

Medicaid and CHIP Maternal Health Webinar Series: Maternal Mental Health Screening, Treatment, and Improvement Strategies

June 4, 2024

Kristen Zycherman, Center for Medicaid and CHIP Services

Lekisha Daniel-Robinson, Mathematica

Nima Sheth, Substance Abuse and Mental Health Services Administration

Meagan Chuey, Michigan Department of Health & Human Services

David Kelley, Pennsylvania Department of Human Services

Technical Instructions

Welcome to the CMS Maternal Health Webinar Series!

- All participants are muted upon entry
- **Close captioning** and WebEx assistance can be accessed at the lower left of the window
- There will be a **Question and Discussion session** at the end of the webinar
 - Please **submit questions using the Q&A panel** throughout the presentation
- Please contact **Derek Mitchell** (Host) through the Q&A panel with any **webinar platform issues**
- There will be a **survey pop-up** at the end of the webinar; please complete this survey before leaving the meeting
- A **recording of the meeting and slides** will be available after the webinar on Medicaid.gov
 - You will receive an email when these materials are posted

How to Submit a Question

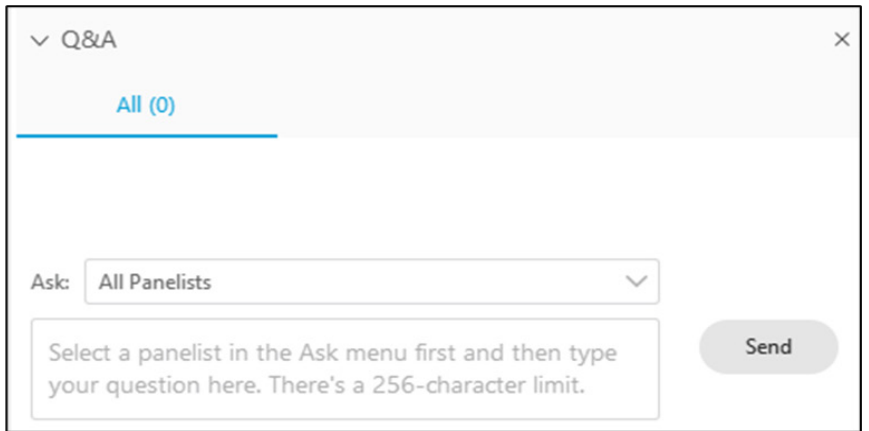
- Use the Q&A panel to submit questions and comments

- To submit a question or comment, click the Q&A panel and select “**All Panelists**” in the “Ask” menu

- Type your question in the text box and click “Send”

- Note: Only the presentation team will be able to see your questions and comments; your questions will be read out for all participants to hear both the question and the discussion

- For webinar platform issues, select “**Host**” in the “Ask” menu



A screenshot of a Q&A panel interface. At the top, it says 'Q&A' with a dropdown arrow and a close button. Below that, it says 'All (0)'. There is a dropdown menu labeled 'Ask:' with 'All Panelists' selected. Below the dropdown is a text input field with the placeholder text 'Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.' To the right of the text box is a 'Send' button. Two red arrows point from the text in the first list item to the 'All Panelists' dropdown and the text input field.



A screenshot of a Q&A panel interface. At the top, it says 'Q & A' with a dropdown arrow and a close button. Below that, it says 'All (0)'. There is a dropdown menu labeled 'Ask:' with 'Host' selected. Below the dropdown is a text input field. A red arrow points from the text in the second list item to the 'Host' dropdown.

Agenda

Topic	Speaker
Introduction	Lekisha Daniel-Robinson, Mathematica
CMS Welcome and Objectives	Kristen Zycherman, CMS
Maternal Mental Health Overview	Lekisha Daniel-Robinson, Mathematica
National Strategy to Improve Maternal Mental Health Care	Nima Sheth, SAMHSA
State Spotlight – Michigan	Meagan Chuey, Michigan Medicaid
State Spotlight – Pennsylvania	David Kelley, Pennsylvania Medicaid
Questions and Discussion	Lekisha Daniel-Robinson, Mathematica

Objectives

- **Provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP**
- **Describe maternal mental health challenges for individuals covered by Medicaid and CHIP**
- **Provide an overview of the National Strategy to Improve Maternal Mental Health Care**
- **Learn about strategies to address maternal mental health in two state Medicaid and CHIP delivery systems**

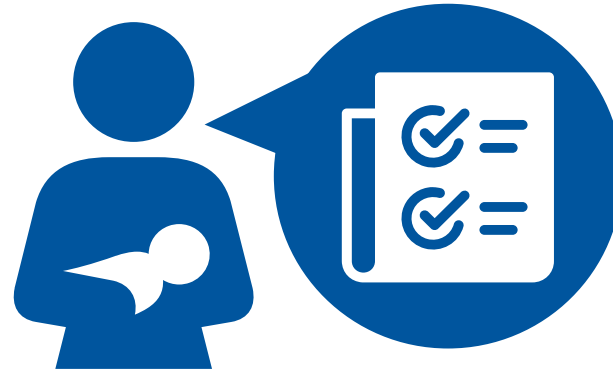
Maternal and Infant Health Initiative

- **The Centers for Medicare & Medicaid Services (CMS) launched the Maternal and Infant Health Initiative (MIHI) in July 2014 to focus on opportunities to improve access and outcomes in Medicaid and CHIP**
 - Emphasizes the need for a comprehensive life-course approach to maternal and infant health
- **Increasing rates of maternal morbidity and mortality and unacceptable disparities led to the White House Blueprint for Addressing the Maternal Health Crisis**
- **Leading drivers of maternal morbidity and mortality in Medicaid and CHIP are associated with treatable conditions such as mental health, substance use disorders, and hypertension and cardiovascular conditions**

