

Mathematica Webinar #1 Promoting Maternal Health Improvement
and Equity Through Collaboration-20240514 1802-1

[Derek Mitchell] Hello, everyone. My name is Derek Mitchell with Mathematica. Thank you for attending today's Medicaid and CHIP Maternal Health Webinar Series. This is the first webinar in the series titled Promoting Maternal Health Improvement and Equity Through Collaboration. Before we begin, we want to cover a few housekeeping items. Next slide.

All participants logged into this webinar have been muted for the best sound quality possible. Closed captioning is available by clicking on the CC icon in the lower left corner of your screen. You can also click Control-Shift-A on your keyboard to enable closed captioning. We welcome audience questions throughout today's webinar through the Q&A panel, which is located in the bottom right corner of your screen. If you would like to submit a question, please select All Panelists in the drop-down menu and then click Send to submit questions or comments. We will be monitoring the Q&A throughout the webinar and will address as many questions as possible. If you have any technical -- excuse me, if you're having technical issues, please use the same Q&A panel to reach out to us. Select Derek Mitchell in the drop-down menu and then click Send to let us know how we can help.

At the end of the webinar, our survey will pop up. We're asking you to please respond and provide feedback to help us improve future webinars. We also would like to let everyone know that today's webinar is being recorded. We will send an email to all meeting registrants when the slides and recording are posted to Medicaid.gov. Now, I'd like to turn it over to Lekisha Daniel-Robinson from Mathematica. Lekisha, you now have the floor.

[Lekisha Daniel-Robinson] Thank you, Derek, and hello again, everyone. During our presentation today, we will hear from Kristen Zycherman from the Center for Medicaid and CHIP Services, review and level-set on maternal health outcomes, introduce a framework for applying health equity in maternal health, and hear a state spotlight from Sarah Krinsky with MassHealth. The presentation will be followed by discussion, so please, you know, begin to tee up your questions, as Derek noted in the intro. I will now turn to Kristen Zycherman, Quality Improvement Technical Director at the Center for Medicaid and CHIP Services. Kristen.

[Kristen Zycherman] Thank you, Lekisha, and thank you all for joining today. I'm so excited to be welcoming you all on behalf of CMS to the MIHI Summer Webinar Series. This webinar series and the follow-up affinity groups have been a long time in coming, based both on feedback and interest from states, as well as data on leading drivers of severe maternal morbidity and mortality, as we'll hear more about later. Improving maternal health outcomes is a priority for CMS, and we're happy that you're all interested in working with us on this.

With that, I will go over the objectives for today's webinar. After today's webinar, you should be able to describe maternal health outcomes for individuals covered by Medicaid and CHIP, provide an overview of CMS's Maternal and Infant Health Initiative, describe opportunities to improve maternal health outcomes in Medicaid and CHIP, and present a framework for applying an equity lens to improve maternal health outcomes. Thank you again for your participation, and we are looking forward to seeing you on the rest of the webinars in our series, as well. And we encourage you to visit our MIHI website for more info on the series, as well as other MIHQI resources. So, now I'll hand it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you, Kristen. Next slide, please. I'll now review some of the maternal health outcomes among individuals covered by Medicaid and CHIP. Next slide. For most of you on the call, you know that the Medicaid and CHIP program provides a vital source of coverage for maternal healthcare. Approximately a quarter of all covered beneficiaries are females within reproductive ages. Forty-one percent of all births nationally are covered by Medicaid, and that amount is higher in some states. The map shows that variation across states where the darker color

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indicates the higher percentages of Medicaid-covered births, coverage between 45 and 67 percent, and the lighter shade, which represents fewer Medicaid-covered births, around 21 to 34 percent. Next slide, please.

This slide shows the distribution of Medicaid births by maternal race and ethnicity, which becomes important as we look at some of the outcomes later. Next slide, please. As we consider the outcomes of pregnancy, maternal deaths are a relatively rare event. However, any death has a tremendous impact on families, and many are considered preventable. In fact, most are considered preventable. The data presented here ranks the causes of death by race and ethnicity.

These data represent a broad population of pregnancies during the time period noted and are not limited to pregnancies covered by Medicaid and CHIP. For Hispanic and Latino individuals, behavioral health conditions and hemorrhage are the leading causes respectively, while cardiac conditions and infections make up the third leading causes for the population. For Black pregnancies, cardiac and coronary conditions, cardiomyopathy, and embolisms are the primary causes of maternal death.

And finally, for maternal deaths in White populations, behavioral health conditions are the primary cause, followed by hemorrhage and cardiac and coronary conditions, along with infections. The graphic does not show results for Native Hawaiian or other Pacific Islanders and American Indian or Alaska Native populations because these data do not meet criteria for statistical reliability, data quality, or confidentiality. However, there are concerns for these populations as well. Next slide, please.

More often occurring than maternal deaths are severe maternal morbidities. These are those unexpected outcomes that can have short-term or long-term impacts on health status and can have detrimental effects on families and infants. In Medicaid, these accounted for 372 births per 10,000 in 2021. Next slide, please. Here we present the primary mental health conditions associated with pregnancy and postpartum periods. Depression and anxiety are both associated with about one-fourth of all pregnancies.

