Postpartum Coverage Extension: Improving Maternal Health during the Postpartum Period

Recorded March 25, 2022

Jodi Anthony:

Good afternoon, everyone. Welcome to today's webinar on "Improving Maternal Health During the Postpartum Period." I'm Jodi Anthony from Mathematica, and I'm excited to kick off this webinar. Next slide.

Please note that all participants logged into this webinar have been muted for the best sound quality possible. We welcome audience questions throughout the webinar through the Q&A window located at the bottom right corner of your screen. To send a question or comment related to the webinar, please highlight "All Panelists" and click "Send" in the "Ask" drop-down list. We'll address as many questions as possible during today's webinar. If you have any technical issues, please also use the Q&A window. Please select "Host" in the "Ask" drop-down menu and describe your technical question. I also want to let everyone know that this meeting is being recorded. Please note that if you'd like to use Closed Captioning, Derek is posting into the Chat instructions to do so.

Lastly, in about two weeks' time a recording of today's session along with the slides and transcript will be posted on Medicaid.gov's "Maternal Infant Health Initiatives" home page, which we'll share with you later in the hour. Next slide.

Here's our agenda for today. First, Amy Lutzky, Deputy Director of the Children and Adult Health Programs Group for CMS, will provide opening remarks. She'll be followed by Kristen Zycherman, the lead for CMS's Maternal/Infant Health Initiative, to discuss the importance and role of postpartum care in maternal health quality measurement and describe the Maternal and Infant Health Initiative. She will then turn it back to me to describe strategies to improve the equitable access to and quality of postpartum care. Kristen will then provide a brief overview of the American Rescue Plan of 2021's 12-month postpartum extension option, and we will have about 10 to 15 minutes for discussion and then wrap it up with providing information about key resources and activities. Next slide.

Objectives for today are to share evidence on the use and quality of postpartum care and disparities for people involved in Medicaid and CHIP, describe drivers to improve the use and quality of postpartum care and offer some examples of how these drivers have been employed and finally, provide a brief overview of ARP's postpartum coverage extension option. With that, I'll turn it over to Amy Lutzky.

Amy Lutzky:

Thank you so much, Jodi. Good afternoon and welcome, everyone, to today's call. We are delighted to bring you this webinar as part of the Medicaid and CHIP Maternal and Infant Quality Improvement Initiative.

As many of you know, CMS launched the Maternal and Infant Health Initiative in 2014 with the purpose to improve access to and quality of care for pregnant and postpartum women and their infants. In light of increasing rates of maternal and infant mortality and morbidity, CMS launched a new phase of the initiative back in December of 2020. This new phase includes technical assistance opportunities for states that focus on three priority areas, including increasing the use and quality of postpartum care visits.

Nearly two out of three adult women enrolled in Medicaid are in their reproductive years; and Medicaid currently finances about 42% of all births in the United States with nearly half of these births to Black,

Hispanic, or American Indian, Alaska Native individuals. Given this, CMS and states can play a major role in improving the quality of maternal care, birth outcomes, measuring how care is delivered to pregnant and postpartum women, and in mitigating health disparities from these individuals served by Medicaid and CHIP.

This webinar offers the opportunity to discuss the importance of equitable access and quality of postpartum care and how extending postpartum coverage can help address maternal health disparities. We are also on the cusp of a new opportunity for states to extend postpartum coverage in Medicaid and CHIP. Beginning in just one week, April 1st, the American Rescue Plan, ARP, offers states the opportunity to provide 12 months of postpartum coverage to pregnant individuals who are enrolled in Medicaid and CHIP. States that want to elect this option must submit state plan amendments to CMS.

As this audience understands, many pregnant individuals and their families rely on Medicaid and CHIP for the ongoing care they need during the postpartum period. Continuity of coverage over a 12-month period can help individuals manage chronic conditions, like hypertension and diabetes, as well as provide access to behavioral health and other mental health services. We are encouraging states to take advantage of this critical ARP option.

Thank you for joining in today's webinar. Most importantly, thank you for all the work you do to advance the quality and coverage of postpartum care to our Medicaid and CHIP beneficiaries. I'll now pass to my colleague, Kristen Zycherman, who's going to more fully elaborate on, "The Importance and Role of Postpartum Care in Maternal Health."