Maternal Mental Health Overview

Lekisha Daniel-Robinson, Mathematica

Prevalence of Maternal Mental Health Conditions



Depression

25.4%

Anxiety symptoms

23%

PTSD full

7.6%

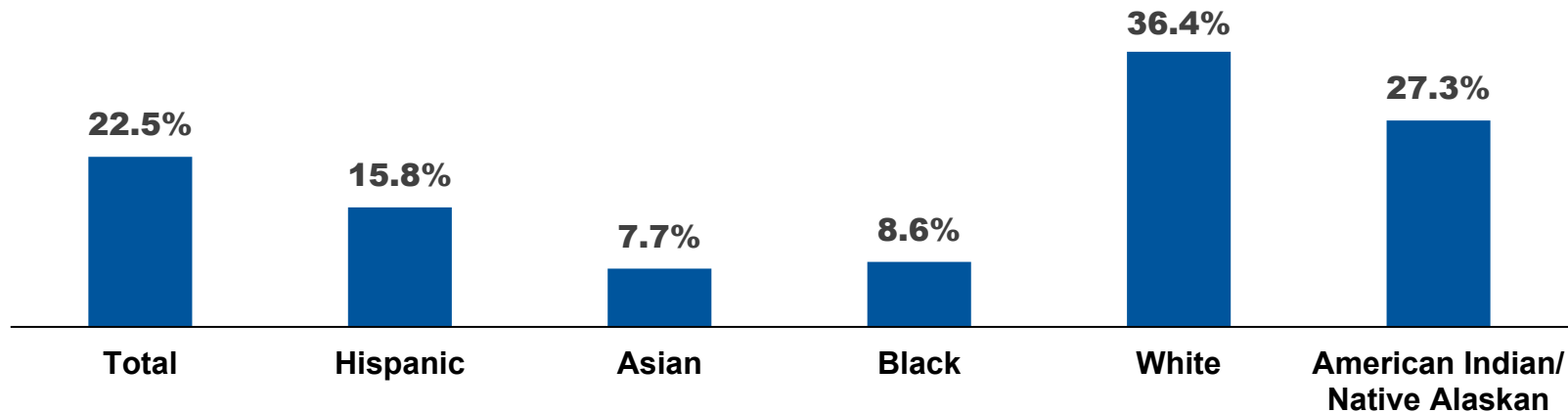
PTSD partial

16.6%

Clarke DE, De Faria L, Alpert JE, The Perinatal Mental Health Advisory Panel, The Perinatal Mental Health Research Team. Perinatal Mental and Substance Use Disorder: White Paper. Washington, DC: American Psychiatric Association; 2023 [Available from: <https://www.psychiatry.org/maternal>].

Prevalence of Pregnancy-Related Deaths with a Mental Health Condition as the Underlying Cause, by Race and Ethnicity (2020)

Percentage of Pregnancy-Related Deaths with Mental Health Conditions as the Underlying Cause, 2020



Note: Pregnancy-related deaths are defined as those “that occur during pregnancy, at the time of delivery, or within 1 year postpartum, regardless of the cause, location of pregnancy, or pregnancy outcome”

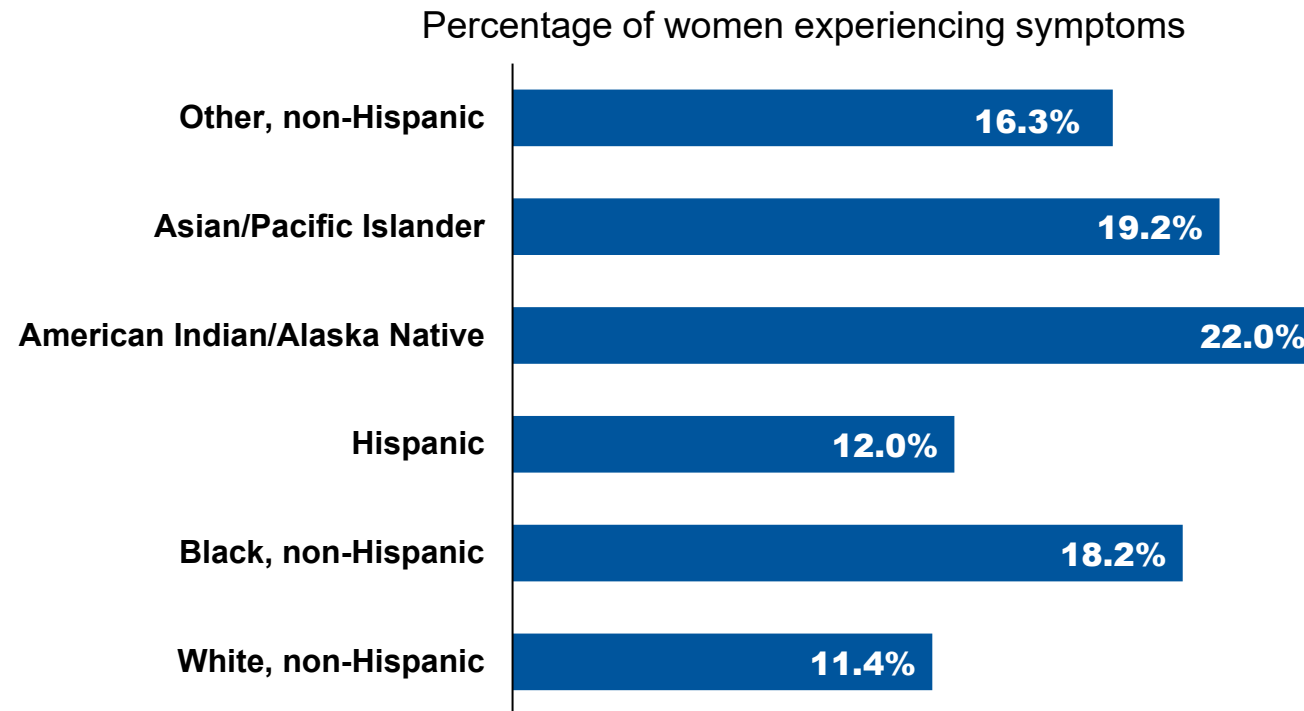
Trost SL, Busacker A, Leonard M, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 38 U.S. States, 2020.

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2024

Trost SL, Busacker A, Leonard M, et al. Pregnancy-Related Deaths Among American Indian or Alaska Native Persons: Data from Maternal Mortality Review Committees in 38 U.S. States, 2020. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2024.

