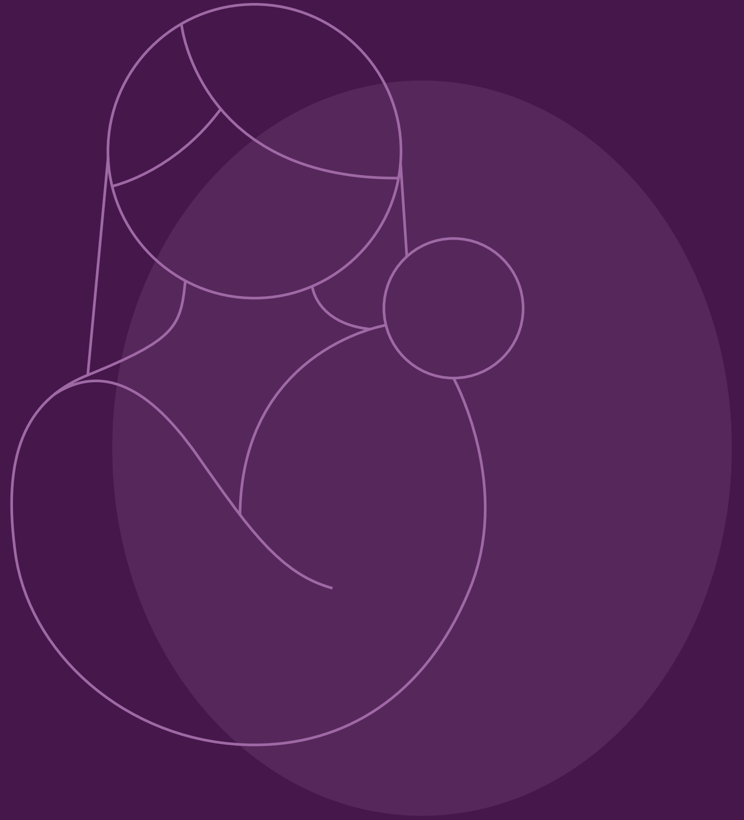


April 2025

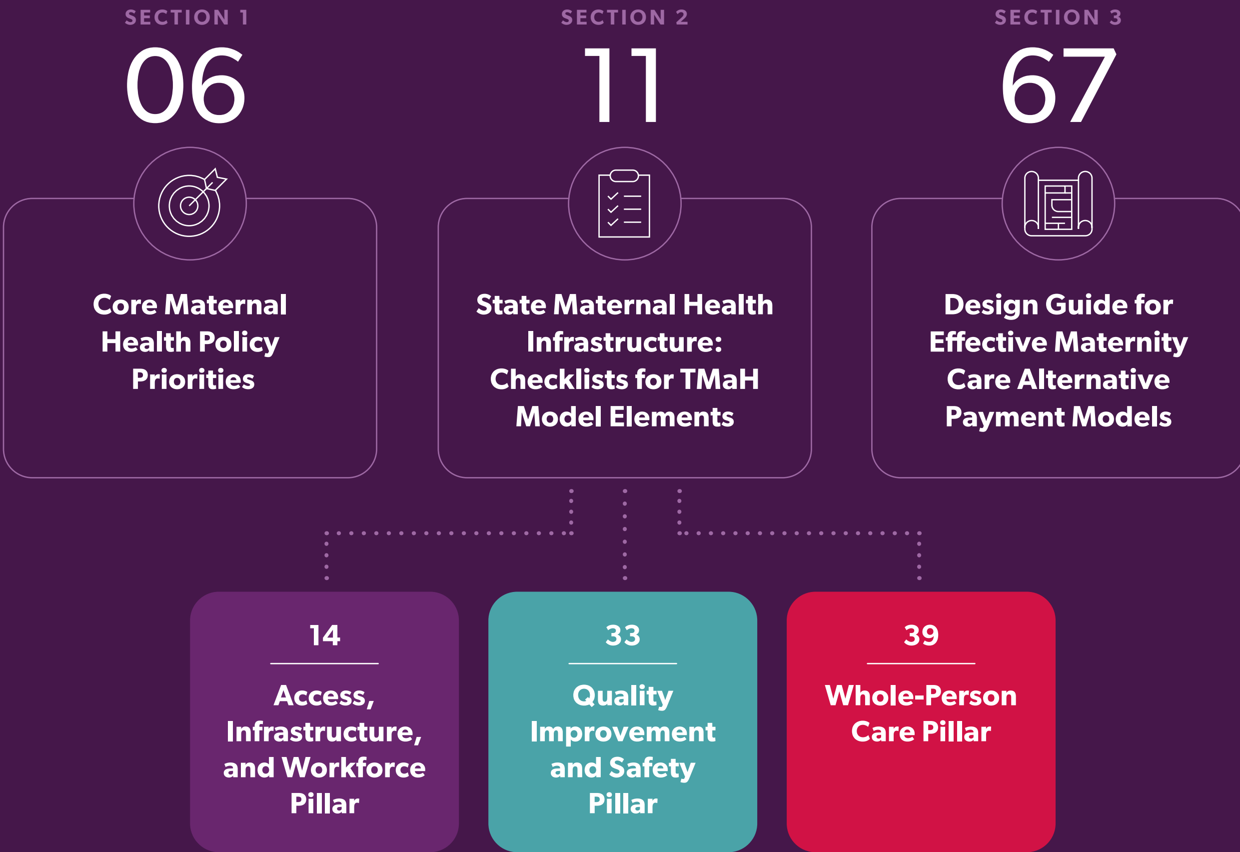
Transforming Maternal Health in Medicaid

A Playbook for State Medicaid Agencies and Their Partners Based on CMS's Transforming Maternal Health (TMaH) Model

Transforming Maternal Health in Medicaid

TABLE OF CONTENTS

Using This Playbook to Improve Maternal Health 03



List of Acronyms 76

About the Authors 78

Acknowledgments 79

Using This Playbook to Improve Maternal Health

Medicaid is arguably the single most important lever for mitigating the nation's dire maternal health crisis. As the largest payer of childbirth services, Medicaid covered 40 percent of births in 2024, including disproportionate numbers of childbearing families from communities bearing the brunt of the crisis.[1] While state Medicaid agencies have been working to improve beneficiaries' maternal health, the United States continues to have the highest rate of maternal mortality among high-income countries.[2]

In June 2024, the Center for Medicare and Medicaid Innovation (CMMI, or the Innovation Center) of the Centers for Medicare & Medicaid Services (CMS) released a Notice of Funding Opportunity (NOFO) for the 10-year Transforming Maternal Health (TMaH) Model.[3] In January 2025, CMS awarded 15 state Medicaid agencies (SMAs) technical and financial assistance to plan and carry out strategies to improve maternal and infant health in Medicaid and the Children's Health Insurance Program (CHIP).[i]

The TMaH framework delineated by CMMI includes many proven elements and leverages payment for better care, experiences, and outcomes. We believe this comprehensive blueprint can advance maternal health in states across the nation, regardless of their participation in the TMaH program. For states that have been selected, the initial three-year pre-implementation period provides critical planning, preparation time, and support for strengthening their maternal health infrastructure so they can achieve maximum impact during the subsequent seven-year implementation period. Pre-implementation activities can shore up such foundational health system issues as workforce, data systems, quality, safety, whole-person care, and payment.

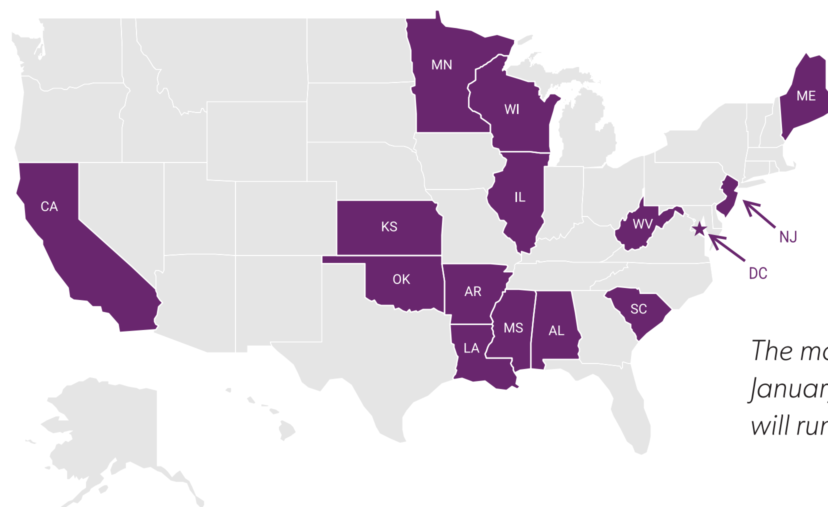
Given the broad utility of the TMaH framework well beyond the selected states, we developed this playbook as a resource for all SMAs and their partners[ii] to improve maternal and infant health through their Medicaid programs, with particular attention to what TMaH grantees should focus on during the three-year pre-implementation period. The playbook provides best practices, policy checklists, and resources, divided into three sections that correspond to core areas of maternal and infant health improvement. These guides can be used independently from each other but will likely be most impactful if implemented together. We understand that each state faces unique challenges and that states are at different points in their maternal health transformation efforts, so we encourage SMAs and their partners to take from the playbook what is most useful and applicable to their specific circumstances. The three sections are:

i The selected states are Alabama, Arkansas, California, District of Columbia, Illinois, Kansas, Louisiana, Maine, Minnesota, Mississippi, New Jersey, Oklahoma, South Carolina, West Virginia, and Wisconsin.

ii Partners might include CMS, state legislators and governors, Medicaid managed care organizations, community-based organizations, clinician groups, hospitals, birth centers, and perinatal quality collaboratives.

1. **Core Maternal Health Policy Priorities: Checklist of Best Practices for State Medicaid Agencies** describes overarching standards and best practices that states working for better maternal health and birth outcomes should weave through their maternal health initiatives, including TMaH if applicable.
2. **State Maternal Health Infrastructure: Policy Checklists for TMaH Model Elements** lays out, by pillar, a summary of the rationale and evidence for each required and optional TMaH model element, the evidence that supports them, their current state of play, policy checklists for their implementation, and curated resources. For TMaH participants, it also presents CMS-provided pre-implementation milestones for required elements. SMAs and their partners can use this resource to identify the policies that their state has not yet implemented and prioritize those most suited to their respective policy environments and goals for a more effective maternal health infrastructure.
3. **Effective Maternity Care Alternative Payment Model Design Guide** identifies elements that should be incorporated into maternity care alternative payment models (APMs) for greatest impact on outcomes. Model design is a crucial factor in APM success. TMaH grantees will work with the Innovation Center during the pre-implementation phase to design the APM that TMaH awardees will be required to implement. SMAs not participating in the TMaH program can use these design features to develop their own APMs or strengthen existing ones in their state. The recommendations here are informed by crucial lessons from a recent landscape analysis of maternity care alternative payment programs[iii] and other cited research about improving maternal and infant health.

States Selected to Participate in TMaH



The model launched on January 1, 2025, and will run for 10 years.

iii A landscape study of maternity care episode payment and maternity care home programs found that the small number of operating programs have not reported improved overall maternal-infant health care and outcomes. In general, designs were weak, and the study identified many ways to strengthen maternity care alternative payment and delivery models. https://nationalpartnership.org/maternityAPM; https://www.healthaffairs.org/content/forefront/toward-maternity-care-apms-improve-outcomes-and-equity

Endnotes

1. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Provisional Natality on CDC WONDER Online Database. Data are from the natality records 2023 through last month, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved February 19, 2025, from https://wonder.cdc.gov/natality-expanded-provisional.html

2. Gunja, M. Z., Gumas, E. D., & Masitha, R. (2024, June 4). Insights into the U.S. maternal mortality crisis: An international comparison. https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison

3. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. Transforming Maternal Health (TMaH) Model, Notice of Funding Opportunity (2024, June 26). https://grants.gov/search-results-detail/354874

SECTION 1

Core Maternal Health Policy Priorities:

Checklist of Best Practices for State Medicaid Agencies

Core Maternal Health Policy Priorities: Checklist of Best Practices for State Medicaid Agencies

Improving maternal and infant health requires state Medicaid agencies to take action in several areas: improving quality, reducing gaps in outcomes, setting improvement expectations and steadily raising the bar over time, and generating maternity care practice culture change. The following checklist offers steps all SMAs can take to transform their maternity care to achieve better outcomes.