Kristen Zycherman:

Thank you, Amy. Next slide. Let me begin with some background that I am sure you are all keenly aware of. The maternal mortality rate in the U.S. is the highest of high-income countries and continuing to trend in the wrong direction. The CDC just released their 2020 maternal mortality data, and that number rose to 861 or more than 20% increase in the maternal death rate over 2019. With good-quality maternity and follow-up care, the majority of those maternal deaths are preventable.

Disparities continue to be a major issue with Blacks, American Indians, and Alaska Native individuals three to four times more likely to die of pregnancy-related causes than their White counterparts even when accounting for other factors such as age, comorbidities, educational attainment, and other socioeconomic factors.

In addition to maternal deaths, over 50,000 birthing persons a year suffer from severe maternal morbidity, significant short- or long-term consequences to their health as the result of pregnancy. Next slide, please.

This slide is a visual representation of the stark disparities that exist in the maternal mortality rates, especially affecting African Americans, American Indians, Alaska Natives, and Black birthing persons. Next slide, please.

The takeaway from this slide is that over half of maternal deaths occur between one day and one year postpartum, with almost 12% occurring after six weeks postpartum. This is actually older data. We are awaiting newer data to come out; but we expect that it's possible, anecdotally hearing from states, that those numbers in the late postpartum period will actually be increasing. Next slide, please.

As Amy said, Medicaid pays for over 42% of births in the United States. So, we are well-positioned to make an impact on the maternal health crisis. The Maternal and Infant Health Initiative (MIHI) was

launched in 2014; but in 2019 to 2020, an expert work group provided updated recommendations of areas of focus for the MIHI This figure is a representation of what the MIHI is focused on today -- low-risk Caesarean deliveries, postpartum care, and infant/well childcare -- and how those topics interconnect to work towards reducing maternal and infant mortality, severe maternal morbidity, and inequity.

As you can see, improving the use and quality of postpartum care is a key component to improving both maternal and infant health outcomes through increased access to contraceptive care, better management of both physical and behavioral health conditions, and increased connection to ongoing care. Next slide, please.

In order to generate improvement in postpartum care, states need to know how they are performing, and that is where quality measurement comes in. Next slide, please.

In order to help states to better understand the quality of care received by Medicaid and CHIP beneficiaries, CMS identified Core Set measures for voluntary reporting. The 2022 Maternity Core Set includes nine perinatal measures, six from the Child Core Set and three from the Adult Core Set. While reporting is currently voluntary, beginning in 2024 reporting on all Child Core Set measures, as well as any behavioral health measures in the Adult Core Set will be mandatory. Next slide, please.

This slide shows the wide variation among states in postpartum infant attendance rates. These rates range from a low of about 20% to a high of nearly 92%, with a median of 72%. Clearly, this shows room for improvement. Next slide, please.

An aspect of quality postpartum care is contraceptive care to facilitate healthy birth spacing. You can see over the next two slides, which cover two age spans of postpartum people, that there is wide variation in this measure as well. This map represents the Child Core Set measure of postpartum individuals ages 15 to 20. The range is 23% to 55%, with a median of 43.9%. We do note that for all of our contraceptive measures, there is no specific benchmark. It is simply the goal that all individuals that provided the information to make informed decisions, and those that wish to obtain contraception are able to access the contraceptive method of their choice and that it is available to them even in the immediate postpartum period if they choose. Next slide, please.

This map represents our Adult Core Set measure of postpartum individuals ages 21 to 44, with a range of 24.7% to 50.8% and a median of 41.6%. What this shows across both of these maps is that the great variation between the states shows that there does continue to be room for improvement. Next slide, please.

Now that we have a better idea of how we as a nation are performing in maternal and postpartum care, we can discuss the next important step of improving equitable access to and quality of postpartum care. Next slide, please.

The idea of quality postpartum care has changed over recent years and has expanded beyond a single six-week postpartum visit. The American College of Obstetricians and Gynecologists, or ACOG, recommends that all postpartum individuals see their provider within the first three weeks of delivery and then have a comprehensive or well-person visit no later than 12 weeks after delivery, this care to be individualized based on health conditions and risk factors. Additionally, the care should go beyond the physical healing from childbirth and include behavioral health screening care, infant care and feeding support, contraceptive care, as well as follow up and referral for any other preexisting or pregnancy-related health conditions. Quality postpartum care also recognizes the systemic impact leading to disparities in outcomes for persons of color. Next slide, please.