Prevalence of Postpartum Depressive Symptoms by Race and Ethnicity

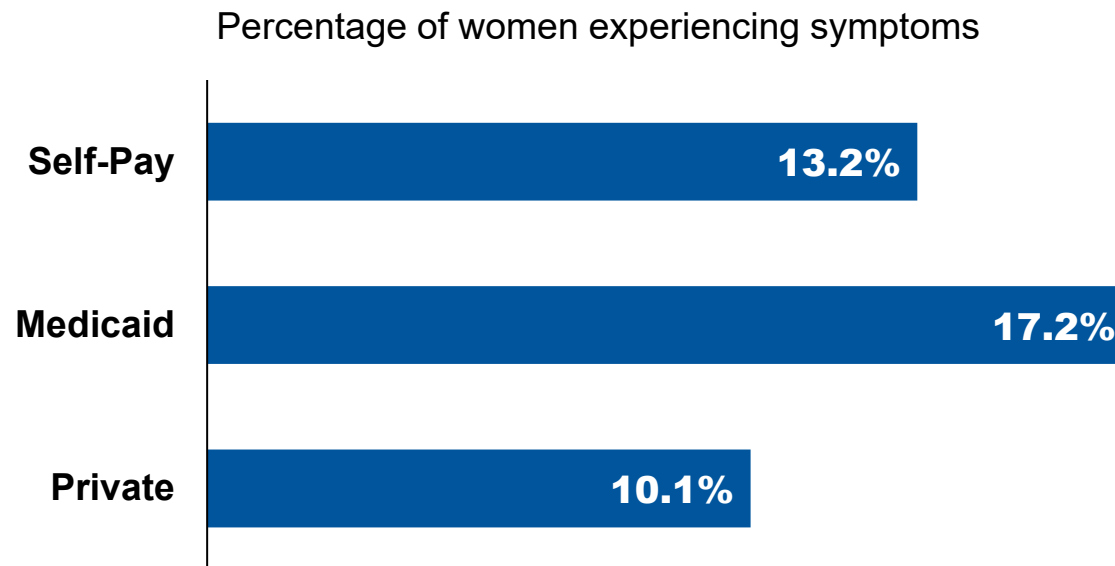
Prevalence of self-reported postpartum depressive symptoms among women with a recent live birth by race/ethnicity (2018)



Bauman BL, Ko JY, Cox S, et al. Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression- United States, 2018. MMWR Morb Mortal Wkly Rep 2020;69:575-581. DOI: <http://dx.doi.org/10.15585/mmwr.mm6919a2>

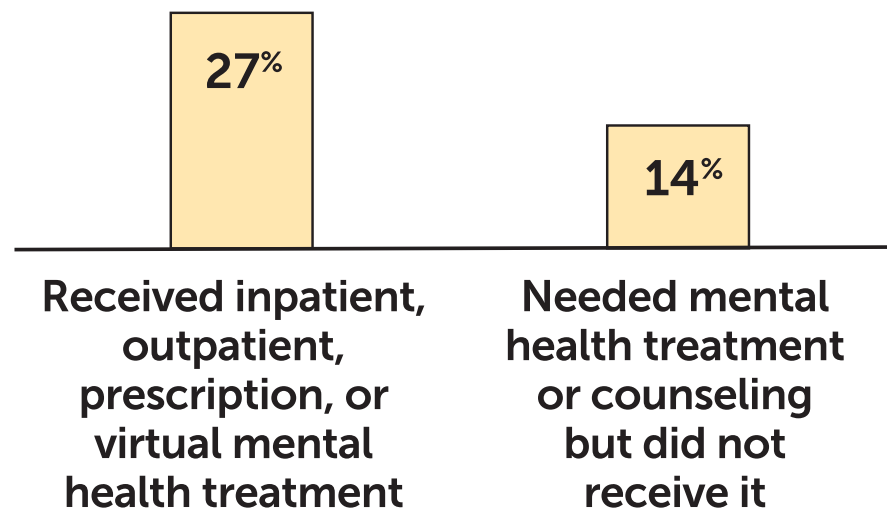
Prevalence of Postpartum Depressive Symptoms by Health Insurance at Delivery

Prevalence of self-reported postpartum depressive symptoms among women with a recent live birth by health insurance at delivery (2018)



Mental Health Treatment among Female Beneficiaries in Medicaid and CHIP

Percentage of Female Medicaid and CHIP Beneficiaries Ages 18–49 Who Reported Receiving and Not Receiving Mental Health Treatment in the Past Year, 2021



Notes: This exhibit reflects self-reported insurance coverage at the time of the survey and self-reported receipt of and perceived unmet need for health care. A specialty facility for illicit drug or alcohol use is defined as a hospital (inpatient), a rehabilitation facility (in or outpatient), or a mental health center. Data include the 50 states and DC.

Based on Mathematica analysis of National Survey on Drug Use and Health data. Data include survey respondents from the 50 states and DC who reported coverage by Medicaid or CHIP at the time of the survey.

Clinical Guidelines for Mental Health Screening

- **Screen for depression and anxiety using standardized, validated instruments during pre-pregnancy, prenatal, and postpartum periods**
- **Multiple screenings for perinatal depression and anxiety:**
 - Initial prenatal visit
 - A later point during pregnancy
 - Postpartum visits
- **Timely access to assessment and diagnosis, treatment, and appropriate monitoring and follow-up for positive mental health screening**
- **Positive screens for self-harm or suicide should be assessed for likelihood, acuity, and severity of risk of suicide attempt and then arrange for risk-tailored management**
- **Provide immediate medical attention for postpartum psychosis**

Improving the Maternal Health Continuum



Maternal Outcomes

Primary aims: Eliminate preventable maternal mortality, SMM, and inequities




Improved access to community and health-related social supports

 Screenings and vaccinations

 Lower risk for C-section delivery

 Decreased severe maternal morbidity

 Decreased postpartum complications

 Increased access to contraceptive care, better management of chronic diseases and mental health conditions, increased connection to ongoing care



Improved birth spacing, early initiation of prenatal care, healthy start of possible subsequent pregnancy