Trauma-related symptoms and posttraumatic stress disorder, and in this case, partial PTSD, which are cases where not all of the diagnostic criteria are met, account for the rates that you see before you. PTSD may be associated with current or prior pregnancy experiences, such as miscarriage or preeclampsia, or other non-pregnancy-related traumas. These conditions may also co-occur, for example, depression and PTSD. All these conditions can have adverse effects on pregnancy and birth outcomes, maternal mental health, and deaths, as we saw in an earlier slide, as well as infant development. Next slide, please.

Yet we observe that there are some unmet needs where individuals are not receiving the treatment that they require for those conditions. The information presented here represents self-reported data among Medicaid and CHIP-covered individuals within the, generally speaking, reproductive age of adults. Next slide. Here we note the percentage of beneficiaries who self-report substance use disorders or illicit drug use or other misuse. Note we also include use of alcohol, which has significant numbers and is also associated with adverse outcomes. However, lately, it's not been the whole focus of attention, but there are some concerns associated there. Next slide.

In this slide, we share the percentage of females covered by Medicaid or CHIP or other state-sponsored plans who report being told that they have high blood pressure. This is for calendar year 2021. You see the rates by age noted along with the rates by race and ethnicity. So now that we've level set, just wanted to talk about CMS's commitment to addressing these outcomes in Medicaid

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and CHIP. In 2014, the CMS launched the Maternal and Infant Health Initiative, which Kristen talked about earlier, to focus on opportunities to improve access and outcomes in Medicaid and CHIP.

There have been a variety of activities to help states focus on quality improvement within their state programs. However, the increasing rates of maternal morbidity and mortality required additional focus, in part championed by the White House Blueprint for Addressing the Maternal Health Crisis and, frankly, the leading drivers of maternal morbidity and mortality data. There has been a shift, and we'll talk more about what that means for the initiative. Next slide, please.

Here we present a diagram about the pregnancy period and the infant outcomes associated with that. Pregnancy, labor and delivery, postpartum, interpregnancy, and that period afterwards represent some really important times to impact not only the maternal health, but the health of any infants that are born. Next slide.

The Maternal Health Webinar Series this summer and the associated affinity groups, however, will focus primarily on the maternal outcomes. There are opportunities associated with screenings at vaccinations, C-sections, those to decrease severe maternal morbidity, postpartum complications, and as well to think about management of chronic diseases, mental health conditions, and ensure that there is connection to ongoing preventive as well as chronic condition care, ultimately to improve the overall health status of individuals, as well as to improve the outcomes in any subsequent pregnancies. Next slide, please.

So a part of the CMS's action or activities associated with improving maternal health outcomes, there is an action plan which is informed by five pillars, coverage and access to care, data, quality of care, workforce and social supports. Each of those complement the blueprint that I mentioned earlier and presents several different opportunities for state programs to focus on quality improvement, as well as the other necessary supports to improve health outcomes. Next slide.

And finally, there are a few federal resources to improve maternal health outcomes, recognizing that this is a truly important time period and has a tremendous impact on the health of the nation. Each of the agencies represented here have -- these are just a sampling, in fact, of some of the activities that are available to improve outcomes. These are some that state Medicaid agencies, and their partners might have opportunity for collaboration and other elements that may be forthcoming that will be available for the broader population to use to impact maternal health outcomes. I'd now like to introduce Rishi Manchanda, Dr. Rishi Manchanda with HealthBegins, the CEO of HealthBegins. Next slide, please. Who will talk about finding a health equity lens to advance maternal health outcomes. Dr. Manchanda.

[Rishi Manchanda] Lekisha, thank you so much. And hi, everyone. Thanks for joining us today. I'm Rishi Manchanda with HealthBegins. We can move to the next slide. We wanted to talk to you today about applying an equity lens to support your work and to give you some more context about myself and my colleagues at HealthBegins.

I wanted to share some key observations that inform the framework we're going to share with you so far, and these are observations that are really not just for this framework and this conversation with you today but are really observations that inform our work with Medicaid providers, with community organizations, and with many others in the health plan space who are trying to advance and meet the growing healthcare equity and social needs requirements in the Medicaid space. The first observation is that health and social inequities are experienced as harm. And the second is that it's not individual behaviors, per se, but really social arrangements that put people, and some people more so than others, in harm's way.

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Thirdly, we understand that equity, therefore, is not just the absence of unjust differences between subpopulations, but it's really the presence also of systems that promote healing and opportunity and justice. Of course, as we understand these social arrangements and the structural kind of forces that put people in harm's way, the fourth observation becomes relevant, which is understanding that that harm is often segregated by location, and therefore any of the strategies that the institutions that provide care, provide services to Medicaid and CHIP beneficiaries, need to be place-based, goal-directed, and work across multiple levels.