Improving equitable access to and quality of postpartum care can take many forms including person-centered models of care, such as doulas and medical homes; cross-cutting strategies, such as partnering with MCOs and GBCs; and addressing specific postpartum physical, social, and emotional needs. Next, I will pass it over to Jodi to discuss some of these strategies in more detail.

Jodi Anthony:

Thanks, Kristen. Before I dive into the specific strategies that state Medicaid agencies and their partners can employ to improve equitable access and quality to postpartum care, I'd like to preface that you're about to see a lot of information. This was deliberate so that you can go back to the slides after today's overview and get more details. You'll also see at the end of the presentation several resources where you can dig deeper. As I said at the top of the hour, we will post these slides along with the transcript and recording on Medicaid.gov.

With that, I'll begin with cross-cutting strategies. The first is partnering with managed care to achieve quality goals. There are several strategies that are critical to improving postpartum care that apply to cross-models of care for health conditions. The first is partnering with managed care to agree on state priorities and cocreate solutions. Contracts specifically can articulate quality requirements and performance goals stratified by race, ethnicity, and geography to pursue equitable care. State Medicaid agencies can also productively partner with their external quality review organizations to develop quality improvement projects explicitly focused on postpartum care. You're going to see that for each identified strategy, we also share a state example. Here we highlight the state of Louisiana, who require their managed care plans to identify and report on high-risk populations and address the social determinants of health. You'll also see for each of the highlights that we provide a source that you can click on and get more information. Next slide.

The next cross-cutting strategy focuses on value-based payment. We have simplified the breadth of payment strategies into three categories, the first being fee-for-service payments linked to quality. This payment approach represents the first step toward value-based payment. Initially, practices may receive payments linked to infrastructure enhancements, transitioning to electronic medical records, paying for care coordination nurses, or pay for reporting with positive and negative incentives that are tied to reporting quality measures. Additionally, providers may receive bonus payments or penalties based on their performance on quality measures, also known as pay for performance.

The next step is alternative payment models on a fee-for-service structure. This model accounts for performance based on both quality and cost. Providers may receive shared savings if they meet quality and cost metrics, or they may be required to reimburse the payer an established amount if they do not meet cost targets. Other examples include bundled payments, episode-based payments for procedure-based care, and primary care with shared savings and losses.

Finally, population-based payments – this model provides a single payment for a comprehensive set of services with specific conditions or populations and expects providers to meet quality metrics. This model offers the strongest incentive for coordinating care across providers in delivering person-centered care, as long as receipt of payment is tied to performance and quality measures. Next slide.

Here's just a few examples: Wyoming is an example of the fee-for-service payments linked to quality with an unbundled postpartum billing code and reimbursement for up to two postpartum visits. With providers and other payers, Ohio designed episode-based payments for postpartum care. New York has adapted several value-based strategies, including payment arrangement specific to postpartum

complications. Providers can realize shared savings if parenting people receive home visits and screening for postpartum depression. Next slide.

To note, these value-based payment strategies are a departure from what is currently widely used, which is bundled payments, where the postpartum visits are included with all the other perinatal services. This creates issues for measuring and improving postpartum care specifically. Next slide.

Next I'd like to show how payment and managed care contracts and partnerships can be applied to support more person-centered models of care and why such care is important. Next slide.

So what do we mean by "person-centered models of care"? Well, they are a holistic approach to delivering care that focuses on individual needs and addresses gender and racial bias. Person-centered models of care employ both medical and non-medical personnel to support individuals, including people of color, from pregnancy to the postpartum period.

In the blue box you see here, we share an article from Kaiser Health News that highlights experiences of Black women who have turned to midwives during the pandemic for care and support during their labor and delivery. It is well-known that one of the widest disparities in women's health care lies in long-standing social inequities, from lack of safe housing and healthy food to inferior care provided at the hospitals where Black women tend to give birth.

TaNefer Camara, one of the Black women featured in this story, is a mother of three and a lactation consultant at Highland Hospital in Oakland, California. She knew she didn't want to have her baby in a hospital bed. She wanted to deliver at home, surrounded by her family, into the hands of an experienced female birth worker as her female ancestors once did; and she wanted a Black midwife.

Jamarah Amani, a Florida midwife and cofounder of the National Black Midwives Alliance also featured in this story, shared that almost every midwife she's talked to "has seen their practice double or sometimes triple in the wake of COVID." Next slide, please.