Pregnancy

Labor and delivery

Postpartum

Interpregnancy

Subsequent pregnancy

Overall health status

C-section = cesarean section; SMM = severe maternal morbidity

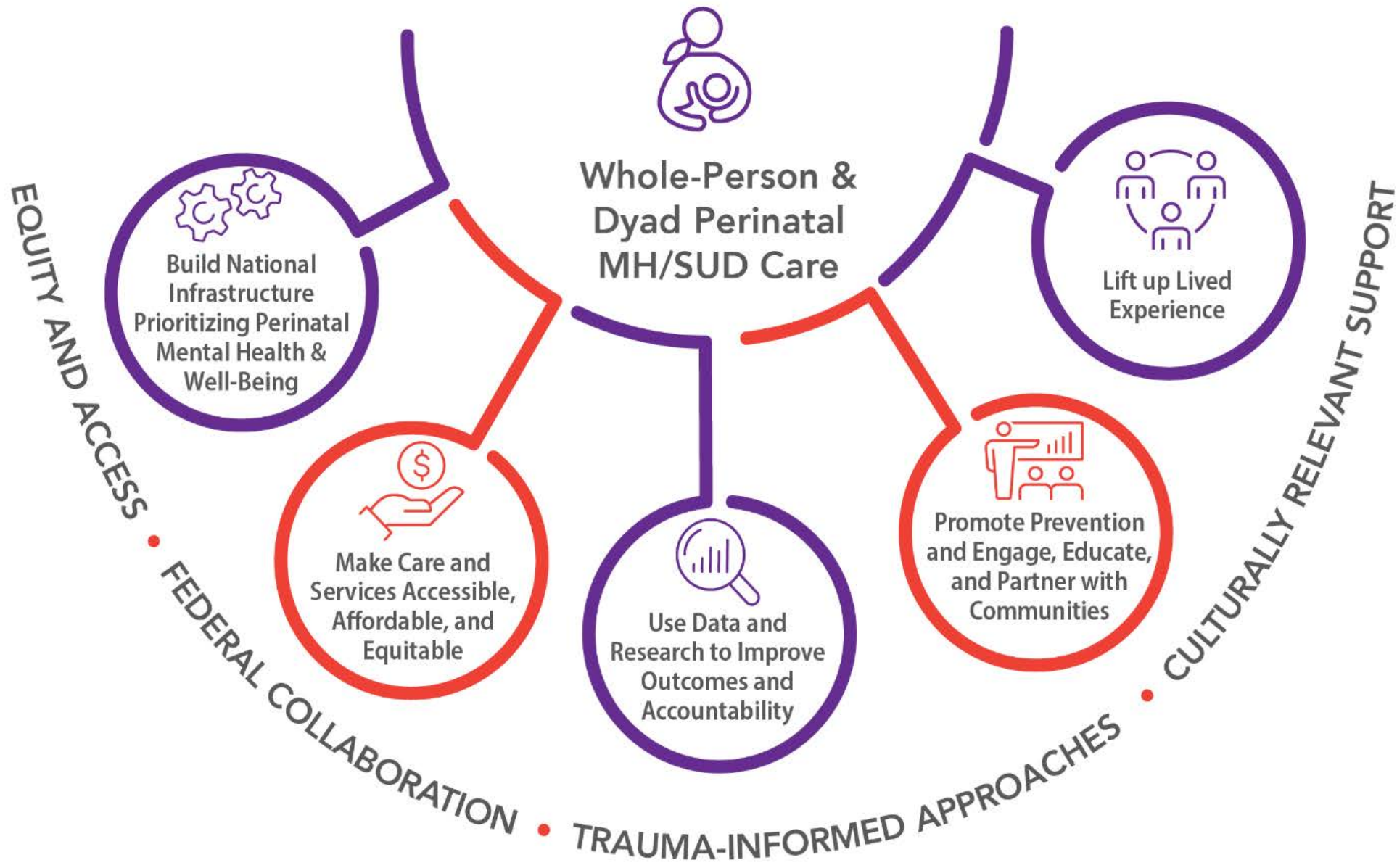
National Strategy to Improve Maternal Mental Health Care

Nima Sheth, Substance Abuse and Mental Health Services Administration (SAMHSA)



National Strategy to Improve Maternal Mental Health Care

Task Force on Maternal Mental Health



Vision

The task force expects that its work—this National Strategy, the report to Congress, and subsequent reports and updates—will improve maternal mental health and well-being for all individuals and communities across the nation.


The task force envisions that perinatal mental health and substance use care in our nation will be seamless and integrated across medical, community, and social systems, such that there will no longer be a distinction between physical and mental health care and that models of care and support will be innovative and sensitive to the individual's experiences, culture and community.

Audience

The primary target audience for this national strategy is the Federal Government - Congress, the Executive Branch, and the many federal departments and agencies that spearhead the provision of health care and services in communities.

The federal government's work cannot be carried out without collaborations and partnerships with states, public-private entities, industry, advocates, medical and professional societies, communities, and individuals with lived experience and their families.

Note that at times the recommendations specify a particular entity within federal government when relevant and in other cases, no particular agency or entity is specified because it is implied that **a whole-of-government approach is needed.**



Build a National Infrastructure that Prioritizes Perinatal Mental Health and Well-Being

PILLAR 1



Priority 1.1:

Establish and Enhance Federal Policies That Promote Integrated Perinatal and Mental Health/SUD Care Models with Holistic Support for Mother-Infant Dyads and Families from Multidisciplinary and Interdisciplinary Teams

RECOMMENDATION 1.1.1: Enact federal laws and align incentives for states, D.C., & territories to mirror the expansion, funding, and enhancement of federal- and state-level integrated perinatal and mental health/SUD care models involving multidisciplinary and interdisciplinary teams that extend from pregnancy through at least 1 year postpartum—including two-generation (maternal and pediatric care) practices, evidence-based screening and prevention, provision of treatment, and linkages to follow-up and support services.

RECOMMENDATION 1.1.2: Enact federal laws that require the implementation of six (6) months of paid family and medical leave and universal child-care in all states, D.C., and U.S. territories.