IMPROVE QUALITY THROUGH ACCOUNTABILITY

- ☐ **Prioritize quality.** Prioritize quality improvement through multifaceted comprehensive programs to eliminate avoidable harm and build health. Develop and apply actuarial models that capture the considerable cost savings of improving maternal-infant health for everyone.[1]
- ☐ **Reduce harm.** Work with perinatal quality collaboratives to implement Alliance for Innovation on Maternal Health (AIM) patient safety bundles[2] to avert largely preventable catastrophic outcomes of hemorrhage, severe hypertension, sepsis, and other severe conditions.[3]
- ☐ **Promote well-being.** Complement strengthened capacity to avert catastrophic outcomes with upstream improvements that enable families to thrive. For example, reduce preterm birth and safely avoidable cesareans, address unmet social needs, avert unwarranted newborn intensive care unit admissions, prevent or address perinatal mental health conditions, and increase access to vaginal birth after cesarean and to lactation support.
- ☐ **Accelerate change.** Catalyze improvements by ensuring access to high-performing models, such as midwifery care, doula support, birth center care, and services of community-based perinatal health workers.
- ☐ **Select impactful aligned measures.** Implement stratified performance measures that align with quality and gap reduction goals. Hold Medicaid health plans, partner providers, and hospitals and other partner care delivery locations accountable for maternity quality measures with potential to impact population health. Use fit-for-purpose maternity care measures developed through consensus-based processes.[4]

REDUCE OUTCOME GAPS[i]

- ☐ **Identify and track the gaps.** To improve quality and outcomes for everyone, stakeholders must first know where the gaps are. Create data systems to collect and track disaggregated provider performance and maternal-infant outcomes. Use results to set and achieve progressively more stringent benchmarks and shrink gaps over time.

---

i To align with the latest federal guidance, we have removed specific references to achieving health equity. You can find more information about reducing racial, ethnic, and other structural inequities at https://nationalpartnership.org/TMaH.

- ☐ **Be comprehensive.** Implement multifaceted systems for addressing outcome gaps that impact purchasers, payers, providers, and people receiving care.
- ☐ **Avoid widening outcome gaps.** Adjust payment and/or performance measurement to encourage appropriate care for pregnant women with higher medical and other health related needs and to enable health professionals and facilities who care for them to succeed.
- ☐ **Center communities.** Meaningfully involve people from the most adversely affected communities in governance across all phases of improvement programs, including TMaH. Learn from their experience and focus on their understanding of problems and solutions. Create and appropriately support Perinatal Community Advisory Boards for program guidance at the levels of state TMaH program, facilities, and health systems.

SET EXPECTATIONS AND PROGRESSIVELY ADJUST GOALS

- ☐ **Begin with where systems and providers are.** Starting from system and provider baselines, work toward improvement and high-quality care and maternal-infant health outcomes over time.
- ☐ **Strengthen system infrastructure.** Address maternal health system shortcomings. These include data, workforce, and access issues. (See Section 2 in this document.)
- ☐ **Support provider professional growth.** Use education, technical assistance, feedback, incentives, and policy levers to advance the culture of professional practice. (See next subsection.)
- ☐ **Progress model designs.** As systems strengthen and provider capacity grows, strengthen model designs. Set expectations for progressive growth and improvement. (See Section 3 in this document.)
- ☐ **Hold stakeholders accountable.** Hold Medicaid managed care organizations and providers, including hospitals, accountable for continuous improvement over time.

GENERATE MATERNITY CARE PRACTICE CULTURE CHANGE

- ☐ **Support culture change.** Support the transition of fee-for-service practice with no clear incentive for improvement to value-based practice with aligned accountability, care team collaboration, and incentives for steady improvement over time.
- ☐ **Support providers.** Help providers succeed through continuous access to performance data, periodic comprehensive reports, technical assistance, and quality improvement initiatives.
- ☐ **Embrace whole-person care.** Transition from a traditional focus on physical health to a whole-person care model inclusive of attention to mental health and health-related social needs. Incorporate payment structures, personnel, infrastructure, and measurement to provide effective support in these essential nontraditional areas.

- ☐ **Foster widespread improvement.** Encourage providers to cultivate respectful care, provide culturally congruent care, use the services of community-based organizations, be good community partners, and integrate across settings and phases of care.
- ☐ **Promote adjacent benefits.** Routinely inform pregnant people of adjacent benefits for which they may be eligible and how to secure them. These may include paid leave, temporary disability, doula support, Early Head Start, home visiting, WIC, maternal mental health hotline, and pregnancy and lactation workplace accommodations. Task dedicated staff with routinely fostering access to these health-promoting services.

Endnotes

1. Health Care Payment Learning & Action Network. (2024, November). *Value of health care redefined: Social return on investment*. Retrieved 7 January 2025 from https://hcp-lan.org/wp-content/uploads/2024/11/CMS-HEAT-Social-ROI.pdf

2. Alliance for Innovation on Maternal Health. *Patient safety bundles*. Retrieved 7 January 2025 from https://saferbirth.org/patient-safety-bundles/

3. Trost, S., Beauregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. (2022). *Pregnancy-related deaths: Data from maternal mortality review committees in 36 US states, 2017–2019.* Centers for Disease Control and Prevention. Retrieved 7 January 2025 from https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html#cdc_research_or_data_summary_res_data-the-data

4. National Partnership for Women & Families. (2024). *Selecting performance measures for maternity care alternative payment models (APMs): Consensus-based maternity care measures recommended for APMs*. Retrieved 7 January 2025 from https://nationalpartnership.org/wp-content/uploads/maternityAPM-performance-measures.pdf; —. (2023, March). *Raising the bar for moms & babies: Priority maternity care quality measures to improve outcomes and equity.* Retrieved 7 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/04/rtb-priority-maternity-care-measures.pdf

SECTION 2

State Maternal Health Infrastructure:

Checklists for TMaH Model Elements

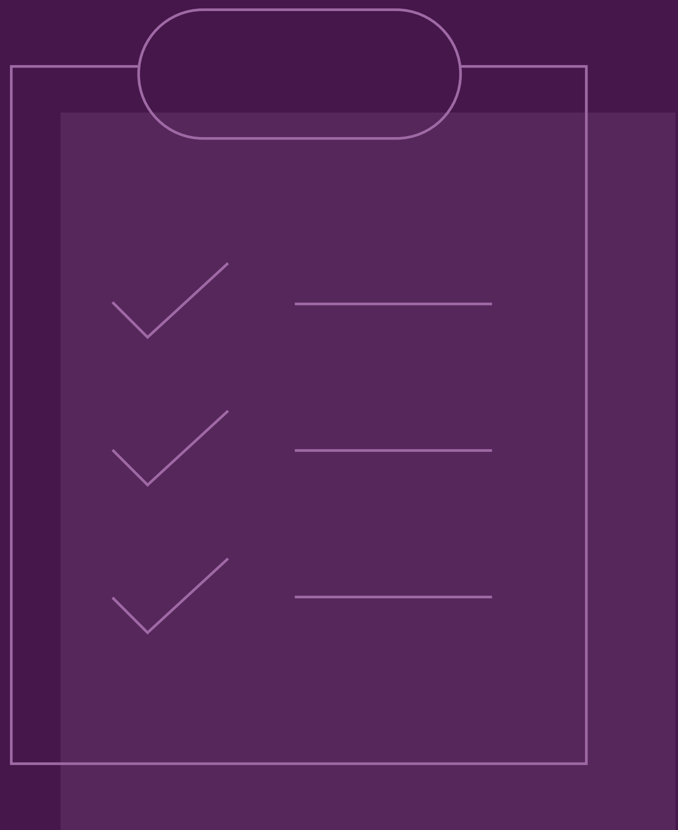


Table of Contents

Access, Infrastructure, and Workforce Pillar

- Increase access to the midwifery workforce 14
- Increase access to birth centers 16
- Cover doula services 19
- Improve data infrastructure 21
- Develop payment model 23
- Cover certified midwives (CMs) and certified professional midwives (CPMs) 25
- Cover perinatal community health workers (CHWs) 27
- Create regional partnerships in rural areas 29
- Extend Medicaid eligibility to 12 months postpartum 31

Quality Improvement and Safety Pillar

- Support implementation of AIM patient safety bundles 33
- Support "Birthing-Friendly" hospital designation 35
- Promote shared decision-making 37

Whole-Person Care Pillar

- Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and HRSN 39
- Increase home monitoring of diabetes and hypertension 43
- Expand group prenatal care 46
- Increase use of home visits, mobile clinics, and telehealth 48
- Expand oral health care 50

State Maternal Health Infrastructure: Checklists for Model Elements

States have a crucial role to play in developing and supporting a policy infrastructure that advances healthy maternal outcomes – especially when it comes to their Medicaid programs. The following policy guidance is organized according to the framework of the Transforming Maternal Health (TMaH) model designed by the Centers for Medicare and Medicaid Services (CMS). The guidance below supports states in strengthening their maternal health infrastructure as a basis for improved quality, experiences, and outcomes of maternal-newborn care. All states would benefit from having these policies in place, whether or not they are part of the TMaH program. These policies will help TMaH states prepare during the pre-implementation period for highly effective implementation of required and optional TMaH model elements across the three program pillars. For each element, an overall policy goal, we identify whether it is required or optional and concisely describe:

- the research rationale for how the element can contribute to better maternal-infant health for all
- the current state for each element to help state Medicaid agencies (SMAs) and their partners understand the "lay of the land"
- CMS-specified milestones that TMaH states must accomplish for required elements during the initial three-year pre-implementation period
- a checklist of policies to strengthen maternal health infrastructure needed for the particular element. In some cases, SMAs will need to work with CMS, governors, legislatures, or other entities to implement specific policies. In states with Medicaid managed care plans, SMAs can contractually direct plans to implement many policies
- key implementation resources for the specific policy

While implementing all identified policies would provide SMAs with the greatest opportunity to improve maternal and infant health and outcome gaps, the checklist is a menu of choices that each SMA and their partners can consider in the context of the state policy environment.

1

REQUIRED

INCREASE ACCESS TO THE MIDWIFERY WORKFORCE

Rationale and Evidence

- Midwives provide care that is better than or comparable to physician care on such key measures as: rates of vaginal birth, breastfeeding, preterm birth, and patient satisfaction; judicious use of interventions; and overall costs.[1]
- Community-based midwifery care, led by those who best understand challenges and solutions, is essential for a just and effective maternity care system.[2]
- States' degree of integration of midwifery is positively associated with better maternal-newborn outcomes and fewer obstetric interventions.[3]
- Medicaid midwife-physician payment parity and less restrictive midwifery licensure are positively associated with the rate of midwife-attended births.[4]
- Childbearing women's interest in having midwifery care is far greater than their actual access and use.[5]
- One study estimated that increasing midwifery-led care to 20 percent of all U.S. births would result in $4 billion in savings over 10 years.[6]
- Training midwives requires less time and money than training physicians.[7]

Current State

- Of the three nationally recognized midwifery licensures, only certified nurse midwives (CNMs) are licensed in all states.
- All Medicaid programs reimburse CNM care.
- In many jurisdictions, CNMs face barriers to providing care more broadly including: limits on their ability to practice independently in line with their competencies and education, limits on prescriptive authority, physician supervision requirements, limits on practice settings, no Medicaid payment parity with physicians (in contrast with Medicare requirements).[8]
- Many states license certified midwives and most license certified professional midwives. CMs and CPMs are not eligible for Medicaid reimbursement in all states that license them. (See more below under the optional element "Cover certified midwives [CMs] and certified professional midwives [CPMs]".)