In this slide, the table summarizes the latest evidence known about person-centered models of care and their associated outcomes. The top row of this table lists different types of person-center models. Just so we're all on the same page, I'll quickly define what we mean by "group-based care" and "team-based care" because at first glace they might sound similar.

Group-based care, and we're following the ACOG definition for this, is a series of visits usually at the start of the second trimester with groups composed of approximately eight to ten women of similar gestational age, their support partners, an obstetrician or other obstetric care provider, and co-facilitator who meet every two to four weeks.

Team-based care, on the other hand, is delivered with team members such as behavioral health providers, parent and peer mentors, and care coordinators with an emphasis on cultural concordance with the population served.

So what you see here is in the first column there are listed outcomes such as postpartum visits, breastfeeding, postpartum depression, contraception, and so on. What you can see, as indicated by these arrows, is that across the board these models of care are associated with better maternal health outcomes. For example, group-based care, team-based care, doula support, and midwives are associated with higher rates of postpartum visits and breastfeeding and lower rates of postpartum depression. Several of these

models are also associated with high rates of postpartum contraception, transition to primary care and social support, as well as lower rates of Caesarean births. Next slide, please.

Now we'll do a deeper dive into some of these models on person-centered care. Group-based care, also known as group-pregnancy care, has shown promise in reducing health care costs as well as improving birth outcomes and is associated with better maternal health outcomes, as we noted from the previous slides, such as increasing the use of postpartum contraceptives and rates of postpartum care visits.

One state that has implemented group-based care in their Medicaid program is Montana, which we describe here on the right of the slide. The Montana Promising Pregnancy Care Program allows approved providers to be reimbursed for state-approved group pregnancy care. The state Medicaid Program pays federally qualified health centers an enhanced prospective payment system rate when a Medicaid member attends a postpartum care group educational service, along with an obstetric visit. For those of you who are interested in implementing group-based care for pregnant people in the Medicaid Program, you may do this with the Medicaid state plan amendment or demonstration or waiver authority to the redesign care systems.

If you have a fee-for-service system, you may design a model under a primary care case management program, as long as they do not restrict the beneficiary's free choice of providers. If you work with managed care plans, you may work with plans in your state to establish the necessary structure and requirements for integrated care models in managed care. Next slide, please.

Next, we'll discuss a type of team-based care. One type is the pregnancy-centered medical home, which provides care coordination as well as perinatal, medical, and behavioral health services. Among high-risk birth persons, pregnancy-centered medical homes have shown promise in increasing standardized postpartum depression screening, counseling on reproductive life choices, and planning during the postpartum period, as well as transition to ongoing primary care.

On the right of this slide, we highlight North Carolina, which has the Pregnancy Medical Home program. This program requires providers to complete a postpartum visit within 60 days of delivery and coordinate with a pregnancy care manager assigned to the practice. Providers receive $150 incentive payment if the visit is completed within 60 days of delivery. At the postpartum visit, providers are required to screen for postpartum depression using a validated tool, review the patient's reproductive life plan, and offer referrals for primary care. Next slide, please.

The last type of person-centered model we want to highlight is doula support. Doula support has been found to be associated with a decreased likelihood of postpartum depression and near universal breastfeeding among low-income women. CMS has issued guidance to states on paying for services delivered by doulas and other non-licensed practitioners. States may pay for services delivered by non-licensed practitioners whose qualifications are based on what states define and recognize.

Again on the right, we want to highlight another state example, Oregon's Traditional Health Worker Program. For a little bit of background, in 2011, the Oregon Legislature passed House Bill 3311, which directed the Oregon Health Authority to explore options for providing or using doulas in the state Medicaid program. Oregon used state plan authority to cover the services of traditional health care workers under the supervision of a licensed health care professional, creating the Traditional Health Worker, or THW, Program to promote better health outcomes and greater health equity. The THW Program office is responsible for certifying, training, and registering THWs, including doulas. Next slide, please.

Okay, so I'm going to pivot a little bit here and talk about addressing specific postpartum needs and specifically around several high-priority ones. Basically, they're not the whole spectrum. Next slide.

To set the stage, people enrolled in Medicaid are more likely to smoke during pregnancy, somewhere around 17% to 20%, and have chronic diseases and less likely to breastfeed than pregnancy-insured individuals. In addition, people of color -- and low-income people, specifically -- have the highest rates of postpartum depression and the lowest rates of post pregnancy health care. Moreover, dental care – which affects both the health of the parent and the infant – is too often missed. Next slide.