And finally, last but not least, we really center our work in understanding that this is about supporting the courageous leaders out there on the front lines who are providing care with support and solidarity to implement strategies, especially equity-focused, upstream quality improvement strategies. And I'll talk more about that in a second. If we go to the next slide, we wanted to share how those observations are animated, how they kind of translate into action, and this is where the multilevel observation really becomes relevant.

In our work, we use an adopted version of the social ecologic model that many of you are familiar with to really become a practical tool to help clarify the different opportunities for advancing equity, starting in the smallest circle when it comes to programs and care, which is how Medicaid providers really can improve services and achieve goals for healthcare equity and social needs to the healthcare system itself and how Medicaid providers themselves can drive internal institutional transformation and culture change to support equity not just for beneficiaries but for employees as well.

At the community level, the ecosystem work is really thinking about ways in which Medicaid providers can work with partners in the community, including those who provide social services, and others to be able to strengthen the relationships across sectors to improve health equity. And lastly, but not least, how at the state level there are opportunities to be able to transform policies and put in place systems and structures to be able to achieve health equity as well. We believe this multilevel approach is really an important context for the conversation today and, of course, for thinking about quality improvement opportunities for the work that you're all pursuing. If we go to the next slide, I'll come back to this in a minute.

But first I wanted to spend a couple minutes just describing what equity-focused upstream quality improvement means. This is a term I just introduced a little bit ago. I know everybody here is familiar with quality improvement and many are experts in applying quality improvement methods and tools to advance better health for Medicaid and CHIP beneficiaries. Equity-focused upstream quality improvement means something a little different. It's focused on these questions of how to advance health equity and address the social drivers of health equity. And so, as we move to the next slide, a couple of key concepts I wanted to share, starting from the common challenges that we know exist when it comes to embedding equity in quality improvement work.

On the left-hand side, you'll see some of the challenges and some of the phrases that we often hear from providers, Medicaid providers and the healthcare system. Some staff, for example, we hear some providers saying that some staff don't think equity is quality work because we should be focusing on all patients. Why focus on just those who are experiencing certain inequities? Or how are we supposed to help address patients' social needs is a common question that many providers ask. At the community level, Medicaid providers and many that they partner with are asking questions about how to go from collecting race, ethnicity, and language data, real data, to acting on it, or asking questions in the middle column at the bottom about how to align equity efforts better when we're working within healthcare and in social services.

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And lastly, at the state level, we know that there are many challenges that we're also hearing about embedding equity in quality improvement work, including how do we help manage care organizations and providers drive equity-focused quality improvement? How do we address equity in different environments, of course, political environments across the country as well, especially ones that have variable access to care? When it comes to advancing equity-focused quality improvement, my question to you, and I really encourage you to feel free to engage in the chat or to put questions in, is when it comes to advancing equity-focused quality improvement, what challenges are you or others that you work with experiencing? In our experience, some of these challenges on the screen here are common ones, and one of the common challenges is, as we go to the next slide, is just the definitions and the concepts.

We find a lot of folks in this space right now who are working in Medicaid and CHIP are using terms of health equity and healthcare equity sometimes interchangeably in ways that confuse things. So, for example, we know that health equity, as is commonly understood in the definition on the screen, as meaning that everyone has the opportunities and resources they need to be as healthy as possible and that no one is disadvantaged due to social circumstances, that that definition is something that is widely kind of held. An emerging area of focus and of clarity really is understanding that healthcare equity is a specific element and a specific step in achieving broader health equity. And healthcare equity, as you can see on the definition here, more narrowly describes equity and the experience of accessing and interacting with the healthcare system specifically in its organizations. This distinction of healthcare equity versus health equity is we find an important element of informing what equity-focused quality improvement can look like.

If we go to the next slide, this also helps us understand social needs and social determinants in a clearer way to understand really that these are social drivers of health and of health equity and to understand that there's a relationship, again, with a multilevel understanding of individual-level social risk factors or social needs, social needs being the social risk factors that individuals identify, disclose, and prioritize, and how those individual risk factors and social needs are influenced themselves by social determinants of health or social drivers of health at the community level, which in turn are, of course, shaped by the deeper structural drivers or structural determinants of health equity, which include the various norms, the macro policies, and, of course, the structural mechanisms that shape the distribution of resources and opportunities, including the distribution of social determinants of health and the distribution and severity and the chronicity of social risk factors.

In other words, health equity is influenced by social drivers of health, and we see an opportunity here to take what we often find is happening on the front lines where there's a disconnect in the discussion about social needs and social determinants from emerging conversations around health equity and healthcare equity. In this context, we're talking about health equity and the social drivers of health equity as a unifying kind of concept.

As we move to the next slide, these concepts are important because this is what underscores an equity-focused upstream quality improvement approach. At a high level, what you see here using the left is a get ready, get set, go approach. This approach really starts with getting ready, meaning getting grounded in the history of how structural forces, including social racism and social arrangements, have impacted some populations more than others and denied opportunities for health. It means looking at data itself, especially being able to understand that data from a structural perspective. It also means engaging and reaching out to people with lived experience as well as, of course, providers and community partners to really engage with that data and that history to make sure that at the outset we're engaging those most impacted by health inequities in

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the design of quality improvement efforts. And it also means looking within, doing an assessment of our own data systems.