Increase Access to the Midwifery Workforce continued

CMS-Provided Pre-Implementation Period Milestones[9]

- Completed an assessment of midwifery workforce capacity in the state and options for covering additional types of midwives licensed in the state.
- Assessed and created a billing pathway for interprofessional consultations between midwives and other providers, including maternal fetal medicine specialists, as appropriate and needed.
- Completed payment analysis that compares the reimbursement rate for midwives as a proportion of a benchmark rate (for fee schedule updates as appropriate) and has a process in place for completing an annual analysis thereafter.

Policy Checklist

- ☐ Remove barriers to independent CNM practice in: AL, CA, CO, FL, GA, IL, IN, KY, LA, MI, MO, MS, NC, NE, NJ, OH, OK, PA, SC, TN, TX, UT, VA, VT, WI, and WV.[10]
- ☐ Remove restrictions on the scope of CNM practice (such as limits on prescriptive authority and practice settings).[11]
- ☐ Equalize Medicaid and CHIP payments between CNMs and physicians in: AL, AK, AZ, AR, DE, FL, HI, ID, IN, IA, KS, KY, LA, MA, MS, MT, NE, NV, NY, and TX.[12]
- ☐ Require Medicaid MCOs to cover CNMs and list them in plan directories in: CO, IN, MD, MO, NC, OR, SC, TN, and UT.[13]
- ☐ Support or create in-state midwifery education programs, including at minority-serving institutions, such as directing resources to schools, programs, students, and/or preceptors.
- ☐ Designate CNMs as Medicaid primary care providers in: AR, CO, CT, DE, FL, GA, ID, LA, MS, MT, NH, OK, SC, VA, and WY.[14]

Key Resources

- ACNM's *Midwifery Policy Toolkit*[15]
- ACNM's *Access to Midwifery Care National Chartbook*[16]
- ACNM's Workforce Study Data Release[17]
- ACNM's Workforce Study Data Briefs[18]
- ACNM's Information to Share about Advanced Practice Midwives[19]
- MACPAC's *Access to Maternity Providers: Midwives and Birth Centers*[20]

2
REQUIRED

INCREASE ACCESS TO BIRTH CENTERS

Rationale and Evidence

- The multisite CMS Strong Start evaluation found that among Medicaid clients with similar risk profiles, compared to those who received typical care, those with birth center care had lower rates of preterm, low birth weight, and cesarean birth; higher rates of vaginal birth after cesarean; high rates of breastfeeding and satisfaction; and lower costs.[21]
- Strong Start clients did not experience outcome gaps in cesarean and breastfeeding rates and care experiences.[22]
- Community-based birth center care, led by those who best understand challenges and solutions, is essential for a just and effective maternity care system.[23]
- Childbearing women's interest in birth center care is far greater than their actual access and use.[24]
- Shifting 1 percent of the nation's births from hospitals to birth centers would save $189 million annually.[25]

Current State

- Federal mandate requires Medicaid agencies to cover freestanding birth centers and their care providers when licensed or otherwise recognized by the state,[26] and CMS subsequently clarified that this also applies to Medicaid health plans.[27] Yet licensure, restrictive regulations, contracting, and payment barriers exist in most states.[28]

CMS-Provided Pre-Implementation Period Milestones

- Completed a payment analysis that compares the facility fee rate for birth centers as a proportion of a relevant benchmark rate and has a process in place for completing annual analyses thereafter.
- Created a plan for providing information to beneficiaries on birth centers, if licensed, accredited, and operating in the state.
- Completed an implementation plan for establishing more sustainable reimbursement rates for birth centers.

Increase Access to Birth Centers continued

Policy Checklist

- ☐ Develop a process for licensing and regulating birth centers using best practices[29] in: AL, IA, ID, ME, NC, ND, VA, VT, and WI.[30]
- ☐ Ensure that Medicaid reimburses birth center facilities and providers and that Medicaid health plans contract with birth centers in their service areas.[31]
- ☐ Remove certificate-of-need (CON) requirements for birth centers in: AL, AR, CT, DE, GA, KY, MA, MD, NJ, NY, OK, RI, VT, and WV.[32]
- ☐ Require Medicaid MCOs to cover birth centers and list them in plan directories in: AZ, AR, CO, FL, HI, IN, KY, MI, MS, NC, OR, SC, and VA.[33]
- ☐ In states that license and/or regulate birth centers, align with best regulatory best practices[34] and remove overly restrictive requirements that are barriers to opening and sustaining birth centers, e.g., for medical directors, written consultative agreements, written hospital transfer agreements, and facility requirements that are relevant to surgical centers.
- ☐ Remove or reduce overly burdensome fees associated with licensing and credentialing.
- ☐ Review reimbursement practices and consider cost-based or prospective payment for Medicaid beneficiaries similar to FQHCs and Rural Health Clinics or reimburse birth centers at the same rates for the same facility codes (e.g., vaginal birth, uncomplicated, and newborn, uncomplicated).
- ☐ Align with recommendations of the Commission for the Accreditation of Birth Centers[35] to standardize facility code sets and payment levels common to all maternal and newborn services, regardless of licensed provider type, licensed facility type, or location of services. The aim is to foster appropriate use of Medicaid and commercial insurance dollars and sustainable birth center payment levels.
- ☐ Reimburse birth centers for longer-than-standard prenatal and postpartum visits that are central to the relationship-based, preventive, education-focused care they provide.
- ☐ Invest in capital costs to develop new birth centers, which may involve working with philanthropy, the legislature, or others.
- ☐ Support any community-led Birth Center Equity member birth centers in your state.[36]

Key Resources

- AABC's *Transforming Maternal Health: Viable Solutions to the Maternal Health Crisis*[37]
- MACPAC's *Access to Maternity Providers: Midwives and Birth Centers*[38]
- PBGH's *Hospital Guide to Integrating the Freestanding Birth Center Model*[39]
- CHQPR's *An Alternative Payment Model for Maternity Care*[40]
- AIM's *Community Birth Transfer Resource Kit*.[41]

3

REQUIRED

COVER DOULA SERVICES

Rationale and Evidence

- Compared to usual care, doula support during childbirth is associated with increased rates of spontaneous vaginal birth, reduced cesareans and use of pain medications, and increased patient satisfaction.[42]
- Doula support extended during pregnancy is associated with lower rates of preterm birth and low birthweight and increased rates of breastfeeding initiation.[43]
- In Medicaid specifically, doula support was associated with 47 percent fewer cesareans, 29 percent fewer preterm births, and a 46 percent increase in having a postpartum visit.[44]
- Community-based doula support, led by those who best understand challenges and solutions, is essential for a just and effective maternity care system.[45]
- Studies show that doula support is cost-effective, in addition to improving outcomes.[46]

Current State

- CMS has state plan amendment and Medicaid authority pathways for reimbursing doula services, which most states have used.
- As of February 2024, 24 state Medicaid programs cover doula services and five others are preparing to implement reimbursement.[47]

CMS-Provided Pre-Implementation Period Milestones

- Completed workplan for initial payment analysis.
- Completed a payment analysis that compares the reimbursement rate for Doula Services as a proportion of a relevant benchmark rate and has a process in place for completing an annual analysis thereafter.
    - Submitted, or has a timeline and process in place for submitting and implementing a State Plan Amendment (SPA)/waiver to cover doula services, if not already covered.
    - Convened a State Doula Support Council, if such a council is newly established.

Cover Doula Services continued

Policy Checklist

- ☐ Complete preparations for Medicaid and CHIP doula reimbursement in: AR, CT, DE, NH, and TN.[48] Build on implementation experiences of other states[49] and data from community consultation.[50] Cocreate programs with doulas.[51]
- ☐ Obtain authority to cover doulas through Medicaid and CHIP via a SPA or other mechanism[52] in: AK, AL, GA, HI, IA, ID, IN, KY, LA, ME, MS, MT, NC, ND, NE, SC, TX, UT, VT, WI, WV, and WY[53].
- ☐ Where Medicaid does cover doula services, strengthen the program, including by supporting doula training and practice and educating Medicaid beneficiaries about the benefit. (AZ, CA, CO, DC, FL, IL, KS, MA, MD, MI, MN, MO, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SD, VA, and WA[54]).
- ☐ Require Medicaid MCOs to cover doulas and list them in plan directories in: AR, AZ, CO, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MA, MS, MO, NE, NH, NM, NY, NC, ND, OH, PA, SC, TN, TX, UT, WA, WV, and WI.[55]
- ☐ Review doula payment rates and increase, as necessary, to allow doulas to be paid:
  - a living wage, taking into account that many are independent contractors and not receiving employee benefits
  - for working in all settings to cover the number and length of visits, and unpredictable nature of work (e.g., scheduling, hours, etc.).
- ☐ Eliminate total hours or visit limits for doula services so they can provide care in accordance with their patient's needs.
- ☐ Support hospitals in creating favorable climates for doula services.[56]

Key Resources

- NPWF's *Increasing Access to High-Performing Maternity Services: Doula Support; Operational Guidance*[57]
- Prenatal-to-3 Policy Impact Center's *Doula State Policy Lever Checklist*[58]
- NHeLP's Doula Medicaid Resource Library[59]
- CHCS's *Incorporating Community-Based Doulas into Medicaid*[60]
- NASHP's *State Medicaid Approaches to Doula Service Benefits*[61]

4

REQUIRED

IMPROVE DATA INFRASTRUCTURE

Rationale and Evidence

- Structural, institutional, and interpersonal partiality is a major driver of maternal morbidity and mortality.[62]
- Accurate data are essential for understanding and effectively addressing health outcome gaps.
- Gaps in maternal care access, quality, experiences, outcomes, and affordability are persistent, large, and widespread and affect a broad range of groups.[63]
- An estimated 84 percent of maternal mortality is considered preventable.[64]

Current State

- Our health care data systems are deeply siloed, and it is hard for states to obtain and link data across different state resources and clinical settings.[65]
- Health systems often fail to accurately capture people's self-provided demographic data.
- Health systems lag in collecting, reporting, and using self-reported data to understand, monitor, and improve maternal and infant health outcome gaps.[66]
- While legacy maternity care alternative payment and delivery programs did not even track outcomes by demographic subgroups, more recent programs, largely led by Medicaid agencies, do work to understand and address gaps.[67]

CMS-Provided Pre-Implementation Period Milestones

- Established a timeline and plan for linking Medicaid data and vital records, if the data have not yet been linked by the end of the pre-implementation period. Plans should include the execution of necessary data-sharing and related agreements for linking Medicaid and vital records. Note: Recipient will identify any state laws and regulations that restrict vital records data-sharing and linkage as required in this NOFO and should propose solutions for obtaining vital records data elements in their application, if needed. See Section F.6.1.2 Evaluation.
- With TA contractor assistance, recipient has completed data needs assessment and draft work plan with partner providers and partner care delivery locations to stratify demographic data and has identified challenges and has a clear timeline and process for resolution.
- With TA contractor assistance, recipient has completed data needs assessment and draft work plan to identify model beneficiaries who are also utilizing social service and benefit programs such as WIC/SNAP, for the purpose of measuring and addressing cross-program enrollment gaps.
- Collect and report stratified demographic data, and match beneficiary data across social service and benefit programs such as WIC/SNAP.

Policy Checklist

- ☐ Ensure that data systems capture Z codes to support social needs screening and follow up.[68]
- ☐ Implement United States Core Data for Interoperability (USCDI)+ Maternal Health Dataset, a standardized set of data elements for interoperable clinical, public health, and other data exchange, including linking of maternal and infant records.[69]
- ☐ Use a maternal health justice data collection and sharing checklist[70] to:
  - Assess the current state of data collection in the state (including in Medicaid and other public programs).
  - Develop an improvement plan to standardize maternal health data.
  - Implement, refine data collection, use, and sharing strategies.
- ☐ Update data systems to capture demographic data according to new federal standards announced in March 2024 by the U.S. Office of Management and Budget (OMB).[71]
- ☐ Ensure that Medicaid health plans adopt and align with the new OMB standards.[72]
- ☐ Ensure that stratified performance measure data are collected, reported, and used to guide improvement goals and benchmarks, as appropriate.[73]

Key Resources

- CMS's *Resource of Health Equity-Related Data Definitions, Standards & Stratification Practices*[74]
- Daw et al.'s Using Modernized Medicaid Data to Advance Evidence-Based Improvements in Maternal Health[75]
- CMS's *CMS Framework for Health Equity 2022–2032*[76]
- Burton et al.'s Principles of Health Equity Science for Public Health Action[77]

5

REQUIRED

DEVELOP PAYMENT MODEL

Rationale and Evidence

- Leveraging payment is an underused and underdeveloped strategy for mitigating the maternal health crisis.[78]
- Leveraging payment is key to reforming care delivery, including improving maternal health outcomes. This means moving from fee-for-service maternity care payment to alternative payment models (APMs).