Let's begin with smoking cessation services. CMS already requires coverage of cessation services. Several states have created special initiatives for their postpartum population, including supporting tailored protocols and specifically training postpartum cessation counselors and paying pediatric providers to screen for tobacco use among other factors. Just to note, there are a lot of general resources for tobacco and smoking cessation on www.Medicaid.gov. Next slide.

State Medicaid agencies can also partner with managed care and providers to develop workflows and seamless handoffs from obstetrical care to mental health support. In addition to using the EPSDT benefit to pay for postpartum depression screening, state Medicaid can also cover family therapy services that benefit both the child and parent. Minnesota is one state example that has used these levers. Next slide.

Breastfeeding can be more effectively supported by financing education, lactation consultation, and equipment rentals. Managed care plans can be required to offer these services or develop warm handoffs to WIC programs and home visiting. Next slide.

Contraceptive care – states should ensure that postpartum individuals have full and accurate information, counseling, and services for contraceptive options without cost sharing. Additionally states can expand Medicaid eligibility for family planning services by adopting the optional family planning limited-benefit group, which is particularly important for individuals losing Medicaid coverage 60 days postpartum. As the Washington example highlights, to increase access to long-acting reversible contraceptives for individuals who want this method, states can increase provider payments to overcome financial barriers to their use. Next slide.

Finally, pregnancy and postpartum dental benefits – I think most people on this call are well-aware of the need to assure access to mental health services, tobacco cessation, and contraceptive choice. But I just want to take a moment to reiterate the importance of dental care for the postpartum individual. Gum disease increases odds of adverse outcomes for both the mother and the infant. Moreover, untreated tooth decay in the parent is highly associated with the children's untreated tooth decay. Medicaid beneficiaries use dental services far less than individuals who are privately insured. The good news is that CMS has subject matter experts available to discuss dental benefits and options with state Medicaid agencies. Next slide. Okay, I'm going to turn it over to Kristen.

Kristen Zycherman:

Thank you, Jodi. As Jodi discussed, there are a lot of care considerations, especially to try to squeeze into 60-ish days following delivery, especially when so many changes are going on with new parents. So that is just another reason why the 12-month coverage extension option is so important. Next slide, please.

This is a very brief, high-level overview of the American Rescue Plans options; and we have many more resources for you following this. But at a high level, the option begins, as Amy said previously, April 1, 2022, and is currently limited to a five-year period. If a state elects this option, people eligible enrolled in

Medicaid or CHIP while pregnant are eligible for extended coverage with continuous eligibility through the last day of the month in which their 12-month postpartum period ends. During that time, states must provide full Medicaid benefits. Now, this is just the tip of the iceberg when it comes to the policy. Next slide, please.

So, I encourage you all to explore the resources that CMS has developed. We have the links on this slide, and all of these slides will be available following the presentation. But these include links to the SHO Letter, as well as the MAC LC slide decks on the postpartum care extension. I would encourage you that if you have any additional questions or would like some TA, please reach out to your state lead or CHIP project officer. Next slide, please, and I'm handing it back to Jodi.

Jodi Anthony:

Okay, well, we've shared a lot of information. Now we really want to open it up to questions and discussion. We have a couple, so I will read them aloud and either try to answer them myself or Kristen or Amy may jump in as well. This first one is for Kristen: "What additional services does CMS have to address smoking in pregnancy?"

Kristen Zycherman:

That is a great question. We have a number of smoking cessation materials that are more general on our Medicaid.gov website. In addition, we have developed and are soon to post our smoking cessation and pregnancy short videos. So they're kind of bite-sized technical assistance offerings that range from about four to six minutes, and they're geared towards providing information on what is available as far as smoking cessation during pregnancy. They will be available as part of our kind of booth materials in the Quality Conference, which Jodi will, I think, highlight later – the CMS Quality Conference, which is coming up. Then, they will also be posted shortly to our Medicaid.gov website; so keep a look out for those.

Jodi Anthony:

Thanks, Kristen. We will take this moment and – actually, Sydney, if you wouldn't mind going just a couple slides ahead because I think this shows – this one. So this is just what Kristen was sharing. There will be a new tobacco cessation technical assistance set of resources that you can find on Medicaid.gov.