This is true for, I think, providers and also at the state level. What does it mean to look within and address our capabilities and our competencies when it comes to equity-focused quality improvement? That get ready process is really a foundational step before getting set. And that get set process, as you can see here, is really a step-by-step process of being able to identify specific patterns of inequity informed by data, for example, inequities of maternal depression that may exist along racial lines, and then being able to identify priority populations, identifying the associated social structural drivers of those inequities, and then identifying opportunities to intervene on those inequities, setting specific aims and measurement plan, selecting early wins and solutions from a menu of opportunities, and then being able to design a quality improvement campaign to pursue those opportunities, which is where the go comes in.

This is an approach that has been tried and true in many different settings across the country. We've worked last year in 29 states using versions of this approach with many different healthcare stakeholders, and I wanted to share it with you here. So, we can go to the next slide.

One key point here in doing the work of equity-focused upstream quality improvement is really about goal setting, about setting those aims when we identify a specific pattern of inequity. So, for example, if we're looking at inequity in pregnant people who are disproportionately experiencing a depression, antepartum or postpartum depression, there is obviously a quality improvement edict that allows us to focus in on setting a clear utilization goal. For example, within 24 months, let's achieve a 20 percent increase in the rate of depression screenings in the entire population and reduce inequities that correspond to that. That itself is not an equity-focused goal. It's a good utilization goal, but an equity-focused goal, as you can see in the second row, is really about getting precise about closing those inequities that exist in that particular outcome. So, for example, decreasing racial inequities in perinatal depression screening.

And finally, an upstream kind of focus, looking at the social drivers of those inequities, allows us to identify at least one social driver of that inequity that we want to influence as well. Equity-focused upstream quality improvement starts with being clear in setting goals, not just for an entire population, but to be clear about setting an equity-focused goal, as well as an upstream goal, in other words, a goal to address the social drivers of that inequity as part of the quality improvement process. So that's an introduction to the equity-focused upstream quality improvement framework.

But if we go to the next slide, the more relevant question, I'm sure, for all of you here today is, so what are the concrete opportunities to be able to apply an advanced equity lens in the work that we're doing? And in the next slide, I'll just describe briefly that, from our perspective, we see opportunities for equity across many levels, including levels of prevention and intervention. On the right-hand side, you'll see a description of levels of intervention, such as at the system level, which means for Medicaid providers, how do we improve the effectiveness of services or build institutional capabilities? At the ecosystem level of intervention, again, on the right, what does it mean to actually help providers not just deliver better care, but to coordinate that delivery of services and to coordinate resources in the ecosystem in which they work with other partners?

And then finally, at the state level, we know that there are levels of intervention there as well, many opportunities to advance equity. There are also opportunities across levels of prevention on the right, right? So, from health promotion to prevention, including primary prevention, where we're trying to prevent the onset of a disease, secondary prevention where we're trying to slow the progression of a disease that's been identified, or even treatment, which is helping to, of course,

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treat those who are already suffering from a condition. In other words, equity opportunities exist across levels of prevention and levels of intervention.

And the key set of questions to inform the identification of those opportunities to advance equity starts with an assessment set of questions and a planning set of questions. So, for example, for any given condition, maternal mental health, what level of intervention or for that matter what level of prevention is your program enabling, is your agency kind of enabling to either prevent or improve this condition? In our experience, many times we don't see this kind of classification process, this categorization or assessment process to look at levels of intervention or prevention when assessing how we're addressing a particular condition. And that also informs the planning process, which is to say, well, now we've done this assessment, are there additional opportunities beyond what we're already doing to lead, to partner, or even support equity-focused efforts across other levels of intervention and prevention.

My last slide here, the next slide, is going to be a way to give you an illustrative example of what happens when we actually go through a process of assessing opportunities to move upstream. For example, using maternal mental health as a specific condition, a focus area, there is a whole portfolio of health equity improvement opportunities that exist across levels of intervention, which are the columns that you can see from left to right, systems, ecosystem, and state Medicaid program. And there's also a way to appreciate those opportunities across levels of prevention, which you can see going from the top to the bottom on the left-hand side, from promotion to levels of prevention as well as treatment. And what we've populated here is just some examples that come from the field, come from both the published literature as well as the great literature of what we're seeing across many states in Medicaid and CHIP experience specifically of ways to be able to advance equity.

The goal here is not to pick one opportunity to pursue equity or to pigeonhole equity as one type of activity to check the box on, but instead to see equity as really something that we can advance with multilevel approaches across levels of prevention and intervention and to do so in a way that creates a portfolio approach. Instead of one program, how do we look at our different programs and create a portfolio of approaches to be able to advance equity? I know that there's a lot that I've covered here today, and there's wonderful examples on the slide. But to really bring this home, I'm excited to know that we're going to have a concrete example coming from our friends at MassHealth in a second. With that, I'll turn the floor back over to Lekisha.