Current State

- To date, few payers have offered maternity care APMs, and provider participation has been limited.[79]
- Maternity care APMs have not provided evidence of improving maternal-infant health. While legacy programs did not focus on outcome gaps, newer, primarily Medicaid-led programs prioritize gap reduction, but are too new to show results.[80]
- Examining maternity care APMs that are operating or under development identifies many opportunities for stronger designs with the potential to advance better care and outcomes.[81]

CMS-Provided Pre-Implementation Period Milestones

- With policy and analytic guidance, created a plan, process and timeline for implementing the MY4 and MY5 payment requirements, including:
    - Using the appropriate Medicaid authority to implement the payment model
    - Listed personnel necessary to implement the payment model, including description of roles and responsibilities and budget to support efforts
    - Stakeholder engagement plan for ongoing conversations with providers and MCP, where applicable
    - Quarterly meeting cadence established with CMS staff and contractors
    - Draft payment model implementation workplan submitted to CMS
    - Final payment model implementation workplan submitted to CMS, including MCP engagement plan, and MCP contracting timeline
    - Establishing payment model benchmarks in partnership with CMS, including cost and quality thresholds

Develop Payment Model continued

Policy Checklist

- ☐ Proactively develop trusted collaboration between all stakeholders, including patients, community-based organizations and leaders; relevant Medicaid health plans; and clinicians and facilities that will provide care within a new APM.
- ☐ Ensure data infrastructure enables standardized collection and analysis of stratified demographic and performance data.
- ☐ Ensure that performance measures are fit-for-purpose: developed through established consensus processes, interpretable at measurement level, and with potential for population-level improvement of core drivers of maternal-infant health; avoid low-impact measures.[82]
- ☐ Ensure that performance measures include person-reported outcome and experience measures.
- ☐ Build systems for near real-time rapid-cycle evaluations of APMs, technical assistance and feedback for providers, and expectations of continuous quality improvement.

Key Resources

- NPWF's Design Guide for Effective Maternity Care Alternative Payment Models (Section 3 of this Playbook).
- NPWF's *Designing Effective Delivery and Payment Programs to Advance Maternal and Infant Health Equity and Excellence: Operational Guidance*[83]
- CHQPR's *An Alternative Payment Model for Maternity Care*[84]
- Maternal Health Hub's *Using Alternative Payment to Transform Maternity Care, Address Disparities, and Improve Outcomes*[85]

6

OPTIONAL

COVER CERTIFIED MIDWIVES (CMs) AND CERTIFIED PROFESSIONAL MIDWIVES (CPMs)

Rationale and Evidence

In addition to the Rationale and Evidence described above at required element "Increase access to the midwifery workforce":

- Certified midwife (CM) and certified professional midwife (CPM) are newer, nationally recognized credentials that have not yet been included in the federal Medicaid statute and thus are licensed and reimbursed by Medicaid on a state-by-state basis.
- CMs are educated to practice in all care settings.
- CPMs are educated to provide care in birth center and home settings.
- CMs and CPMs expand access to midwifery care and choice among care settings.

Current State

- 13 states and the District of Columbia license CMs.
- 37 states and the District of Columbia license CPMs.
- Only about half of the states that license CMs and CPMs, respectively, provide Medicaid reimbursement to midwives with these credentials

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Cover Certified Midwives (CMs) and Certified Professional Midwives (CPMs) continued

Policy Checklist

- ☐ Enact CM licensure without restrictions to support full-scope midwifery in accordance with CM competencies and education, as well as Medicaid reimbursement with physician payment parity in: AK, AL, AZ, CA, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NV, OH, OR, PA, SC, SD, TN, TX, UT, VT, WA, WI, WV, WY, and all U.S. territories.
- ☐ Enact CPM licensure without restrictions to support full-scope midwifery in accordance with CPM competencies and education, as well as Medicaid reimbursement with physician payment parity in: CT, GA, KS, MO, MS, NC, ND, NE, NV, NY, OH, PA, WV, and all U.S. territories.
- ☐ Remove existing statutory and regulatory restrictions to enable CMs and CPMs to practice full-scope midwifery in accordance with their competencies and education.
- ☐ Mandate Medicaid reimbursement of CMs and/or CPMs at 100 percent of the physician rate in the following states: AL, AR, CO, CT, DE, GA, HI, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, ND, NE, NV, OH, OK, PA, RI, SD, TN, UT, WI, and WV.
- ☐ Require Medicaid MCOs to cover CMs and CNMs, as licensed, and list in provider directories in: AZ, AR, CO, DC, GA, HI, IL, IN, KS, KY, LA, MD, MA, MI, MS, MO, NE, NC, ND, OH, OR, PA, RI, SC, TN, UT, VA, WA, and WV.[86]
- ☐ Support or create in-state CM and CPM midwifery education programs, including at minority-serving institutions, to increase the supply of CMs and CPMs. Support could include directing resources to schools or programs, to students, and/or to preceptors.

Key Resources

- ACNM's *Midwifery Policy Toolkit*[87]
- ACNM's *Access to Midwifery Care National Chartbook*[88]
- ACNM's Workforce Study Data Release[89]
- ACNM's Workforce Study Data Briefs[90]
- ACNM's Information to Share About Advanced Practice Midwives[91]
- MACPAC's *Access to Maternity Providers: Midwives and Birth Centers*[92]

7

OPTIONAL

COVER PERINATAL COMMUNITY HEALTH WORKERS (CHWs)

Rationale and Evidence

- When integrated into clinical care and public health, CHWs provide bridges with communities and can help with prevention, chronic condition management, gaps in outcomes, experiences, and lower costs.[93]
- Birth workers provide perinatal health support services (e.g., lactation, doula, and childbirth education), but rarely identify as CHWs.[94]
- Perinatal health workers use support skills similar to CHWs and may be especially well-positioned to support childbearing families.[95]
- Both birth workers and perinatal CHWs provide tailored, often culturally congruent, trust-based support for low-resource high-need families.[96]
- Many birth workers report providing uncompensated services in addition to those they are paid for.[97]

Current State

- Many childbearing families need help with mental health, care navigation, and social and other needs for better health outcomes.
- Providing CHWs with additional maternity-specific training and credentials and/or birth workers with additional training and credentials as CHWs may increase the cadre of workers who can meet needs of childbearing families *and* receive reliable payment and support.[98]
- While few programs train perinatal CHWs, there is great potential to build on those programs and on CHW work in other clinical areas for many established perinatal roles, including care navigation; lactation support; peer mental health support; pregnancy, childbirth, and parenting education; and doula support.[99]

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Policy Checklist

- ☐ Establish mechanisms to pay perinatal community health workers adequately in community and health care settings through the most appropriate Medicaid/CHIP vehicle (such as SPAs, 1115 waivers, ACA Health Home options or through managed care requirements) in these states: AL, AK, CT, DE, DC, FL, HI, IA, ID, MO, MS, MT, NE, NH, OH, SC, TN, TX, VA, WI, WV, and WY.[100]
- ☐ Review access, payment levels, education, and other supports for perinatal CHWs and improve, as needed, to allow perinatal CHWs to gain perinatal expertise, make a living wage, and be paid for their work in community and health care settings in the following states, which pay CHWs through Medicaid/CHIP and/or Medicaid health plans: AR, AZ, CA, CO, GA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, NC, ND, NJ, NM, NV, NY, OK, OR, PA, RI, SD, UT, and WA.[101]
- ☐ Require Medicaid MCOs to cover CHWs and list them in plan directories in AZ, AR, CO, DC, DE, FL, GA, HI, IL, IN, IA, KS, KY, MD, MA, MS, MO, NE, NH, NM, NY, NC, ND, OR, PA, RI, SC, TN, UT, VA, WA, WV, and WI.[102]
- ☐ In states that recognize and support CHWs, provide educational opportunities and other supports for birth workers to be recognized as CHWs.[103]
- ☐ Contract with and provide access to the services of community-based perinatal health worker groups and CHWs with perinatal health expertise.[104]

Key Resources

- NACHW's website[105]
- NASHP's *State Community Health Worker Policies*[106]
- CMS's *On the Front Lines of Health Equity: Community Health Workers*[107]
- HHS Office of Inspector General's *States Could Better Leverage Coverage and Access Requirements to Promote Maternal Health Care Access in Medicaid Managed Care*[108]
- Policy Center for Maternal Mental Health's *Gaps in Peer Support Reimbursement and Certification in the United States*[109]

8

OPTIONAL

CREATE REGIONAL PARTNERSHIPS IN RURAL AREAS

Rationale and Evidence

- Rural regional partnerships pool diverse care resources and technologies to fill maternity service care gaps in rural areas.
- Limited access to maternity care services in rural areas requires extensive travel to hospitals that have maternity wards, limits options for childbearing women who depend on emergency departments, and puts them at higher risk for perinatal complications.[110]
- Compared to childbearing women in adequate and moderate maternity care access counties, those in no-access counties are more likely to have lower incomes, be uninsured, have chronic conditions, have more babies, and have preterm births.[111]
- Key factors in maternity unit closures are low volume, insufficient reimbursement rates, and personnel shortages.[112]
- Outcomes for birth center clients in rural areas are comparable to those in urban and suburban areas.[113]

Current State

- More than 35 percent of U.S. counties (1,104 of 3,142) are "maternity care deserts" with neither a birthing facility nor a maternity care provider; many additional counties have low maternity care access.[114]
- Annually, more than 150,000 babies are born to families residing in maternity care deserts, and 200,000 are born to families in low-access counties.[115]
- Access to maternity services in rural areas is steadily eroding. More than 100 maternity units closed over a recent two-year period.[116]

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Create Regional Partnerships in Rural Areas continued

Policy Checklist

- ☐ Increase access for remote childbearing families by pooling diverse care resources and technologies through partnerships with, e.g., the state Medicaid agency, hospital systems, federally qualified health centers, rural health clinics, birth centers, and mental health agencies.
- ☐ Cover telemedicine for maternal health care and reimburse at parity with in-person care.
- ☐ Use mobile clinics for access to prenatal and postpartum care.
- ☐ Establish payment systems with standby payments to cover fixed costs of having maternity services available locally and surmount unsustainable payment based on volume alone.[117]
- ☐ Support enhanced education in rural maternal-newborn care for family physicians and other providers who desire rural setting practice.
- ☐ Augment general surgeon education with skills for cesarean birth and repair of severe perineal tears, complemented by CNM and CM skills for surgical first assist, assisted vaginal birth, ultrasonography, and perinatal mental health.
- ☐ Develop agreements for on-demand synchronous consultation with high-risk centers for rural emergency departments and rural maternity units.
- ☐ Collaborate with stakeholders to establish midwifery-led birth centers in rural settings.