May I also ask, Sydney, for you to drop into the Chat the Maternal/Infant Health Initiative link so folks can find the resources that Kristen was just talking about plus all of the other resources we'll be talking about today. The other thing is to put into the Chat the link to the Quality Conference.

Kristen Zycherman:

In addition to these resources that we'll be posting, individualized quality improvement coaching related to tobacco cessation for pregnant and postpartum people will be available upon request.

Jodi Anthony:

Thanks, Kristen. Just checking for other questions. [Pause] Okay, so I see a question talking about the North Carolina Pregnancy Medical Homes. This question is: "Are there other examples where there isn't Medicaid expansion or extension that have innovative programs looking at behavioral health or substance use disorder for postpartum folks? Also, is there data regarding how effective these programs are?"

That's a great question, and I certainly can do a little bit more digging. I don't know about another example in the South in particular that's working on this; although people could certainly put into the Chat if they know of one that can support the question, and I can read that aloud. Kristen, I don't think you have anything to add here.

Kristen Zycherman:

It's certainly something that some of our improving postpartum care affinity group states are exploring; but I don't think we have kind of reached a point where we can share that information since it's a fairly new group, and we don't have a lot of data coming out of it quite yet. But it's certainly something that we can do some more digging on and get back to you with, as Jodi said.

Jodi Anthony:

Another question has come in: "I am the Advocacy Coordinator for Wyoming Women's Foundation. We submitted an Interim Session packet on Maternal Health Perinatal Care specifically with the goal to extend postpartum benefits in our state to 12 months postpartum. Can states still apply for the ARP funds for the extension, or is that submitted to CMS prior to April 1st?

Kristen Zycherman:

States still have the ability to submit options for the – was that the – is it the question of can you still submit a SPA for the extension?

Jodi Anthony:

Mm-hmm

Kristen Zycherman:

Yes, there's not a time limit. Well, there's the five-year time limit; but you don't have to submit by April 1st. That is correct.

Jodi Anthony:

Thanks, Kristen. Actually, I'm so happy somebody responded to the original question about SUD. So Wisconsin, while I know not in the South but another good example, recently sent up a substance use disorder health home using a hub and spoke model, and included women who are pregnant and 12 months postpartum as one of the "chronic conditions" to be eligible in addition to expanding an SUD.

There's another question here: "Could you talk more about how some of these quality improvement goals fit into the proposed Medicaid QRS?"

Kristen Zycherman:

Oops, sorry, I had trouble coming off mute for that one. Thanks for that question. As you may know, we're in the midst of rulemaking for the Medicaid and CHIP Managed Care Quality QRS, so we're limited in what we can discuss on that today. But it is taken into consideration in development.

Jodi Anthony:

Great. Then there's one more question...let's see here: "How does CMS address the growing health care systems that are religiously affiliated in not offering contraception to their patients?"

Kristen Zycherman:

Thank you for that question. It's definitely something that is being discussed and addressed within CMS. We don't have that particular expertise on the phone today, I'm sorry to say; but we'd be happy to take your information and follow up with that once we talk to the right subject matter expert.

Jodi Anthony:

Okay, so this question: "In Texas ten years ago, we made it mandatory to have mom fill out the PHQ-9 for the first visit. Postpartum depression has had a deep impact on attachment in causing insecure attachment and is a detriment." So, I think it's just a comment. I'm not sure if there was a specific question here. It's just adding to the conversation.

Kristen Zycherman:

And I can tell you that we agree with that, and that is something that came up in our expert work group meetings where we discussed topics to focus on the Maternal/Infant Health Initiative. There was a strong focus on how maternal outcomes affect child outcomes, infant outcomes, child development. So, there was that strong emphasis on that dyad care and that approach of how those outcomes are intertwined. So I can tell you that it's something we consider heavily in our work.

Jodi Anthony:

Thanks, Kristen. "Can you speak to how CMS is including patient-reported experience measure as a core quality measure?"

Kristen Zycherman:

I can tell you that our Core Set is -- the way that measures are added to the Core Set is not unilaterally by CMS. It's a completely external stakeholder-driven process. So if the measures are brought and put forward for addition to the Core Set, they get discussed and debated and voted upon by the Core Set work group. So that's kind of how it is addressed -- is whether or not they are brought up in the Core Set annual review process; and then that determines what ends up on our Medicaid and CHIP Core Sets.