Priority 1.1:

Establish and Enhance Federal Policies That Promote Integrated Perinatal and Mental Health/SUD Care Models with Holistic Support for Maternal-Infant Dyads and Families from Multi- and Interdisciplinary Teams

RECOMMENDATION 1.1.3: Establish policies that support non-stigmatizing and non-punitive approaches to screening for substance use disorders, mental health conditions, and suicide in pregnant and postpartum individuals and ensure access to culturally responsive, evidence-based, trauma-informed, family-centered care.

RECOMMENDATION 1.1.4: Invest federal funding to create trauma-informed, accessible and equitable family-friendly health care facilities across the spectrums of inpatient, residential, and outpatient care by ensuring free embedded child-care.

RECOMMENDATION 1.1.5: Increase the implementation of well-deliberated, clinically sound recommendations, practice guidelines, and evidence-based interventions related to the treatment and support of individuals and mother-infant dyads with perinatal mental health conditions, substance use, and SUDs in all relevant health care systems.



Priority 1.2:

Establish and Enhance Federal Policies That Promote Perinatal Mental Health and Well-Being with a Focus on Reducing Disparities

RECOMMENDATION 1.2.1: Expand, enhance, and increase funding for federal programs serving perinatal populations to ensure that mental health, SUD, and GBV screening and preventive services, linkages to timely holistic treatment, and resources and referrals to community-based recovery support services for mental health conditions and SUDs are included.

RECOMMENDATION 1.2.2: Recognize the effects that structural racism and historical trauma have on creating and worsening mental health and SUDs and prioritize solutions for improving racial equity, addressing trauma and resolving disparities in care.

RECOMMENDATION 1.2.3: Appropriate sufficient funds to maintain and federally administer the work of the current Task Force on Maternal Mental Health to enhance, coordinate, and sustain efforts and partnerships on perinatal mental health and substance use. Establish in future legislation with funding - before the 2027 sunset of the task force - an ongoing coordinating committee on maternal mental health that includes federal and nonfederal representatives.



Make Care and Services Accessible, Affordable, and Equitable

PILLAR 2

Priority 2.1:

Implement culturally relevant and trauma-informed clinical screening and diagnosis and improve linkages to accessible timely intervention and treatment.

RECOMMENDATION 2.1.1: Establish comprehensive pathways to improve routine culturally relevant and trauma-informed screening for the presence of and assessment of risk factors related to developing perinatal mental health conditions and substance use, and SUDs, along with GBV, trauma, and SDOH—with the provision of appropriate preventive resources, referrals, and linkages to timely intervention in all relevant care settings.

RECOMMENDATION 2.1.2: Clarify, modify, and adopt universal diagnostic criteria (e.g., language and definitions) that reflect more accurate symptom presentation, range, timing, frequency, and severity of perinatal mental health disorders and that improve reimbursement for screening, assessment, and intervention.



Priority 2.2:

Create Accessible and Integrated Evidence-Based Services That Are Affordable and Reimbursable

RECOMMENDATION 2.2.1: Create federal mechanisms to fund and develop infrastructure that supports innovation in care delivery models for mental health conditions, substance use, and SUDs, and GBV during the perinatal period to reduce barriers to more accessible, holistic, and multigenerational dyadic care.

RECOMMENDATION 2.2.2: Improve federal funding and support for implementation of integrated crisis intervention services for perinatal populations and their families, training of the workforce on crisis care provision that is trauma-informed and culturally relevant, and development of infrastructure that leverages the support of state and local crisis systems.



Priority 2.2:

Create Accessible and Integrated Evidence-Based Services That Are Affordable and Reimbursable

RECOMMENDATION 2.2.3: Work with states and all payors to help establish financial incentives, including increased reimbursement, and support for perinatal mental health and SUD interventions that demonstrate positive outcomes.

RECOMMENDATION 2.2.4: Strengthen the continuity of care in the community by encouraging federal agencies to add requirements to their notices of funding opportunities that direct recipients to collaborate with other federally funded programs and develop partnerships with community-based organizations, and regional/state programs, to expand access and referral to treatment and recovery support services.



Priority 2.3:

Build Capacity by Training, Expanding, and Diversifying the Perinatal Mental Health Workforce

RECOMMENDATION 2.3.1: Require all relevant existing federally funded training, curricula, and technical assistance programs to incorporate how to prevent, screen, assess, and treat perinatal mental health conditions, inclusive of SUD and GBV.

RECOMMENDATION 2.3.2: Educate future and current clinical providers in perinatal mental health conditions, substance use, SUDs, and GBV by ensuring that these topics are included in the curricula for both health care and mental health care providers (e.g., in medical and nursing school, mental health and substance use training programs, and allied health and mental health programs) and in continuing education requirements.



Priority 2.3:

Build Capacity by Training, Expanding, and Diversifying the Perinatal Mental Health Workforce

RECOMMENDATION 2.3.3: Allocate long-term funding to establish, expand, and sustain perinatal mental health, substance use, and GBV consultation programs for medical, mental health and substance use, nursing, allied health providers, as well as non-clinical community-based workers.

RECOMMENDATION 2.3.4: Fund, incentivize, and bolster recruitment and training efforts to expand and diversify the perinatal clinical and non-clinical mental health and substance use workforce, particularly in under-resourced areas.



Use Data and Research to Improve Outcomes and Accountability

PILLAR 3

Priority 3.1:

Use Data and Research to Support Strategies and Innovations That Improve Outcomes

RECOMMENDATION 3.1.1: Establish an interdisciplinary, interagency expert panel to determine high-priority areas of research, surveillance, and implementation science that will directly affect national improvements in perinatal mental health conditions and SUDs. The expert panel would be charged with ensuring coordination across the federal government, translating data to action, and monitoring and sustaining research and surveillance in this area.

RECOMMENDATION 3.1.2: Invest in ways to build the trust of under-resourced communities who have experienced abuses when participating in research and data collection efforts. Rebuild safety by engaging communities- namely pregnant and postpartum people with higher risk- in partnerships (e.g., through community-based participatory research) to ensure that research, data collection, analysis and reporting on perinatal mental health and substance use are equity-focused, are representative, are culturally relevant, are trauma-informed, and maintain necessary confidentiality protections with the highest ethical regard for vulnerable and under-resourced populations.