Key Resources

- National Rural Health Association's Obstetric Readiness in Rural Communities Lacking Hospital Labor and Delivery Units[118]
- RHIhub's Rural Maternal Health Toolkit[119]
- CMS's Advancing Rural Maternal Health Equity[120]
- March of Dimes' *Nowhere to Go: Maternity Care Deserts Across the US; 2024 Report*[121]
- CMS's *Improving Access to Maternal Health Care in Rural Communities*[122]
- AIM's *Obstetric Emergency Readiness Resource Kit*[123]
- HRSA's Rural Maternity and Obstetrics Management Strategies (RMOMS) Program[124]
- HRSA's *Evaluation of the Rural Maternity and Obstetrics Management Strategies (RMOMS) Programs*[125]
- NPWF's *Foster an Optimal Maternity Care Workforce Composition and Distribution*[126]
- Gilburg et al.'s *Innovations in Rural Obstetrics to Maintain Access to Care*[127]

9

OPTIONAL

EXTEND MEDICAID ELIGIBILITY TO 12 MONTHS POSTPARTUM

Rationale and Evidence

- The option to extend Medicaid coverage to 12 months postpartum has been in effect since April 1, 2022.[128]
- Many maternal deaths and cases of severe maternal morbidity occur within the year after birth.[129]
- Much new-onset maternal morbidity starting in the first two months after birth persists through six months or more.[130]
- The severe health conditions that happen during the first year after birth include: hypertension, sepsis, diabetes, cardiovascular, and mental health conditions.[131]
- Extending Medicaid coverage is especially helpful for childbearing women who are unmarried, have lower education levels, and live in states that have not expanded Medicaid to low-income adults, among other groups.[132]

Current State

- As of January 17, 2025, 48 states and DC had implemented Medicaid extension to 12 months postpartum.[133]
- As of January 17, 2025, WI had proposed a 90-day extension, and AR had rejected extension.[134]
- As of February 12, 2025, the following 10 states had not implemented Medicaid expansion: AL, FL, GA, KS, MS, SC, TN, TX, WI, and WY.[135]
- The following nine states have trigger laws that will end Medicaid expansion if a future policy lowers the federal matching below 90 percent or a specified threshold: AR, AZ, IL, IN, MT, NC, NH, UT, and VA. Three states require fiscal mitigation to offset funds in the event of reduced federal matching: IA, ID, and NM.[136]

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Policy Checklist

- ☐ Preserve access/improvements in the 48 states that have extended Medicaid coverage to 12 months postpartum.
- ☐ AR and WI should submit state plan amendments (SPAs) to extend Medicaid coverage to 12 months postpartum and remove any restrictions on the minimum essential benefits during this period.[137]
- ☐ States that have implemented Medicaid 12 months postpartum extension should educate beneficiaries, providers, and other stakeholders about the availability of continuous extended postpartum coverage. They may use Medicaid and CHIP administrative matching funds for education and outreach.[138]
- ☐ Educate Medicaid members about this benefit and maximize its impact by working with plans, providers, and home visiting programs to identify and support those with postpartum needs.[139]

Key Resources

- CMS's *Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)*[140]
- NASHP's *Optimizing Postpartum Coverage Extension*[141]
- ACOG's *Questions and Answers: Extending Medicaid Coverage for Pregnant People Beyond 60 Days Postpartum*[142]

1

REQUIRED

SUPPORT IMPLEMENTATION OF ALLIANCE FOR INNOVATION ON MATERNAL HEALTH (AIM) PATIENT SAFETY BUNDLES

Rationale and Evidence

- Most severe maternal health outcomes are preventable, including an estimated 84 percent of pregnancy-related deaths.[143]
- To avert avoidable maternal and infant harm and support quality improvement, the Alliance for Innovation on Maternal Health (AIM) has developed, and periodically updates, patient safety bundles to improve care processes and outcomes.[144]
- State perinatal quality collaboratives (PQCs) use these AIM bundles to lead statewide quality improvement initiatives that improve various maternal health outcomes and avert catastrophic harm.[145]

Current State

- All 50 states have perinatal quality collaboratives (PQCs), with some under development.[146] PQCs lead quality improvement projects for better maternal and infant health for all.
- PQCs work in partnership with hospitals, health systems, providers, patients, public health leaders, and others toward specific improvement goals, such as improving care processes relating to hemorrhage, sepsis, or preeclampsia.
- PQCs often use patient safety bundles from AIM.

CMS-Provided Pre-Implementation Period Milestones

- Established partnership (regularly participate in meetings, share information and action items) with PQC or entity leading AIM patient safety bundles across the state, particularly in facilities where no bundles have been implemented.
- Designed implementation plan to build capacity for participating in AIM patient safety bundles.
- Developed data collection and monitoring plan to support state safety bundle activity.
- Work with AIM and PQC convenors to expand database to systematically collect relevant quality, process, or structure and outcomes measures data.

Policy Checklist

- ☐ Strengthen data infrastructure to be able to collect and share bundle-related performance information, stratified by priority demographics.
- ☐ Encourage or incentivize facilities not actively working with a PQC on implementing AIM bundles to commit to doing so.
- ☐ Participating facilities should avoid backsliding by integrating "completed" bundle practices and learnings into their workflows and maternity culture to achieve and sustain high levels of performance.
- ☐ Given that bundle activities focus on averting catastrophic harm, consider as well how Medicaid can encourage additional QI activities focused on upstream preventive practices.

Key Resources

- AIM's website[147]
- CDC's *Developing and Sustaining Perinatal Quality Collaboratives*[148]

2

REQUIRED

SUPPORT "BIRTHING-FRIENDLY" HOSPITAL DESIGNATION

Rationale and Evidence

- CMS awards the Birthing-Friendly hospital designation to any hospital or health system that annually attests that it meets both elements of the Maternal Morbidity Structural Measure: participation in a perinatal quality collaborative (PQC) and implementation of patient safety bundles with the PQC.[149]
- During the initial performance period for the Maternal Morbidity Structural Measure, a majority of the nation's hospitals with maternity units received this designation.[150]
- To better differentiate birthing facilities, CMS plans to add additional designation criteria in the future.

Current State

- Most hospitals (2,225) with maternity units have received the birthing-friendly designation, and just 135 hospitals did not meet the criteria for receiving the designation.[151]
- The Care Compare website identifies hospitals that have received the designation[152] and CMS encourage provider directories to identify hospitals with this designation.
- Consumers would benefit from adding more criteria to the designation and identifying a smaller proportion of high-quality facilities.[153]

CMS-Provided Pre-Implementation Period Milestones

- Completed analysis of hospitals and critical access hospitals with birthing facilities to identify challenges in attaining the birthing-friendly designation and actions that can be taken so that any remaining hospitals achieve the birthing-friendly designation.
- Attested that the birthing-friendly hospital designation is displayed in provider directories, where applicable.

Policy Checklist

- ☐ Support hospitals in your state to implement quality improvement strategies led by the PQC.
- ☐ As CMS adds new criteria to the Birthing-Friendly hospital designation, support hospitals in meeting them.

Key Resources

- CMS's Fact Sheet: *Vice President Kamala Harris Announces Call to Action to Reduce Maternal Mortality and Morbidity*[154]
- CMS's *Maternal Morbidity Structural Measure*[155]

3

OPTIONAL

PROMOTE SHARED DECISION-MAKING

Rationale and Evidence

- Informed consent is a legal and ethical standard in health care. More formal, person-centered, individualized, and proactive shared decision-making processes support widely held values of agency, autonomy, personal choice, and improved health care experiences.
- The American College of Obstetricians and Gynecologists (ACOG) supports shared decision-making in reproductive health care.[156]
- Patient use of decision aids is associated with values-congruent care, better knowledge and understanding of risks, involvement in decision-making, and feeling informed and clear about values.[157]
- In maternity care, the use of decision aids increased knowledge, reduced anxiety and decisional conflict, and improved experience of care.[158]

Current State

- For key maternity care decisions, care processes align poorly with shared decision-making standards.[159] More reliable alignment could potentially offer great benefit to patients.[160]

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Policy Checklist

- ☐ Require providers (through direct or Medicaid health plan contracts) to implement shared decision-making and use patient decision aids that meet core criteria. Available topics include breastfeeding, childbirth, prematurity, prenatal testing, and vaccination.[161]
- ☐ Encourage providers to develop decision worksheets for priority maternity care decisions where decision aids are not available.[162]
- ☐ Offer personal decision guide tools to patients facing specific decisions to help them think about the decision, clarify what matters most to them, and plan next steps.[163]
- ☐ Provide shared decision-making trainings to care teams.[164]
- ☐ Use a nationally endorsed shared decision-making performance measure to assess baseline shared decision-making practice and monitor trends.[165]
- ☐ Consider adopting the comprehensive SHARE approach, with trainings, workshops, tools, and success stories.[166]

Key Resources

- AHRQ's SHARE Approach[167]
- OHRI's Patient Decision Aids Research Group[168]
- MGH's Health Decision Sciences Center[169]

1

REQUIRED

INCREASE RISK ASSESSMENTS, SCREENINGS, REFERRALS AND FOLLOW-UP FOR PERINATAL DEPRESSION, ANXIETY, TOBACCO USE, SUBSTANCE USE DISORDER, AND HEALTH-RELATED SOCIAL NEEDS

Rationale and Evidence

- Whole-person care is widely understood to involve caring for a person's physical health, mental/behavioral health, and unmet social needs.
- Unmet social needs play a major role in poor maternal-infant health outcomes and health outcome gaps.[170]
- Perinatal mental health conditions are the most common complication of childbearing[171] and the leading cause of pregnancy-related deaths,[172] yet health systems fail to address these treatable conditions in up the three-quarters of cases.[173]
- Substance use disorder (SUD) is a serious yet preventable maternal-infant health risk factor.[174]
- Individuals from many communities and low-income individuals disproportionately experience both perinatal mental health conditions and unmet social needs.[175]
- Smoking during pregnancy has many short- and long-term harms for both the pregnant person and child.[176]
- Although there are effective interventions for smoking cessation in pregnancy,[177] in 2022, about 4 percent of pregnant women in the United States smoked, with highest rates among AIAN, followed by white individuals.[178]

Current State

- Maternity care is generally *not* oriented toward providing whole-person care, especially attention to mental/behavioral health and social needs.
- Screening for mental health, social needs, and substance use issues, is not standard in maternity care.
- Many providers are reluctant to screen, as they lack knowledge of community referrals.
- The primary focus on physical health needs is partly driven by resources available for office visits: about four-fifths of all dollars paid on behalf of the birthing person and newborn are allocated to the hospital phase of care.[179]
- The maternity care home model, with personnel who are prepared, tasked, resourced, and held accountable for helping with social and mental health needs and other supports, is extremely limited at present.[180]
- CMS has identified various Medicaid authorities that states could use to resource for better whole-person care, such as engaging community-based personnel and covering unmet social needs.[181] (See also: "Cover Perinatal Community Health Workers," above.)

CMS-Provided Pre-Implementation Period Milestones

- **Risk assessment**
  - Identification and selection of risk assessment tools, as appropriate
  - Plan to implement medical and social risk assessments for risk appropriate care
- **Screening/referral for behavioral health needs**
  - Drafted a process/journey map of existing screening and referral processes for perinatal beneficiaries with behavioral health needs
  - Identified workflows and data collection processes for related quality measures
  - Selected specific screening tools
  - Identified areas of improvement through completed process map
  - Drafted implementation plan to address identified gaps
  - Trained hospital and provider staff, as appropriate, on selected screening tools
  - Established specific follow-up protocol for positive behavioral health screens and behavioral health workforce linkages made
- **Screening/referral for SUD and tobacco use**
  - Drafted a process/journey map of existing screening and referral processes for perinatal beneficiaries with SUD or tobacco use
  - Identified workflows and data collection processes for quality measures
  - Selected specific screening tools
  - Identified areas of improvement through completed process map
  - Drafted implementation plan to address identified gaps
  - Trained hospital and provider staff, as appropriate, on specific screening tools
  - Established specific follow-up protocol for positive SUD or tobacco-use screens and behavioral health workforce linkages made, where needed
- **Screening/referral for HRSNs**
  - Drafted implementation plan to address identified gaps
  - Identified workflows and data collection processes for quality measures
  - Selected specific screening tools
  - Established bi-directional referral pathways such that providers can connect beneficiaries to CBOs and receive notification when the CBO is engaged
  - Trained staff on specific screening tools
  - Established specific follow-up protocols for identified needs