[Lekisha Daniel-Robinson] Thank you, Rishi, for that. Well, now I'd like to introduce Sarah Krinsky, who is a passionate maternal health advocate and trained birth doula. She is also the deputy director of perinatal and maternal health policy at MassHealth, Massachusetts Medicaid and CHIP program, which covers roughly 40 percent of all births in the Commonwealth. Sarah.

[Sarah Krinsky] Thank you, Lekisha. Thanks for having me. You can go to the next slide, please. And just want to acknowledge, I think we're really thrilled to see all of the investments and the momentum to address maternal health equity at the federal level. A lot of the work that Lekisha highlighted earlier is so critical. And we're also really grateful here in Massachusetts to have our administration so committed to prioritizing maternal health in Massachusetts, especially since we've seen from our partners at the Department of Public Health, rates of severe maternal morbidity have doubled in Massachusetts between 2011 and 2020. And we also see disparities in terms of Black birthing people and those with disabilities in particular who are at increased risk. So really grateful to have both the state and federal level momentum around this.

As Lekisha mentioned, MassHealth is Massachusetts Medicaid and CHIP program, and we cover roughly 40 percent of births in the Commonwealth, which is about 25,000 births per year. And at

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MassHealth, we're really taking a multi-pronged approach to try and improve the health outcomes of our diverse pregnant and birthing members and their infants by providing equitable access to high-quality healthcare services and supports. So, on the page here, this is not an all-inclusive list, but we wanted to highlight a few key policies, both those that have been implemented already, and then also some that we're actively exploring currently.

So first off, in April 2022, MassHealth expanded coverage through 12 months postpartum, inclusive of all pregnancy outcomes. So critical, especially as we know that the vast majority of maternal deaths happen in the 12-month postpartum period. We also cover undocumented, pregnant and postpartum folks at state cost here in Massachusetts through MassHealth. Our accountable care organization -- something key to note here is that in Massachusetts, the vast majority of our MassHealth members are in managed care. So, either an accountable care organization, ACO, or in some cases, a managed care organization or MCO. And within those constructs, we have requirements to identify high risk perinatal members for enhanced care coordination, as well as to receive critical housing and nutrition supports. I also wanted to note that many of our ACOs also offer additional services or benefits on top of this. Things like free car seats, et cetera.

Particularly very excited about this, myself being a doula, that as of December 8th, 2023, about six months ago, MassHealth covers doula services for pregnant, birthing and postpartum members. And that also is through the 12-month postpartum period, inclusive of all pregnancy outcomes. And we know that doula services are an evidence-based approach to improve outcomes for parents and babies. MassHealth is also investing millions of dollars to tackle perinatal care quality and equity, both within our ACOs and our ACO participating hospitals. We require and pay for postpartum depression screenings at every pediatric visit. And then we also have family planning policies with robust access to contraceptives.

Again, those are just some highlighted policies, but ones that we think are really important to prioritize maternal health here in Massachusetts. In addition to those policies that were already implemented, we also are actively exploring and developing policies and have initiatives in several other areas. One of our main focuses is really continuing our member outreach efforts related to coverage and services. So, we know that we can cover really great services like doulas and other things, but if members don't know that we're covering them, we have a problem on our hands. So really trying to make sure that folks are aware of what we cover and can get access to those services in an equitable way. We're also working, especially with our partners, again, at the Department of Public Health in Massachusetts on expanding our maternal health data collection and analysis efforts so we can really make informed evidence-based policy decisions.

We are actively exploring coverage of perinatal remote blood pressure monitoring, as well as payment parity for certified nurse midwives or CNMs. And then finally, we're exploring a number of other key policy areas, including reviewing our global obstetric fees, sometimes referred to as a bundle payment. We're looking a lot at home visiting, perinatal behavioral health, especially substance use disorder. We know that SUD is a driving factor of maternal deaths, especially in Massachusetts. And then finally, breastfeeding and lactation support. Again, lots of other work underway, but wanted to highlight a few key areas here. And I think we all know we have a lot of work to do. At MassHealth, we are committed to doing our part to improve maternal health and reduce disparities in Massachusetts. Thank you so much for having me. And I'll turn it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you, Sarah. I appreciate both of those presentations, and now we will open it up for questions and discussion. So next slide will show you again how to submit your questions via the Q&A function below. And you all have been thinking already, so we'll get to those

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questions momentarily. But I would like to announce that the Biden-Harris administration announced just before the start of this meeting, the Maternal Mental Health Task Force's National Strategy to Improve Maternal Mental Health Care Amid Urgent Public Health Crisis.

We'll put the link to that announcement and the strategy in the chat for you to check out as you are able to. But to the questions that have come in, so this first one here is about data. And the question is, is there a way to move forward if you can't get data, but there is an opportunity to do so, but you can't quite quantify it? So if so, how would one go about that? I'll pose that one to Rishi from HealthBegins.