Priority 3.1:

Use Data and Research to Support Strategies and Innovations That Improve Outcomes

RECOMMENDATION 3.1.3: Support and fund integrated data systems by sharing data across health care and community-based services while preserving patient confidentiality. Use data to inform and drive the development of more equitable policies, effective practices, innovative interventions and approaches to treatment, and improved outcomes.

RECOMMENDATION 3.1.4: Increase investment in current perinatal health data collection programs and create a central clearinghouse of information so that providers, public health and government officials, and the public can quickly identify and use resources for perinatal health data.

RECOMMENDATION 3.1.5: Create mechanisms to pair implementation guidance and dissemination strategies with research, scientific and surveillance findings on perinatal mental health, substance use, SUDs, and GBV for wide use, application, and adoption of the most up-to-date interventions, guidelines, and data.



Priority 3.2:

Build a Foundation for Accountability in Prevention, Screening, Intervention, and Treatment

RECOMMENDATION 3.2.1: Establish and implement quality improvement metrics for providers, hospital systems, and insurers—with multiyear longitudinal tracking of costs and outcomes. Create mechanisms to ensure implementation of evidence-based solutions.

RECOMMENDATION 3.2.2: Fully fund and expand support for perinatal quality collaboratives (PQCs) fully in all 50 states, D.C., and all U.S. territories, including military and veteran spaces.

RECOMMENDATION 3.2.3: Continue to fully fund maternal mortality review committees (MMRCs) in all 50 states, D.C., and all U.S. territories.



Promote Prevention and Engage, Educate, and Partner with Communities

PILLAR 4



Priority 4.1:

Promote and Fund Primary Prevention Strategies at the Community Level

RECOMMENDATION 4.1.1: Elevate and fund the implementation of evidence-based best practices and programs that promote person-centered, culturally relevant, and community-level detection and prevention of perinatal mental health conditions and SUDs, especially in under-resourced communities at high risk for these conditions and ensure related Medicaid and private payer coverage.



Priority 4.2:

Elevate Education of the Public About Perinatal Mental Health and Substance Use and Engage Communities with Outreach and Communications

RECOMMENDATION 4.2.1: Support a nationwide approach to clarifying the messaging and target audiences of all mental health, SUD, GBV and crisis support warmlines and hotlines for the perinatal populations and their families.

RECOMMENDATION 4.2.2: Improve federal strategies to communicate with and engage families, personal networks, those with lived experience, and communities in conversations about perinatal mental health, substance use, SUDs, and care—with a focus on decreasing stigma, raising awareness, and addressing safety—on an ongoing basis.



Lift Up Lived Experience

PILLAR 5



Priority 5.1:

Listen to the Perspectives and Voices of People with Lived Experience*

- Continue to Focus on and Care for Mothers
- Build Trust
- Understand Mothers as People and What Is Happening in Their Lives
- Respond to the Needs of Mothers and Their Families

**from the USDS Lived Experience Report*

Priority 5.2:

Prioritize the Recommendations from People with Lived Experience*

**from the USDS Lived Experience Report*

- Opportunities to connect to experienced mothers to build community
- Information, preparation, and community connections during early pregnancy
- Access to high-quality care for everyone
- Perinatal mental health check-ins with providers (having conversations about mental health early and often)
- Education about available medications that benefit people with mental health conditions and using them during the perinatal period
- Clear information on continuing medications for mental health conditions during pregnancy and during breastfeeding
- Recognition that breastfeeding greatly affects perinatal mental health
- Services that meet mothers and babies where they are
- Sleep strategies and support during early pregnancy
- Acknowledgment that screening alone is not enough, and the need for providers to make time for personal connection and explanation
- Recognition that care for perinatal mental health is health care
- Acknowledgment that paid family and medical leave improves outcomes for the entire family
- Specialty training in perinatal mental health support for diverse members of the workforce

Priority 5.2:

Prioritize the Recommendations from People with Lived Experience*

- A national paid family and medical leave policy (*Rec 1.1.2*)
- A diverse, interdisciplinary, culturally competent perinatal health workforce (*Priority 2.3*)
- Peer support and a group care model (*Priority 2.3*)
- Measures of the quality of patients' experiences with maternity care, including mental health care (*Priority 3.2*)
- Holistic care models that integrate treatment of both mothers and babies (*Priority 1.1; Rec 2.2.1*)
- Screenings for different types of perinatal mood and anxiety disorders (PMADs), such as anxiety, obsessive-compulsive disorder, and bipolar disorder (*Pillar 1, Pillar 2*)
- Human-centered training and implementation of PMAD screening (*Priority 2.3*)
- Closed-loop referral systems for perinatal mental health (*Priority 2.1, Rec 2.1.1*)
- Continuing education requirements for perinatal mental health providers, including medication management (*Priority 2.3, Rec 2.3.2*)

**from the USDS Lived Experience Report*



Next Steps

- **Implementation Planning**
- **Report to Governors**
- **Annual Updates**

Contact Information

- [Task Force on Maternal Mental Health | SAMHSA](#)

Contacts

- Nima Sheth, MD, SAMHSA
 - Nima.Sheth@samhsa.hhs.gov
- Dorothy Fink, MD, OASH/OWH
 - Dorothy.Fink@hhs.gov