Policy Checklist

- ☐ Identify mental health, substance misuse, and social needs screening tools and companion implementation resources from key inventories, including PROMIS and SIREN.[182]
- ☐ If in TMaH, note that it requires screening and follow-up on food insecurity, housing instability, and transportation needs, using a validated IT-encoded tool such as the Accountable Health Communities Health-Related Social Needs Screening tool.[183]
- ☐ If in TMaH, prepare your program for the incorporation of a depression screening and follow-up measure into the calculation of performance incentive provider payments in model year 4.[184]
- ☐ Integrate screening, follow-up, performance measure documentation activities, and associated personnel into clinical workflows and data systems.[185]
- ☐ Require Medicaid care teams (through direct contracts or managed care plans) to use standardized, validated tools for perinatal depression and anxiety, social needs, and substance use screening, and provide support.[186]
- ☐ Consider establishing maternity care home delivery and payment reform models, with accountability mechanisms, to address maternity care provider capacity limits, engage community-based and other personnel, provide care navigation, monitor and track activities and performance, and meet related needs.[187]
- ☐ Use Medicaid authorities and other Medicaid resources to provide screening, referral, and flexible funding for meeting social needs and behavioral and mental health needs.[188]
- ☐ Work with stakeholders, especially community leaders and organizations, to establish community care hubs for meeting social needs to ensure a continuously updated inventory of the most promising and accessible place-based resources for those who need them.[189]
- ☐ Participate in CMS maternal mental health and substance use disorder support programming.[190]

Increase Risk Assessments, Screenings, Referrals... continued

Key Resources

Generally:

- PROMIS: Patient-Reported Outcomes Measurement Information System[191]
- KFF's *Medicaid Coverage of Pregnancy-Related Services: Findings From a 2021 State Survey*[192]

For social needs:

- Domestic Policy Council's *U.S. Playbook to Address Social Determinants of Health*[193]
- CMS's *Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program*[194]
- SIREN's Evidence and Resource Library[195]
- NPWF's *Addressing Social Drivers of Health in Maternity Care Settings*[196]

For perinatal mental health:

- HHS's *Task Force on Maternal Mental Health's Report to Congress*[197]
- SAMHSA's *National Strategy to Improve Maternal Mental Health Care*[198]
- AIM's Perinatal Mental Health Conditions[199]
- MMHLA's Maternal Mental Health Toolkits[200]
- MMHLA's Resource Hub[201]
- The Policy Center for Maternal Mental Health's State Report Cards[202]
- The Policy Center for Maternal Mental Health's *2023 State Maternal Mental Health Legislation Report*[203]
- The Policy Center for Maternal Mental Health's *2025 Pending State Maternal Mental Health Legislation*[204]
- The Policy Center for Maternal Mental Health's Maternal Mental Health Nonprofit Map[205]
- The Policy Center for Maternal Mental Health's Resources for Providers[206]
- The Policy Center for Mental Health's Certified Peer Support[207]
- CMS's webinars on maternal mental health and substance use disorder[208]
- AIM's *Care for Pregnant and Postpartum People with Substance Use Disorder*[209]
- KFF's *Opioid Use Disorder and Treatment Among Pregnant and Postpartum Medicaid Enrollees*[210]

2

REQUIRED

INCREASE HOME MONITORING OF DIABETES AND HYPERTENSION

Rationale and Evidence

- Pre-existing diabetes and hypertension, as well as the new onset of these conditions during pregnancy, increase health risks during and beyond childbearing.[211]
- According to 2023 birth certificates (which may undercount) the prevalence of pre-pregnancy hypertension is 3 percent, gestational hypertension is 10 percent, pre-pregnancy diabetes is 1 percent, and gestational diabetes is 8 percent, and there are gaps among demographic groups and geographies. [212]
- Home blood pressure monitoring, an increasingly common component of pregnancy care, has established benefits,[213] as do continuous and intermittent glucose monitoring.[214]
- ACOG recommends self-monitoring of blood pressure in pregnancy and routine monitoring of glucose levels with gestational diabetes.[215]

Current State

- While most state Medicaid programs cover pregnancy-related at-home automated blood pressure devices and continuous glucose monitors, some do not, and others have restrictive prior authorization or medical necessity requirements that create unnecessary barriers to this best practice.[216]
- Among 41 states responding to a 2021 survey, most provided some pregnancy-related blood pressure monitor coverage. Ten did not cover blood pressure monitors (FL, KS, LA, MT, OK, SC, TN, WA, NV, and WY), four required prior authorization (AZ, CO, CT, and MS), one required a prescription (NJ), five required a statement of medical necessity (AK, CA, MO, MS, and NC), and two placed quantity limits (NC and PA).[217]
- Among 41 states responding to a 2021 survey, 35 provided some pregnancy-related coverage of glucose monitors. Six required prior authorization (MS, NC, NV, OK, TX, and WA), three required a statement of medical necessity (CA, LA, and MT), two placed quantity limits (NC and PA), and six states provided no coverage (AK, CT, FL, KS, OR, and WI). A 2023 online review found that 42 states and DC provided adult Medicaid beneficiaries with continuous glucose monitoring for Type 1 diabetes (9 states) or both Type 1 and Type 2 (33 states plus DC).[218]
- Both clinicians and pregnant and postpartum women would benefit from training aiming to ensure that appropriately selected women routinely undertake home monitoring of these conditions.

CMS-Provided Pre-Implementation Period Milestones

- Determined whether a SPA or waiver is needed for Medicaid coverage of home monitoring.
- Created a draft partnership plan between the recipient and public health department, MCP and/or other organization (e.g., university) on the design and implementation of home monitoring, as appropriate.
- Completed draft SPA/waiver documents, as needed, and submitted for internal review, as required.
- Met with partners, such as the state public health department, MCP, and/or other organization (e.g., university) and updated partnership plan, as appropriate.
- Drafted a plan (including information on Medicaid coverage and reimbursement, information for providers on offering and tracking home monitoring services, devices, and apps needed) for how to implement home monitoring so that this intervention can be implemented in the implementation phase.

Policy Checklist

- ☐ Provide Medicaid coverage of blood pressure and glucose monitoring equipment, patient education, and other clinical support for self-monitoring, without requiring prior authorization or medical necessity processes.
- ☐ Cover blood pressure monitoring equipment in FL, KS, LA, MT, OK, SC, TN, WA, WV, and WY.[219]
- ☐ Remove prior authorization for blood pressure equipment in AZ, CO, CT, MS, and CO.[220]
- ☐ Reimburse providers for support of self-measured blood pressure in AL, AK, AR, CA, CT, DC, IL, IA, ME, MD, MA, MN, MS, MO, NV, NH, NY, ND, OK, SC, SD, TN, UT, VT, WA, and WI.[221]
- ☐ Provide Medicaid coverage for continuous glucose monitoring and nutritional counseling for women with gestational diabetes.[222]
- ☐ Consider pharmacy equipment benefits, which are often more convenient and take less time than procuring durable medical equipment.
- ☐ Develop a campaign to educate the Medicaid provider community to increase awareness of any new benefit or removal of coverage restrictions.
- ☐ Reimburse providers for supporting home monitoring and remotely monitoring data through connected at-home blood pressure or glucose monitors.
- ☐ Participate in CMS and CDC maternal hypertension control and cardiovascular support programming.[223]

Key Resources

- AIM's *Maternal Early Warning System Implementation Resource Kit*[224]
- AIM's *Severe Hypertension in Pregnancy*[225]
- CDC's *Hear Her* campaign[226]

A Note on Health Equity Plans

To align with latest federal policy, we have not included creating a "Health Equity Plan" in this playbook. For more information on the importance of creating and implementing health equity plans, and information on how to do so, please visit https://nationalpartnership.org/TMaH.

3

OPTIONAL

EXPAND GROUP PERINATAL CARE

Rationale and Evidence

- Compared to conventional individual prenatal care, group prenatal care with participants at similar points in their pregnancies typically offers longer visits, the opportunity to connect with and learn from peers, and self-managed wellness checks.
- The American College of Obstetricians and Gynecologists supports both group and individual prenatal care models.[227]
- Group prenatal care confers benefits for mental health. Reports are mixed as to whether this model has better or similar results to individual prenatal care for preterm birth, NICU admission, and breastfeeding.[228]
- Groups at higher risk for poor birth outcomes (including pregnant women who are adolescents, from underserved communities, and have substance use disorder or other chronic conditions) may especially benefit from group prenatal care.[229]
- Studies show that group prenatal care models that are designed to close outcome gaps or specifically tailored to be culturally concordant show potential for improving outcomes for some demographic groups.[230]

Current State

- Twelve of 41 state Medicaid programs responding to a 2021 survey covered group prenatal care as a Medicaid benefit: AZ, CA, CO, IL, IN, MI, MT, NJ, OR, SC, TX, and UT.[231]
- In recent years, opportunities to participate in group prenatal care have increased, although the extent of availability is unknown.
- Centering Pregnancy, a model offered by the Centering Healthcare Institute,[232] Supportive Pregnancy Care[233] from the March of Dimes, and less standardized models of group prenatal care are available.
- Some leaders have developed tailored group prenatal care programs for specific demographic groups (e.g., EMBRACE, Expect With Me) to foster better outcomes for all.[234]
- Pregnant women at greatest need appear to be most likely to benefit from group prenatal care.

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Expand Group Perinatal Care continued

Policy Checklist

- ☐ Incorporate group prenatal care into alternative payment models.[235]
- ☐ Help ensure that pregnant Medicaid beneficiaries have a choice between traditional one-to-one prenatal visits and a course of group prenatal visits.
- ☐ Activate Medicaid billing codes that allow for reimbursement, and especially higher reimbursement, for group prenatal care; do not place limits on number of visits and hours.[236]
- ☐ Develop an educational campaign to inform pregnant beneficiaries about group prenatal care, its benefits, and how they can receive it.
- ☐ Activate any state, federal, or private funding that can be used to increase access to group prenatal care, especially in higher-need communities.
- ☐ Work with your state legislature to expand access to group prenatal care.[237]

Key Resources

- Centering Healthcare Institute's website[238]
- March of Dimes' Supportive Pregnancy Care[239]
- Prenatal-to-3 Policy Impact Center's *Group Prenatal Care State Policy Lever Checklist*[240]
- Prenatal-to-3 Policy Impact Center's Resources for Group Prenatal Care[241]
- Pekkala et al.'s Key Considerations for Implementing Group Prenatal Care: Lessons from 60 Practices[242]

4

OPTIONAL

INCREASE THE USE OF HOME VISITS, MOBILE CLINICS, AND TELEHEALTH

Rationale and Evidence

- Both the Healthy Start and many Home Visiting programs provide home visits to childbearing families. Both offer support services, and Healthy Start offers prenatal and postpartum care.[243]
- In addition to potentially living in maternity care deserts or low-access areas,[244] pregnant women often face other barriers to traveling to clinical service locations, including paid employment (that often does not provide paid leave or paid sick time), child or other family care responsibilities, and lack of transportation.[245]
- Alternative modalities for providing health care access, such as home visits, mobile units, and telehealth, can help address these barriers, and can also provide access to such additional services as lactation support, doula support, genetic counseling, and mental health services.
- A telehealth option in maternity care can increase access and improve outcomes, is widely appreciated by both patients and professionals, and was widely piloted during the COVID-19 pandemic.[246]
- Replacing or supplementing standard maternity care with telehealth is associated with clinical outcomes and patient satisfaction that are similar to or better than in-person care.[247]
- Mobile clinics have a high return on investment, tend to reach neighborhoods with high social vulnerability and disease burden, and are associated with earlier prenatal care initiation than other community health clinics.[248]

Current State

- In FY2023, home visiting programs served about 140,000 parents and children in all 50 states.[249]
- In 2022, Healthy Start served about 85,000 people in most states.[250]
- Telehealth was widely used to provide prenatal and postpartum care during the COVID-19 pandemic.
- While telehealth has the potential to improve maternal health outcomes for all, evidence to date is limited.[251]
- Mobile Health Map, a network of mobile clinics, identifies 109 mobile clinics providing maternity services in 35 states. There are approximately 3,000 mobile clinics operating in the United States.[252]
- Medicaid authorities that can be used to provide care through telehealth include waivers and managed care flexibilities.[253]