[Rishi Manchanda] Can you repeat the question one more time, Lekisha, please?

[Lekisha Daniel-Robinson] Sure. So is there a way to move forward if you can't get data, but know that there is, in fact, an opportunity, but you're just not able to quantify it? And if so, what would you recommend?

[Rishi Manchanda] Yeah, I really appreciate the question. It's such a great insight. And it speaks to the foundational importance of data collection and stratification, really, because the quality of, the validity of race, ethnicity, language data, for that matter, sexual orientation and gender identity data or other data fields really allows us to be able to identify any previously invisible patterns of inequity that may exist in outcomes. And to the questioner's point, it can feel somewhat limiting or challenging to try to implement a quality improvement effort that's equity-focused if we don't have those insights to begin with, if we don't feel like we have enough data or high-quality enough data to do that. And so, this is not an uncommon challenge.

The good news is that we're not alone in experiencing that. And the ways in which we've seen the vanguards kind of address this, both at the local level, the state level, and even through national collaboratives now is to actually turn the goal of data collection and stratification into the primary kind of quality improvement focus for when data is challenged, when data is limited. So, in other words, how can we create an improvement campaign to first assess the quality and validity of the data we have, identify the gaps when it comes to race, ethnicity, language, or other forms of data, and then be able to set, based on our priorities at the local level, at the national level, then set really clear, demonstrable goals to be able to improve the collection quality of that data, as well as to be able to then practice stratifying that data to uncover any disparities or inequities. So, data collection is a foundational challenge, and I think that it can also be a starting point for really powerful quality improvement campaigns in and of itself.

[Lekisha Daniel-Robinson] Thank you, Rishi. Our next question I think I'll pose to both of you. It is, if we're just starting to think about addressing -- well, I'll pose it to Rishi first. If we're just starting to think about addressing social drivers of maternal health outcomes, where do you recommend that we start? And then I think I'd like to get a reaction from you, Sarah, about your state's starting points.

[Rishi Manchanda] Yeah, again, great question, and I'll be brief so we can hear from Sarah. The good news is there's a lot of great starting points, and, of course, it depends on the specific situation in your state as you're thinking about where to start or where to build on social needs or social drivers work. In many cases, there are a variety of healthcare settings that are already starting to collect social needs, and social needs screening kind of questions becomes a big part of this. And so, are there opportunities to be able to improve and standardize screening of social needs?

There are opportunities beyond screening, of course, to thinking about the ways to collect and code and collect and share the data on social needs as well, and so there's varieties of quality

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improvement opportunities in that step. And then there's, of course, opportunities to think about how to connect individuals who have identified social needs with opportunities in the community, and this is where there's a lot of work being done right now to help not just implement closed-loop referral systems, to be able to connect people to resources in the community, but to go beyond measuring referral rates to actually successful connections, in other words, where the social needs actually met as well. So the good news is there's a lot of wonderful efforts going on and a lot of great practices that are emerging across many states right now to be able to improve any one of those, screening, collection, encoding, data sharing, as well as referrals and successful connections to social needs in this space. Sarah, I would love to hear from you about your thoughts about that question.

[Sarah Krinsky] Sure, and sorry, I think I missed the question. It's about data collection?

[Lekisha Daniel-Robinson] Right, so if you're thinking about addressing social drivers and maternal health outcomes, kind of what that start might be.

[Sarah Krinsky] Sure.

[Lekisha Daniel-Robinson] Yeah.

[Sarah Krinsky] Yeah. A lot of the work that MassHealth is doing in terms of health-related social needs is happening within our managed care program. So, like I mentioned, I think I mentioned the vast majority of MassHealth members who are pregnant or postpartum are in managed care. It's actually about 90 percent. And so I think a lot of the work that's being done around identifying folks who have needs, connecting them to services, and then really the care coordination and making sure that those services are actually being accessed. And also when you have a number of cooks in the kitchen, kind of just coordinating to make sure that the member is at the center and really getting streamlined support as well. A lot of that is really happening within our managed care plans.

[Sarah Krinsky] Lekisha, can I add on to that to Sarah's point and share it with you first?

[Lekisha Daniel-Robinson] Sure.

[Sarah Krinsky] So in the spirit of kind of plugging your resource as well, I'll see if I can put this into the chat, and this might be a helpful resource as well. One of the things that's emerging is a really great cataloging of the ways in which vanguard states, including what Sarah and your colleagues are doing in Massachusetts, there's a lot of cataloging now of a lot of the work that's happening in social needs and organizations like Kaiser Family Foundation, for example, are cataloging some of these things. Our friends at the Center for Healthcare Strategies are some, and then even with the link I put in the chat around food security specifically, there's a cataloging now what's happening in the Medicaid space around food security screening. And so there are a great number of resources as well that can be really helpful in answering that question, too, as people are thinking about how to just advance their work on addressing social drivers.

[Lekisha Daniel-Robinson] And one way that some states are addressing social drivers is around the use of doulas in order to make connections within the community to additional services, in addition to the support that they provide during delivery. So a number of questions have come in for you, Sarah, around doula care. So first --

[Sarah Krinsky] Sure.