State Spotlight - Michigan

Meagan Chuey, MDHHS Division of Maternal and Infant Health

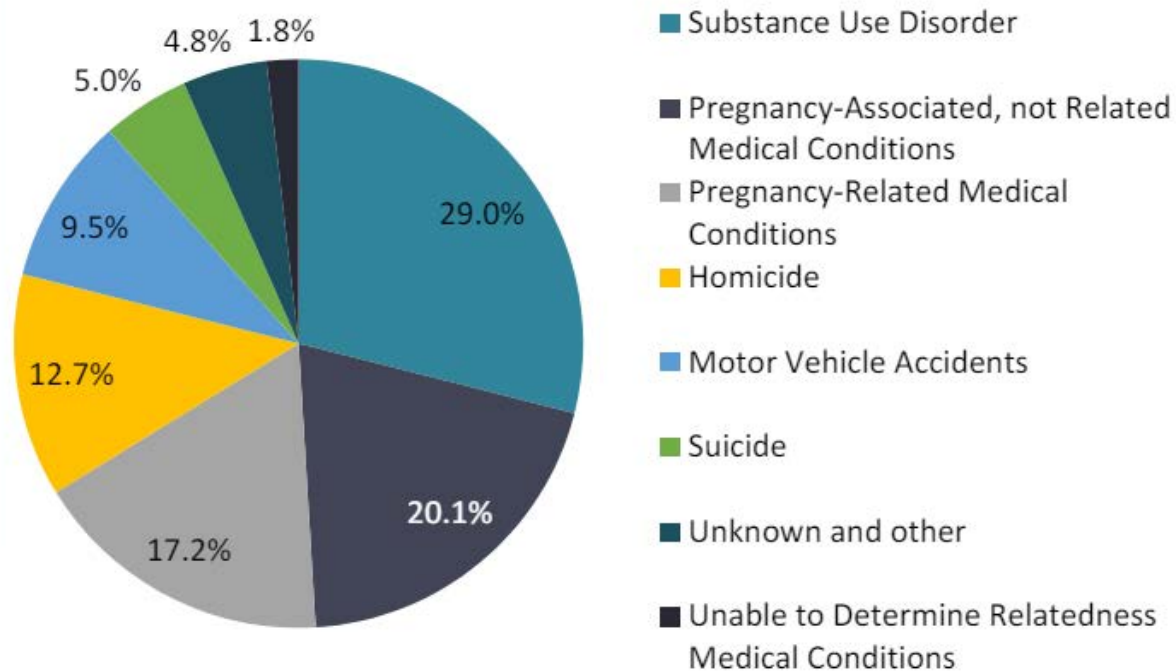
Connecting Michigan Families with State-Specific Mental Health Resources: *Utilizing a Smart Phone App*

Meagan Chuey, PhD, CNM, RN



Maternal Mental Health in Michigan

Causes of Pregnancy-Associated Mortality, Michigan, 2016-2020



- Depression is relevant in the peripartum period:
 - Prior to pregnancy : 20.9%
 - During pregnancy: 19.3%
 - Following pregnancy: 16.5%
- A third (34.5%) of postpartum people report anxiety in the three months before pregnancy
- Suicide accounts for 5% of pregnancy-associated mortality in Michigan
- Substance Use Disorder accounts for 29% of pregnancy-associated mortality in Michigan

Connecting With App Creator

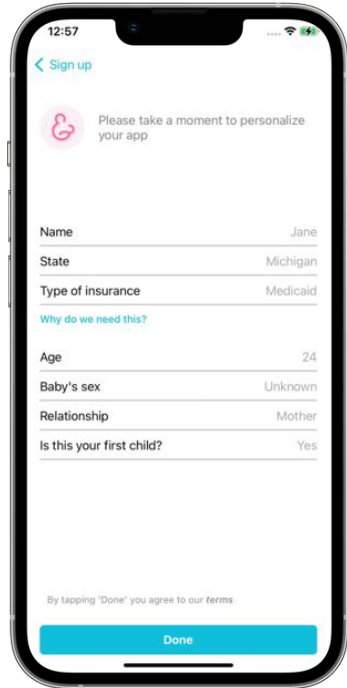
- Conducted a bidding process to identify an app creator that had a wide reach with the capacity to:
 - Incorporate articles with links to state-specific resources
 - In-app surveying of users
 - Data reporting
- Selected app that had an established far-reaching platform
 - Available in 22 languages
 - 3D baby development model, with user-chosen race
 - 1.5 million downloads annually in the United States, including 43% of first-time pregnant people
 - Of existing users, 45% reported receiving Medicaid

Connecting With App Creator

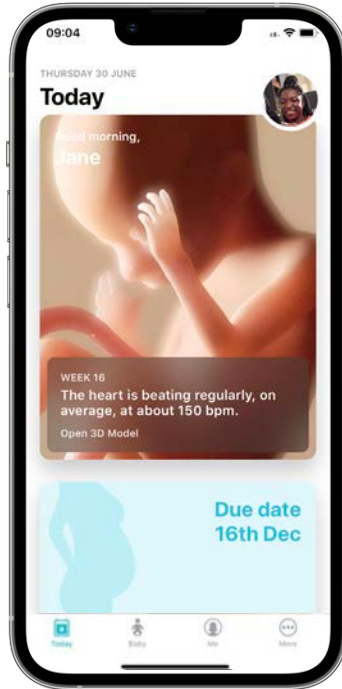
- In Michigan specifically:
 - 37% of pregnant people already downloading the app
 - 53% of users are eligible for Medicaid
 - 57% of users have a high school education or less
 - 35% of users are Black/African American



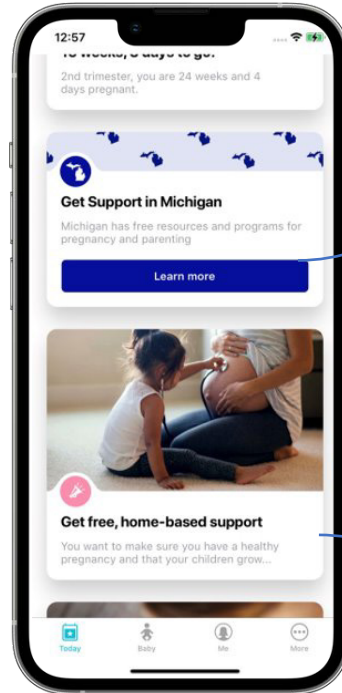
User Access Points



User enters state of residence and insurance during on-boarding.



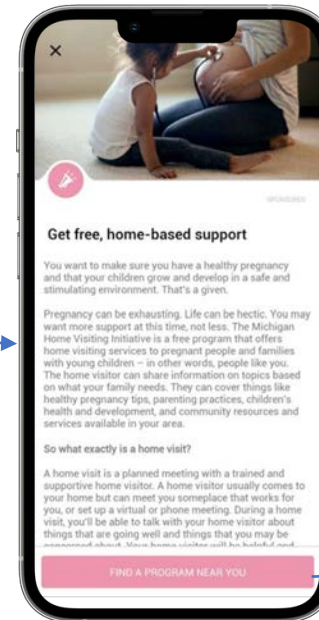
User is shown a personalized feed based on the info entered in onboarding. In this example the user has the Michigan Sticky resource card and an additional article on Michigan specific content.