Jodi Anthony:

Great. Okay, let's see, I have a couple more here: "You mentioned the group prenatal care models. Are there states or example programs to point to outside of centering pregnancy?"

I think generally those are the models that have -- that is the model that has the most evidence.

Kristen Zycherman:

I know that was something that was looked at as part of the CMMI Strong Start Model, and I'm not sure if they limited it to centering pregnancy or whether there were other models taken into account for that particular one. But I would encourage you to look into the Strong Start findings.

Jodi Anthony:

"How about home health nursing and expansion of maternal/child health initiatives through nursing?" I'm thinking you mean like a nurse home-visiting model. Certainly that was one of – oh, were you going to say something?

Kristen Zycherman:

I was going to say the same thing. That is something that states have employed – various home visiting models, nurse/family partnership, other various nurse-driven home visiting models – and something that states are continuing to experiment with or implement if it has shown promise for them in a particular state. I don't know if you have other things to add, Jodi, go ahead.

Jodi Anthony:

That was exactly what I was going to say – and certainly considered one of the person-centered models as well. If you're looking for more information on informed, evidence-based models of home visiting, HRSA has a wonderful website that provides those examples.
Okay, I think those are all of the questions at this point. So unless there are additional questions, I'm just going to quickly go through the rest of the resources. Thanks, Sydney. Next slide, please.

So Kristen mentioned that there is a postpartum care learning collaborative or three webinars that we conducted where we highlighted in more detail some of what we shared today. You can find all of these on Medicaid.gov's website. After that series of webinars, we then and are currently in the second year of the Postpartum Care Affinity Group, where nine states – state Medicaid and CHIP programs – are learning together, testing different change ideas, and participating in quality improvement projects. Those states are Georgia, Kansas, Kentucky, Missouri, Montana, Oklahoma, South Carolina, Texas, and Wyoming. Next slide, please.

We've already covered the tobacco cessation. This is all of the various websites that you'll go to for things that are happening and all of what CMS is doing to support maternal health, infant health, in particular postpartum care.

There's the MIHI webpage. MIHI is the Maternal Infant Health Initiative webpage. We also have a Beneficiary Profile that provides a really comprehensive set of data. There's also much of the work that we are doing now and what Kristen described earlier is from the Expert Work Group's Recommendation Report. There's also more information about the Core Set and a Chart Pack which provides more detailed information about quality measurement and Core Set reporting. Next slide, please.

I think that is it. So, I'm going to go with the last comment that I see here, which is, "Thank you. This is so valuable." So, I'm hoping it was valuable to others.

Kristen Zycherman:

Jodi?

Jodi Anthony:

Yes?

Kristen Zycherman:

Sorry, Jodi, I think I see a couple questions that you may have missed.

Jodi Anthony:

Oh, great.

Kristen Zycherman:

I'm just scrolling back here. I see that there's a question: "Are there any CMS efforts to have doulas covered by CMS and not by the states?"

The issue with Medicaid – maybe not issue, maybe a plus/maybe a minus – is that it is a state- and federally-run partnership, so the states ultimately determine whether doulas are covered. Doula coverage is allowed by CMS, and there is a CMS informational bulletin that went out – well, it's been several years ago now, maybe 2016 if I'm remembering correctly – talking about doula coverage. Certainly if states have any trouble developing that, I encourage them to reach out to their state leads for help in figuring out the intricacies of that. But it is a state/CMS partnership, so I don't think that there are efforts currently for CMS to cover doulas directly in place of states.

Jodi Anthony:

Thanks, Kristen. I think the other question was about: "Are there thoughts on the role of digital platforms, like an actual virtual session to continue engagement over the full course of the postpartum year?"

What I can say is that I do think that there have been several pilots that have shown the importance and usefulness of virtual meetings. In particular, I've seen some work being done in terms of improving access for the people living in rural areas and how virtual platforms can be helpful. I don't know anything offhand specifically that CMS is working on, but there's certainly some work out there that I think you can probably (inaudible) some interesting pilots.

Okay, so I think -- Kristen, any last thoughts from you?

Kristen Zycherman:

I just want to thank everyone for joining. We appreciate all your efforts in partnering with us and with the communities to improve postpartum care and look forward to more in the future. Thank you.

Jodi Anthony:

Thanks, Kristen. Thanks, everybody. Thanks for your time this afternoon. Take care.