[Lekisha Daniel-Robinson] So there's a pop-up here that I can't quite seem to get rid of so I can see the rest of the question. But the first one is around the certification and services. Who is overseeing

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that in Massachusetts and whether or not there is a global fee associated with maternal care? So just kind of an understanding of what the payment landscape looks like, the services and the certification.

[Sarah Krinsky] Sure. Yeah. Happy to talk a little bit about this. And I just put a couple of links in the chat that have a lot more information about our doula program if anyone wants to get into the weeds on that. We have both a member facing webpage that's translated into our top six languages that members speak. And then we also have a doula facing webpage that gets into the nitty-gritty details around regulations and payment and all of that. But just a couple of key highlights of our policy.

So, in terms of qualifications for doulas, unlike in many other states that cover doula services through Medicaid, which I believe there's like 12 or 13, at least 12 or 13 states that currently cover doula services through Medicaid. Unlike in many of those states, currently our Department of Public Health doesn't certify or credential doulas for the entire Commonwealth of Massachusetts. There wasn't a bill or legislation that passed saying that our department had to do that. And so, in the meantime, MassHealth, when we started covering doula services, put into regulation our qualifications for what it takes to enroll as a MassHealth doula provider.

We have two pathways for folks to enroll as doulas, recognizing that doulas come into this work through a variety of ways. We have both the formal training pathway, and we also have an experience pathway. And both of those pathways are really centered around a list of competencies as opposed to, for example, having a specific list of training organizations that are acceptable as an example. And in terms of payment, that information is available on the doula-facing webpage that I posted in the chat.

We pay for up to eight hours of perinatal visits, which can happen anytime during the pregnancy period and then 12 months following the end of pregnancy based on the member's needs. We also have a prior authorization process if a member needs more than those eight hours of visits during the perinatal period. And then in addition, we cover the labor and delivery support. And all of this is inclusive of all pregnancy outcomes through 12 months postpartum.

[Lekisha Daniel-Robinson] Great, thank you. More questions for you around the doula care in particular. Have you been able to assess the impacts of doulas on care?

[Sarah Krinsky] Yeah, that's a great question. We're definitely going to be looking at that. So, the benefit only went live about six months ago, and we've really been focusing the last few months on just enrolling a robust network of MassHealth doula providers, not only in terms of volume, but making sure that we have doulas who reflect the needs of our members in terms of their language, their race and ethnicity, their cultural background, where they live. So that's been our primary focus so far, although we do have members who are already accessing doula services, which is great. We will be tracking outcomes and looking not only to see what impact doula care has on our members, but also looking at gaps, you know, who doesn't have access or who has access but isn't utilizing the benefit. But in the meantime, we do have a robust body of literature that I think is pretty clear on the benefits of doulas, particularly for reducing inequities in maternal health outcomes.

[Lekisha Daniel-Robinson] Indeed, there are. But I know a number of people want to see what it looks like from a Medicaid specific perspective. So, I think we have a number of states that we can look to for that in the coming years. Another question related to just the breadth of services that you are offering. How are you letting your constituents know about them? What does your outreach look like?

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[Sarah Krinsky] Great question. Yeah. Member outreach is so critical. And this is something that it's a journey. I don't think we'll ever get to a point where we say, we have reached our end of -- you know, this is what it looks like to outreach to members. So it's an evolving journey. We have focused a lot on just getting information on the Web. So, for example, I'll put in the chat in a second, we have what we kind of call a one-stop shop for mass health members who are pregnant to go and see kind of everything that you might need to know when you become pregnant. I think anyone who's on the line who's been pregnant knows it can be very overwhelming.

You know, where do I go for prenatal care? What do I need to be thinking about? How do I prepare for baby? And so we created this webpage, again, translated in the top languages that our members speak as a one-stop shop with a checklist of these are the types of things you should be thinking about and talking to your provider about, here are all of the different supports that might be available to you. We're also working on continuing to ramp up our communications materials again, multilingual and really thinking about how we can meet members where they're at in community. We've been attending community-based events.

So our team has been to a couple of community-based baby showers and really kind of going to, again, meet members where they are and trying to get the information out. And we also rely heavily on our partners, our managed care health plans, our clinicians, our partners at the Department of Public Health and other state agencies, as well as a number of community-based and advocacy organizations. So really relying on them as well to help us spread the word far and wide.

[Lekisha Daniel-Robinson] Great. Thank you so much. I'll give you a moment to catch your breath. A different type of question has come in as well, and it is about the data presented earlier, the substance use data and whether or not -- it's from -- I know that name -- if the data presented includes tobacco use. And it does not include tobacco use, we do have some data broken out specifically about maternal tobacco use. But the data on that particular graphic does not include that information. Okay. Let's see, what else do we have? This conversation is so good. So how was the transition from doula being paramedical and OOP to a state-funded and traditional billing service? I know you're only six months in.