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Policy Checklist

- ☐ Use the full extent of SMA authority to cover the provision of maternal health care through telemedicine, home visits, and mobile clinics, and reimburse at the same level as care provided in traditional clinical locations.
- ☐ Apply for federal grants to create or expand home visiting programs.[254]
- ☐ Work with other stakeholders to explore funding sources to acquire mobile clinic vehicles.[255]

Key Resources

- CMS's *State Medicaid and CHIP Telehealth Toolkit*[256]
- HHS's Telehealth for Maternal Health Services[257]
- KFF's *Telemedicine and Pregnancy Care*[258]
- Mobile Healthcare Association's website[259]
- Mobile Health Map's Looking for a Place to Start?[260]

5

OPTIONAL

EXPAND ORAL HEALTH CARE

Rationale and Evidence

- Oral health is integrally related to a person's whole health and well-being through bidirectional relationships shaped by biology, behavior, and social-environmental factors.[261]
- Hormonal fluctuations during pregnancy may increase risks for periodontal disease and tooth loss, and for such serious birth outcomes as preterm birth, low birth weight, and preeclampsia.[262]
- Pregnant women's barriers to access to oral health services include lack of oral health insurance coverage, cost, lack of accessible dental health professionals, limited dental health education, and greater social needs.[263]

Current State

- As of December 31, 2023, 11 state Medicaid programs offer varying dental benefits to prenatal women that are generally not offered to other adults: AL, CO, GA, KY, MN, MO, NV, OR, UT, VT, and VA. Seven states also provide varying coverage to postpartum women: AL, CO, GA, MN, MO, VT, and VA. [264]
- In addition, effective October 20, 2022, states offered varying types of dental services to adult Medicaid beneficiaries:
  - Extensive: AK, CA, CO, CT, DC, ID, IL, IA, ME, MA, MT, NJ, NM, NY, NC, ND, OH, OK, OR, RI, SD, VT, VA, WA, WV, and WI
  - Limited: AR, DE, IN, KS, KY, LA, MI, MN, MS, MO, NE, NV, PA, SC, and WY
  - Emergency: AZ, FL, GA, HA, NV, NH, TX, and UT
  - None: AL, MD, and TN[265]
- State Medicaid utilization controls for pregnancy dental benefits include prior authorization, spending caps, and service limits.[266]

CMS-Provided Pre-Implementation Period Milestones

- To be established during Model Year 1 for states that select this optional element.

Expand Oral Health Care continued

Policy Checklist

- ☐ Cover preventive, diagnostic, restorative, and emergency dental services for Medicaid beneficiaries from pregnancy through 12 months postpartum in all states.
- ☐ Remove, and do not impose, restrictions, including prior authorization, spending caps, and limiting coverage to emergencies.
- ☐ Educate pregnant Medicaid beneficiaries about the dental services for which they are eligible.

Key Resources

- National Maternal and Child Oral Health Resource Center website[267]
- CareQuest's *Pregnancy and Oral Health*[268]
- Consortium for Oral Health Systems Integration and Improvement's *Capacity Inventory for Integrating Oral Health Care and Primary Care for Pregnant Women*[269]
- AAP's Oral Health Campaign Toolkit[270]

Endnotes

1. Sandall, J., Fernandez Turienzo, C., Devane, D., Soltani, H., Gillespie, P., Gates, S., … Rayment-Jones, H. (2024, April 1). Midwife continuity of care models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*. Retrieved 10 January 2025 from https://doi.org/10.1002/14651858.CD004667.pub6; Hoxha, I., Grezda, K., Udutha, A., Taganoviq, B., Agahi, R., Brajshori, N., & Rising, S. S. (2023, November 30). Systematic review and meta-analysis examining the effects of midwife care on cesarean birth. *Birth Issues in Perinatal Care*. Retrieved 10 January 2025 from https://doi.org/10.1111/birt.12801; Johantgen, M., Fountain, L., Zangaro, G., Newhouse, R., Stanik-Hutt, J., & White, K. (2011, August 23). Comparison of labor and delivery care provided by certified nurse-midwives and physicians: a systematic review, 1990 to 2008. *Women's Health Issues*, 22(1). DOI: 10.1016/j.whi.2011.06.005; Sutcliffe, K., Caird, J., Kavanagh, J., Rees, R., Oliver, K., Dickson, … Thomas, J. (2012, April 11). Comparing midwife-led and doctor-led maternity care: A systematic review of reviews. *Journal of Advanced Nursing*, 68(11), 2376–2386. https://doi.org/10.1111/j.1365-2648.2012.05998.x

2. Karbeah, J., Hardeman, R., Almanza, J., & Kozhimannil, K. B. (2019, August 2). Identifying the key elements of racially concordant care in a freestanding birth center. *Journal of Midwifery & Women's Health*, 64(5) 592–597. https://doi.org/10.1111/jmwh.13018; Suárez-Baquero, D. F. M., Joseph, J., & McLemore, M. R. (2024, August 11). Traditional Black midwifery to enhance birth justice. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*. https://www.doi.org/10.1016/j.jogn.2024.07.003

3. Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., … Kennedy, H. P. (2018, February 21). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PLOS One*. Retrieved 10 January 2025 from https://doi.org/10.1371/journal.pone.0192523

4. Herndon, A., & Vanderlaan, J. (2023, June 24). Associations between state practice regulations and access to midwifery care. *Journal of Midwifery & Women's Health*, 69(1) 17–24. https://doi.org/10.1111/jmwh.13528; Ranchoff, B. L., & Declercq, E. R. (2019, July 18). The scope of midwifery practice regulations and the availability of the certified nurse-midwifery and certified midwifery workforce, 2012–2016. *Journal of Midwifery & Women's Health*, 65(1) 119–130. https://doi.org/10.1111/jmwh.13007

5. Sakala, C., Declercq, E. R., Turon, J. M., & Corry, M. P. (2018, September). *Listening to mothers in California: A population-based survey of women's childbearing experiences*. National Partnership for Women & Families. Retrieved 10 January 2025 from https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf

6. Kozhimannil, K. B., Attanasio, L., & Alarid-Escudero, F. (2019, November). *More midwife-led care could generate cost savings and health improvements*. University of Minnesota School of Public Health. Retrieved 10 January 2025 from https://www.sph.umn.edu/sph/wp-content/uploads/docs/policy-brief-midwife-led-care-nov-2019.pdf; —. (2019, November 3). Midwife-led care and obstetrician-led care for low-risk pregnancies: A cost comparison. *Birth Issues in Perinatal Care*, 47(1) 57–66. https://doi.org/10.1111/birt.12464

7. Nurse.com. Become a certified nurse-midwife. Retrieved 10 January 2025 from https://www.nurse.com/schools/aprn-programs/become-a-certified-nurse-midwife/; Hanson, M. (2024, November 9). *Average cost of medical school*. Education Data Initiative. Retrieved 10 January 2025 from https://educationdata.org/average-cost-of-medical-school; Buys, E., & Galvin S. (2016, October). Training costs in a surgical subspecialty. *Obstetrics & Gynecology*, 128() 51S. https://doi.org/10.1097/01.AOG.0000502704.51513.e2

8. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2010, August 6). *CMS manual system pub 100-04 Medicare claims processing*. Retrieved 10 January 2025 from https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2024cp.pdf

9. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. (2024, June 26). *Transforming maternal health (TMaH) model, notice of funding opportunity*. Retrieved 10 January 2025 from https://grants.gov/search-results-detail/354874

10. NCSL. *Advanced Practice Registered Nurses*. Retrieved 10 January 2025 from https://www.ncsl.org/scope-of-practice-policy/practitioners/advanced-practice-registered-nurses/sop/certified-nurse-midwife-practice-authority

11. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. *Reinforcement of interpretive guidance for nurse midwives*. Retrieved 10 January 2025 from https://www.cms.gov/files/document/qso-23-22-hospital.pdf

12. National Academy for State Health Policy. (2023, April 28). *Midwife Medicaid reimbursement policies by state*. Retrieved 10 January 2025 from https://nashp.org/state-tracker/

midwife-medicaid-reimbursement-policies-by-state/#tab-id-1; Jefferson, K. (2024, July 8). Personal communication. (Director of Professional Practice and Policy, American College of Nurse-Midwives)

13. U.S. Department of Health and Human Services, Office of Inspector General. (2024, September). *States could better leverage coverage and access requirements to promote maternal health care access in Medicaid managed care*. Retrieved 10 January 2025 from https://oig.hhs.gov/documents/evaluation/10016/OEI-05-22-00330.pdf

14. See Note 12, Section 1.

15. Vanderlaan, J., & Jefferson, K. *Midwifery policy toolkit*. American College of Nurse-Midwives. Retrieved 25 March 2025 from https://midwife.org/wp-content/uploads/2024/09/2024_policy_advocacy_toolkit_final.pdf

16. Vanderlaan, J. *Access to midwifery care national chartbook*. American College of Nurse-Midwives. Retrieved 25 March 2025 from https://midwife.org/wp-content/uploads/2025/02/Access-to-Midwifery-Care-National_Chartbook_20241024.pdf

17. American College of Nurse-Midwives. *Workforce study data release*. Retrieved 25 March 2025 from https://midwife.org/midwifery-workforce-study/#:~:text=Workforce%20Study%20Data%20Release,Published%20December%2C%202022

18. —. *Workforce study data briefs*. Retrieved 25 March 2025 from https://midwife.org/midwifery-workforce-study/#:~:text=Workforce%20Study%20Data,leave%20clinical%20practice%3F

19. —. *Transforming Maternal Health (TMaH): Information to share about advanced practice midwives*. Retrieved 25 March 2025 from https://legacy.midwife.org/cmmi-s-transforming-maternal-health-model-tmah#:~:text=Information%20to%20Share,Outcomes%20Under%20Medicaid

20. Medicaid and CHIP Payment and Access Commission. *Access to maternity providers: Midwives and birth centers*. Retrieved 10 January 2025 from https://www.macpac.gov/wp-content/uploads/2023/05/Access-to-Maternity-Providers-Midwives-and-Birth-Centers.pdf

21. Dubay, L., Hill, I., Garrett, B., Blavin, F., Johnston, E., Howell, E., … Cross-Barnet, C. (2020, June). Improving birth outcomes and lowering costs for women on Medicaid: Impacts of 'Strong Start for mothers and newborns.' *Health Affairs*, 39(6). https://doi.org/10.1377/hlthaff.2019.01042

22. Stapleton, S., Wright, J., & Jolles, D. R. (2020, January/March). Improving the experience of care: Results of the American Association of Birth Centers Strong Start client experience of care registry pilot program, 2015–2016. *The Journal of Perinatal & Neonatal Nursing*, 34(1) 27–37. https://doi.org/10.1097/JPN.0000000000000454

23. Welch, L., & Baril, N. (2022, Winter). Birthing Black: Community birth centers as portals to gentle futures. *Nonprofit Quarterly*. Retrieved 10 January 2025 from https://407546.fs1.hubspotusercontent-na1.net/hubfs/407546/Magazine%20PDFs/2904_Welch_and_Baril_REPRINT.pdf; Karbeah, J., Hardeman, R., Almanza, J., & Kozhimannil, K. B. (2019, August 2). Identifying the key elements of racially concordant care in a freestanding birth center. *Journal of Midwifery & Women's Health*, 64(5) 592–597. https://doi.org/10.1111/jmwh.13018; Karbeah, J., Hardeman, R., Katz, N., Orionzi, D., & Kozhimannil, K. B. (2022). From a place of love: The experiences of birthing in a Black-owned culturally-centered community birth center. *Journal of Health Disparities Research and Practice*, 15(2). https://digitalscholarship.unlv.edu/jhdrp/vol15/iss2/6/; Welch, L., Branch Canady, R., Harmell, C., White, N., Snow, C., & Kane Low, L. (2022, April/June). We are not asking permission to save our own lives: Black-led birth centers to address health inequities. *Journal of Perinatal & Neonatal Nursing*, 36(2) 138–149. https://doi.org/10.1097/JPN.0000000000000649

24. See Note 5.

25. Anderson, D. A., & Gilkison, G. M. (2021, October 1). The cost of home birth in the United States. *International Journal of Environmental Research and Public Health*, 18(19). https://doi.org/10.3390/ijerph181910361

