives and disincentives may be used. ● MACPAC found that it remains unclear whether VBP models have improved quality and access to maternity care. However, some APMs have been found to improve clinical and cost outcomes:	**Federal documents and professional guidelines** ● American College of Obstetricians and Gynecologists (ACOG). (2018). ACOG committee opinion No. 744: Value-Based Payments in Obstetrics and Gynecology. https://www.acog.org/clinical/clinical-guidance/committeeopinion/articles/2018/08/value-based-payments-in-obstetrics-and-gynecology ● Bigby, J., Anthony, J., Hsu, R., Fiorentini, C., & Rosenbach, M. (2020). Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program. Mathematica for the U.S. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf ● U.S. Department of Health and Human Services. (2022). Federal Register, 87 FR 28108. https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
A 2020 review of all Medicaid programs found that 41 states had implemented payment-focused programs to improve maternal health. One-quarter of state programs have pay-for-performance programs for maternity services.	○ Connecticut reports its pay-for-performance model has had mixed results, decreasing preterm births but not increasing early prenatal care. ○ MN- Minnesota's Medicaid program's blended payments for uncomplicated deliveries was found to successfully reduce the C-section rate. ○ TN- In Tennessee, perinatal costs dropped 3.4% as a result of bundling perinatal episodes. ○ AR -In Arkansas, spending on perinatal episodes decreased 3.8% compared to surrounding states, but quality of care did not improve. ● Unbundling payments can be useful for postpartum services. For example, some states have separated the payment for postpartum visits from the birth/delivery care payment in order to provide greater incentives for providers to complete postpartum visits. ● Questions remain regarding the impact of various types of payment reform initiatives on elements such as payments for doulas, midwives, and birth centers.	**Other key resources** ● MACPAC. (2021). Medicaid payment initiatives to improve maternal and birth outcomes. (Issue Brief). https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf ● MACPAC. (2019). Medicaid payment initiatives to improve maternal and birth outcomes. (Issue Brief). https://www.macpac.gov/wp-content/uploads/2019/04/Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf ● MACPAC. (2021a). Arkansas Perinatal Episode of Care. https://www.macpac.gov/publication/arkansas-perinatal-episode-of-care/ ● MACPAC. (2021b). Colorado Hospital Quality Incentive Payment Program and Maternity Bundled Payment Program. https://www.macpac.gov/publication/colorado-hospital-quality-incentive-payment-program-and-maternity-bundled-paymentprogram/. ● Baker, M. V., Butler-Tobah, Y. S., Famuyide, A. O., & Theiler, R. N. (2021). Medicaid cost and reimbursement for low-risk prenatal care in the United States. *Journal of midwifery & women's health*. *66*(5): 589–596. https://doi.org/10.1111/jmwh.13271 ● Mathematica. (2020). Inventory of state-level Medicaid policies, programs, and initiatives to improve maternity care and outcomes. Prepared for MACPAC. https://www.macpac.gov/publication/inventoryof-state-level-medicaid-policies-programs-and-initiatives-toimprove-maternitycare-and-outcomes/ ● Oregon Health Authority. Maternity Care Delivery Area. (Website). https://www.oregon.gov/oha/HPA/dsi-tc/Pages/VBP-CDA-Maternity-Care.aspx ● Khanal, P., McGinnis, T., & Zephyrin, L. (2020). Tracking State Policies to Improve Maternal Health Outcomes. Commonwealth Fund. https://www.commonwealthfund.org/blog/2020/tracking-state-policies-improve-maternal-health-outcomes ● Johnson, K. (2021). Finance and Payment Innovation: Improving Equity in

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		Perinatal Care and Maternal and Infant Outcomes. Michigan Council on Maternal and Child Health. https://search.issuelab.org/resource/finance-and-payment-innovation-improving-equity-in-perinatal-care-and-maternal-and-infant-outcomes.html ● de Vries, E. F., Scheefhals, Z., de Bruin-Kooistra, M., Baan, C. A., & Struijs, J. N. (2021). A Scoping Review of Alternative Payment Models in Maternity Care: Insights in Key Design Elements and Effects on Health and Spending. *International journal of integrated care*. *21*(2): 6. https://doi.org/10.5334/ijic.5535 ● Berrien, K., A. Ollendorff, and M.K. Menard. (2015). Pregnancy medical home care pathways improve quality of perinatal care and birth outcomes. *North Carolina Medical Journal.* 76(4): 263-6. https://pubmed.ncbi.nlm.nih.gov/26509523/ ● Carroll, C., Chernew, M., Fendrick, A. M., Thompson, J., & Rose, S. (2018). Effects of episode-based payment on health care spending and utilization: Evidence from perinatal care in Arkansas. *Journal of health economics*. *61*: 47–62. https://doi.org/10.1016/j.jhealeco.2018.06.010 ● Arkansas Center for Health Improvement (ACHI). (2019). Arkansas health care payment improvement initiative. 4th Annual Statewide Tracking Report. https://achi.net/wpcontent/uploads/2019/09/ACHI_Statewide_Tracking_Report_2019_4th_Annual.pdf ● New York Department of Health. (2018). Maternity Care Value-Based Payment. (Factsheet). https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2017-08-01_maternity.htm ● Dahlen, H. M., McCullough, J. M., Fertig, A. R., Dowd, B. E., & Riley, W. J. (2017). Texas Medicaid payment reform: Fewer early elective deliveries and increased gestational age and birthweight. *Health Affairs*. *36*(3): 460–467. https://doi.org/10.1377/hlthaff.2016.0910 ● Bailit Health. (2020). State strategies to promote value-based payment through Medicaid manage care: Final report. Prepared for MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-

The following appendix is part of a Commonwealth Fund blog, Sara Rosenbaum et al., "The Road to Maternal Health Runs Through Medicaid Managed Care," *To the Point* (blog), Commonwealth Fund, May 22, 2023. https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care

Key Domains, Definitions, and Current Medicaid Policy	Summary of Guidelines and Evidence	Supporting Literature[1]
		State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf ● Smith, V., Gifford, K., Ellis, E., et al. (2016). Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017. Kaiser Family Foundation. http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017. ● Kozhimannil, K. B., Graves, A. J., Ecklund, A. M., Shah, N., Aggarwal, R., & Snowden, J. M. (2018). Cesarean delivery rates and costs of childbirth in a state Medicaid program after implementation of a blended payment policy. *Medical Care*. *56*(8): 658–664. https://doi.org/10.1097/MLR.0000000000000937 ● Rodin, D. & Kirkegaard, M. (2019). Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Model: Strategies to Sustain a Successful Model of Prenatal Care Centering Healthcare Institute. https://www.healthmanagement.com/insights/briefs-reports/white-paper-prepared-by-hma-aligns-centeringpregnancy-with-value-based-payment-models/