[Sarah Krinsky] Yeah.

[Lekisha Daniel-Robinson] So there's certainly probably a curve there, but any early lessons?

[Sarah Krinsky] It's a great question. I think it's, you know, it's early on in the process. But, you know, I think there's a lot. There's a lot that is unknown and we know that they're going to continue to be things that come up, questions, challenges, potentially just by virtue of the fact that at least in Massachusetts, for the most part, doula have not been integrated into the formal healthcare system in a way like this. MassHealth is the first payer to pay for doula services. And so that brings a number of kind of unique challenges and also opportunities.

So, I think, you know, part of our focus, and this, again, is really something that we're focused on with our partners at the Department of Public Health, is really thinking about how we can ensure that doula are integrated into the care team at various hospitals and with providers and that members are getting these services in a holistic wraparound way. So hopefully we'll have more lessons learned to share as we're a little bit further along in the program.

[Lekisha Daniel-Robinson] All right. Thank you, Sarah. So, this one is for you, Rishi, but perhaps you might want to address as well, Sarah. But I'll give you a moment. So, it's a data question. For some populations that can be vulnerable to harm through data collection being stored, i.e., language as a proxy for immigration or SOGI data, are there any recommendations or best practices that you

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might recommend to collect and store the data responsibly? Or is that data that should not be collected? What are your thoughts there? Let's start with you, Rishi.

[Rishi Manchanda] Thanks, Lekisha. It's such a great question, and I think it's relevant to not just data on language, but there are certainly kind of valid concerns around other types of data as well. So, for example, there are some stakeholders that have raised concerns about sexual orientation and gender identity, given the concerns about how that data might be used as well. So it's a really important concern and a valid one. I think what we found, and I can share it in the resource in the chat shortly, with some concrete tips that we pulled together from about 50 stakeholders across the country a couple of years ago when we were thinking about ways to improve data collection to advance racial equity, specifically in primary care.

And some of the tips start with the ability to, from the get-go in the planning and the design of a data collection effort or any equity-focused quality improvement effort, is to really sit down first with partners and key stakeholders in the community, including organizations that represent people with lived experience, if not people themselves. It's so fundamentally important to make sure that the process is as inclusive as possible, rather than coming in after the fact and realizing that there was a key concern that a stakeholder group had about privacy or concerns and finding later that it's too late to kind of address the problem.

So step one is really making sure that the process is as inclusive as possible and you're bringing in key stakeholders. To answer some of these questions, there are technical kind of challenges as well that I think can be unique to certain states. And, Sarah, I'll welcome your thoughts on this question about what it looks like in Massachusetts. But for the most part, it really starts with making sure that there is key engagement of stakeholders in the design of any data collection effort.

[Sarah Krinsky] Yeah, I mean, so this is a complex one. There's a lot going on here at MassHealth in terms of data. I think, you know, one piece to highlight is we're really trying to work on kind of streamlining. There are so many different data sources, some of which we have ownership or access to, for example, claims data. But then there's so many other data sources, some of which live within our Department of Public Health and other places. So really trying to find ways to integrate all of those data sources to get the full picture, including looking at both the parent as well as outcomes for the child, which is difficult to link the parent and baby sometimes using claims data alone since the data would be living in those two separate places.

So, we're working a lot on this. I would also just add, you know, I think sometimes when we talk about data, I know at least with, my brain goes to numbers. But we also are really working also on collecting data in the form of qualitative experiences of members, for example, from members, from providers, et cetera. So also, I would just kind of note the importance of not only the quantitative, you know, what are we seeing in terms of outcomes or utilization, but also looking at what is the member experience? What does it look like to be, in our case, a MassHealth member trying to get access to some of these services and really leveraging that to improve equitable access to care?

[Lekisha Daniel-Robinson] Thank you. We are running close on time. I wanted to read a comment that was shared from South Dakota. South Dakota Medicaid recently started a pregnancy program. One of the enhanced payments program enrolled providers can bill to in South Dakota is SDOH screen. We will also allow an enhanced payment for a person-centered care plan which will be partially derived from the SDOH screen. So just wanted to end with that. I wanted to say that this has been a fabulous start to the webinar series. Next slide, please.

Thanks, of course, to our presenters and to the audience engagement. Next slide. Just wanted to share a few of the upcoming webinars within the series. June 4th is our next one, followed by the

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others that you see before you. These webinars will include state presenters, experts and other federal agency representatives. And we look forward to you joining those. Next slide, please.

And then on August 6th, there will be a webinar that will describe and provide information on the affinity groups that we talked about. There will be an affinity group on addressing maternal mental health and substance use, as well as one on improving maternal hypertension control. So, stay tuned for more information on that one as well. And finally, next slide, please.

Thank you again for your participation. As Derek noted at the start of the webinar, there will be an evaluation that comes up as you exit. Please complete it. It helps to inform future webinars. And if you have any questions, please email them to MedicaidCHIPQI@cms.hhs.gov. Thank you again for joining us today. And I look forward to hearing from you in future webinars. Take care.