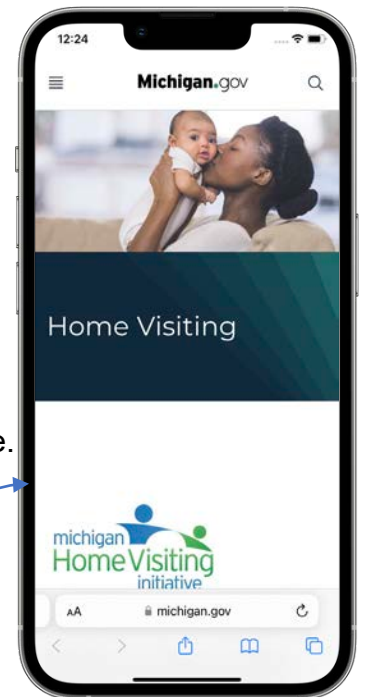
On click article is opened.



On click user is taken to the MDHHS Maternal Infant Health Resource page.



User clicks CTA and is taken to the specific resource site.



Mental Health Resources in App

- Mental health-specific article:
 - Normalizes peripartum mental health struggles
 - Lists possible symptoms of anxiety and depression
 - Links to Michigan's behavioral resource finder (searchable by county)
- Substance Use articles:
 - Substance use in pregnancy
 - Medication safety
 - Plan of Safe Care

Home Visiting Resources in App

- Funds for the app come from *Healthy Moms Healthy Babies* Home Visiting funds.
- Home visiting links families to needed resources, including mental health and substance use supports.
- The app at any time has 8-10 articles, videos, and stories related to home visiting.
 - Links to MI 2-1-1 Home Visiting website, where families can send referrals to home visiting agencies electronically.

Contact

Meagan Chuey, PhD, CNM, RN
ChueyM@Michigan.gov



State Spotlight - Pennsylvania

David Kelley, DHS Office of Medical Assistance Programs

▶ Pennsylvania Medicaid Maternal Mental Health (MH) Initiatives

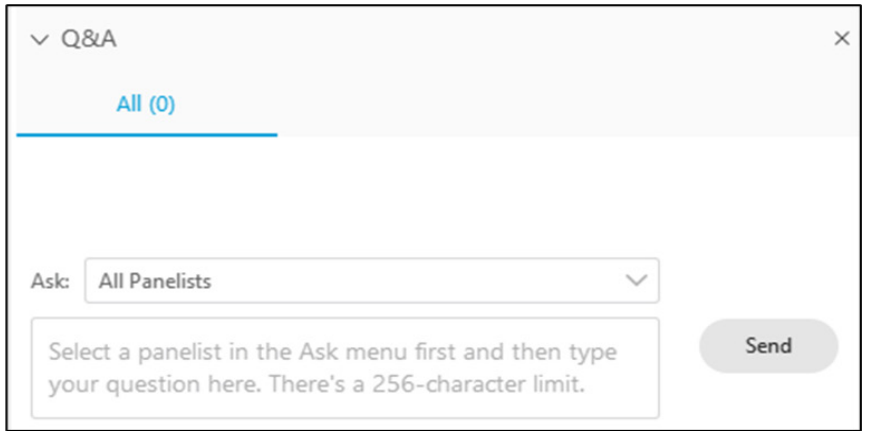
- Mandatory managed care state for over 2.7 million participants, over 40,000 live births (33%), adult and postpartum expansion, behavioral health carve out.
- Screening mom for depression at well-child visits.
- Obstetrical Needs Assessment Form reports MH conditions to MCOs. ([ONAF](#))
- MCOs annually report prenatal/postpartum screening/treatment quality measures.
- Perinatal Quality Collaborative- Moving on Maternal Depression (MOMD).
[Pennsylvania PQC - MOMD \(papqc.org\)](#) [Pennsylvania PQC - SUD/ODU \(papqc.org\)](#)
- Large integrated health systems with collaborative care models and telemedicine.
- Home visitation program offers additional support to families during the perinatal period up to 18 months postpartum.
- Maternity care bundle/gainshare program that rewards for prenatal and postpartum depression treatment.
- Perinatal behavioral health consultation program.

Questions and Discussion

Lekisha Daniel-Robinson, Mathematica

How to Submit a Question

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Q&A

All (0)

Ask: All Panelists

Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.

Send

Upcoming Events and Opportunities

Lekisha Daniel-Robinson, Mathematica

Maternal Health Webinar Series

- **Decreasing Fragmentation in Maternal Substance Use Disorder Screening and Treatment** (June 25, 2024, 2:00 pm ET)
- **Addressing Hypertension Before, During, and After Pregnancy** (July 16, 2024, 2:00 pm ET)
- **Medicaid and CHIP Program Collaboration with Hospitals on AIM Bundles** (August 20, 2024, 2:00 pm ET)

Maternal Health Affinity Groups

- **Expression of Interest Webinar (August 6, 2024, 2:00 pm ET)**
 - Action-oriented affinity groups will support state Medicaid and CHIP programs and their partners in identifying, testing, and implementing evidence-based change ideas to address maternal health
 - Two Affinity Groups focused on
 - **Addressing Maternal Mental Health and Substance Use**
 - **Improving Maternal Hypertension Control**
 - More information will be available in early Summer 2024

Maternal Health Resources

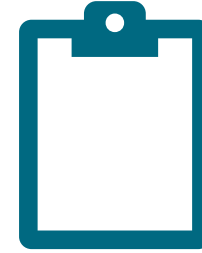
Visit the [2024 Medicaid & CHIP Beneficiaries at a Glance: Maternal Health Infographic](#) on Medicaid.gov for a snapshot of maternal health demographics, health outcomes, risk factors, and more

Visit the [Addressing Maternal Mental Health and Substance Use Care and Outcomes](#) landing page on Medicaid.gov for information about the upcoming webinars and affinity groups.



Thank you for participating!

- Please **complete the survey** as you exit the webinar.



- If you have any **questions**, email MedicaidCHIPQI@cms.hhs.gov