26. Patient Protection and Affordable Care Act, Subtitle D, Section 2301.

27. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2016, April 26). FQHC and RHC supplemental payment requirements and FQHC, RHC, and FBC network sufficiency under Medicaid and CHIP managed care. Retrieved 10 January 2025 from https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16006.pdf

28. National Partnership for Women & Families. (2022, April). *Improving our maternity care now through community birth settings*. Retrieved 10 January 2025 from https://nationalpartnership.org/report/community-birth-settings/

29. American Association of Birth Centers. *AABC toolkit: Best practices in birth center regulations*. Retrieved 10 January 2025 from https://www.birthcenters.org/products/toolkit-regs

30. — *Birth center regulations*. Retrieved 10 January 2025 from https://www.birthcenters.org/bc-regulations

31. See Note 27; Courtot, B., Hill, I., Cross-Barnet, C., & Markell, J. (2020, December). Midwifery and birth centers under state Medicaid programs: Current limits to beneficiary access to a high-value model of care. *Milbank Quarterly*, 98(4) 1091–1113. https://doi.org/10.1111/1468-0009.12473

32. See Note 30.

33. See Note 13.

34. See Note 29.

35. American Association of Birth Centers. (2024, September). *Sustainable reimbursement for midwifery-led birth center care*. Retrieved 10 January 2025 from https://assets.noviams.com/novi-file-uploads/aabc/pdfs-and-documents/PositionStatements/AABC_PS_-_Sustainable_Reimbursement_092724.pdf

36. Birth Center Equity. *Community birth centers*. Retrieved 10 January 2025 from https://birthcenterequity.org/bce-centers/

37. American Association of Birth Centers. *Transforming maternal health: Viable solutions to the maternal health crisis*. Retrieved 10 January 2025 from https://assets.noviams.com/novi-file-uploads/aabc/pdfs-and-documents/AABC_Webinar_-_BCs_and_TMaH_-_5_29_24.pdf

38. See Note 20.

39. Purchaser Business Group on Health. *Hospital guide to integrating the freestanding birth center model*. Retrieved 10 January 2025 from https://www.pbgh.org/wp-content/uploads/2023/02/Hospital-Guide-to-Integrating-the-Freestanding-Birth-Center-Model.pdf

40. Center for Healthcare Quality & Payment Reform. *An alternative payment model for maternity care*. Retrieved 10 January 2025 from https://chqpr.org/downloads/MaternityCare_APM.pdf.

41. Alliance for Innovation on Maternal Health. *Community birth transfer resource kit*. Retrieved 10 January 2025 from https://saferbirth.org/wp-content/uploads/AIM_CBTRK_091924_FINAL2.pdf

42. Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K. & Cuthbert, A. (2017, July 6). *Cochrane Database of Systematic Reviews*, (7). https://doi.org/10.1002/14651858.CD003766.pub6

43. Sakala, C., & Wei, R. (2022, September). *Improving our maternity care now through doula support*. National Partnership for Women & Families. Retrieved 10 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/02/improving-maternity-doula-support.pdf

44. Falconi, A. M., Ramirez, L., Cobb, R., Levin, C., Nguyen, M., & Inglis, T. (2024, October 2). Role of doulas in improving maternal health and health equity among Medicaid enrollees, 2014–2023. *American Journal of Public Health*, (114) 1275–1285. https://doi.org/10.2105/AJPH.2024.307805

45. Kozhimannil, K. B., Vogelsang, C. A., Hardeman, R. R., & Prasad, S. (2016, May). Disrupting the pathways of social determinants of health: Doula support during pregnancy and childbirth. *Journal of the American Board of Family* Medicine, 29(3) 308–317. https://doi.org/10.3122/jabfm.2016.03.150300; See Note 23, Section 2; Thomas, M.-P., Ammann, G., Onyebeke, C., Gomez, T. K., Lobis, S., Li, W., & Huynh, M. (2023, January 10). Birth equity on the front lines: Impact of a community-based doula program in Brooklyn, NY. *Birth Issues in Perinatal Care*, 50(1) 138–150. https://doi.org/10.1111/birt.12701; Prenatal-to-3 Policy. *Community-based doulas*. Retrieved 10 January 2025 from https://pn3policy.org/pn-3-state-policy-roadmap-2024/us/community-based-doulas/

46. Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016, January 14). Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth Issues in Prenatal Care*, 43(1) 20–27. https://doi.org/10.1111/birt.12218; Chapple, W., Gilliland, A., Li, D., Shier, E., & Wright, E. (2013, April). An economic model of the benefits of professional doula labor support in Wisconsin births. *Wisconsin Medical Journal*, 112(2) 58–64. https://wmjonline.org/wp-content/uploads/2013/112/2/58.pdf; Greiner, K. S., Hersh, A. R., Hersh, S. R., Remer, J. M., Gallagher, A. C., Caughey, A. B., & Tilden, E. L. (2019, April 29). The cost effectiveness of professional doula care for a woman's first two births: A decision analysis model. *Journal of Midwifery & Women's Health*, 64(4) 410–420. https://www.doi.org/10.1111/jmwh.12972; Greiner, K. S., Hersh, A. R., Hersh, S. R., Gallagher, A. C., Caughey, A. B., & Tilden, E. L. (2019, September). Cost-effectiveness of continuous support from a layperson during a woman's first two births. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 48(5) 538–551. https://www.doi.org/10.1016/j.jogn.2019.06.002; Mottl-Santiago, J., Dukhovny, D., Feinberg, E., Moore, J., Parker, V., Cabral, H., … Declercq, G. (2024, October 11). Return-on-investment analysis of an enhanced community doula program: Pre- and post–COVID-19 considerations. *Birth Issues in Perinatal Care*. Retrieved 10 January 2025 from https://doi.org/10.1111/birt.12886

47. National Health Law Program, Doula Medicaid Project. *Current state efforts at expanding access to doula care*. Retrieved 25 February 2025 from https://docs.google.com/spreadsheets/

d/1vsZTIecerW5t49Gg01pya2fURuZ-L6tDimC2e3QeleE/edit?gid=1534310451#gid=1534310451

48. *Ibid*.

49. Medicaid and CHIP Payment and Access Commission. (2023, November). *Doulas in Medicaid: Case study findings*. Retrieved 10 January 2025 from https://www.macpac.gov/wp-content/uploads/2023/11/Doulas-in-Medicaid-Case-Study-Findings.pdf

50. Robles-Fradet, A., & Chen, A. *California doula workforce analysis: Findings from the California Doula Workforce Survey*. National Health Law Program. Retrieved 10 January 2025 from https://nhelp.app.box.com/v/CA-DoulaScape-Analysis2-0

51. Center for Health Care Strategies. (2022, December). *Incorporating community-based doulas into Medicaid: state and plan considerations to encourage doula participation*. Retrieved 10 January 2025 from https://www.chcs.org/media/Incorporating-Community-Based-Doulas-into-Medicaid-_Fact-Sheet_120822.pdf

52. *Ibid*.; U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2021, December 7). *Improving maternal health and extending postpartum coverage in Medicaid and the Children's Health Insurance Program (CHIP)*. Retrieved 10 January 2025 from https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf

53. See Note 47.

54. *Ibid*.

55. See Note 13.

56. New Jersey Health Care Quality Institute. (2024, June). *Guide for hospital doula policy creation*. Retrieved 10 January 2025 from https://www.njhcqi.org/wp-content/uploads/2024/06/Guide-for-Hospital-Doula-Policy-Creation.pdf

57. National Partnership for Women & Families. (2023, May). *Raising the bar for moms & babies: Increasing access to high-performing maternity services: Doula support*. Retrieved 10 January 2025 from https://nationalpartnership.org/wp-content/uploads/rtb-op-guidance-increase-access-doula-support.pdf

58. Prenatal-to-3 Policy Impact Center. (2023, September). *State policy lever checklist: Community-based doulas*. Retrieved 10 January 2025 from https://pn3policy.org/wp-content/uploads/2023/09/PN3PIC_StatePolicyLeverChecklist_Doulas.pdf;

59. See Note 47.

60. See Note 51.

61. Hasan, A. (2024, April 16). *State Medicaid approaches to doula service benefits*. National Academy of State Health Policy. Retrieved 10 January 2025 from https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2022/07/NASHP-Medicaid-Doula-Tracker_pdf.pdf

62. Crear-Perry, J., Correa-de-Araujo, R., Johnson, T. L., McLemore, M. R., Neilson, E., & Wallace, M. (2021, February 2). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health*, 30(2). https://doi.org/10.1089/jwh.2020.8882

63. National Partnership for Women & Families. (2023, March). *Raising the bar for maternal health equity and excellence: Actionable strategies for healthcare systems*. Retrieved 10 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/04/raisingthebar-report.pdf; March of Dimes. (2024). *Nowhere to go: Maternity care deserts across the US*. Retrieved 10 January 2025 from https://www.marchofdimes.org/maternity-care-deserts-report

64. Trost, S., Beauregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. A. *Pregnancy-related deaths: Data from maternal mortality review committees in 36 US states, 2017–2019*. Retrieved 10 January 2025 from https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html#cdc_research_or_data_summary_res_data-the-data

65. NORC at the University of Chicago and Academy Health. (2020, December). State Data for Conducting Patient Centered Outcomes Research to Improve Maternal Health: Stakeholder Discussions Summary Report. Retrieved 11 January 2025 from https://academyhealth.org/sites/default/files/statedataforpcormaternalhealth_december2020.pdf

66. Chappell, A., DeLew, N., Grigorescu, V., & Smith, S. R. (2021, August 11). Addressing the maternal health crisis through improved data infrastructure: Guiding principles for progress. *Health Affairs*. Retrieved 10 January 2025 from https://doi.org/10.1377/forefront.20210729.265068

67. National Partnership for Women & Families. (2024, February). *Maternity care payment reform: Leveraging payment reform to tackle the maternal health crisis*. Retrieved 10 January 2025 from https://nationalpartnership.org/report/maternityapm/

68. ICD10Data.com. *Factors influencing health status and contact with health services*. Retrieved 10 January 2025 from https://www.icd10data.com/ICD10CM/Codes/Z00-Z99

69. Office of the National Coordinator for Health Information Technology. (2024, March). *Interoperability of maternity*

health care records: Best practices informational resource. Retrieved 10 January 2025 from https://www.healthit.gov/sites/default/files/page/2024-03/FY23%20ONC%20Maternity%20Care%20Info%20Resource%20Guide_508%20%281%29.pdf; —. *Maternal Health*. Retrieved 10 January 2025 from https://uscdiplus.healthit.gov/uscdi?id=uscdi_record&table=x_g_sshh_uscdi_domain&sys_id=75df78228745b95098e5edb90cbb3528&view=sp; —. *United States core data for interoperability (USCDI)+*. Retrieved 10 January 2025 from https://uscdiplus.healthit.gov/uscdi; Dailey, R. (2024, November 20). Addressing the maternal mortality crisis by improving interoperability. *Health Affairs*. Retrieved 10 January 2025 from https://doi.org/10.1377/forefront.20241118.552343

70. National Partnership for Women & Families. (2023, March). *Raising the bar for moms & babies: Maternal health equity data collection and sharing*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/05/rtb-data-collection-maternal-health-equity.pdf

71. Government Publishing Office. (2024, March 29). Office of Management and Budget. *Federal Register*, 89(62) 22182–22196. https://www.govinfo.gov/content/pkg/FR-2024-03-29/pdf/2024-06469.pdf

72. Haley, J. M., Dubay, L., & Garrett, B. (2024, August 29). Implementing revised federal race/ethnicity data standards won't sufficiently address health inequities. *Health Affairs*. Retrieved 11 January 2025 from https://doi.org/10.1377/forefront.20240828.438120

73. National Quality Forum. (2022, December). *Risk adjustment technical guidance final report: Phase 2*. Retrieved 11 January 2025 from https://www.qualityforum.org/Publications/2022/12/Risk_Adjustment_Technical_Guidance_Final_Report_-_Phase_2.aspx

74. Centers for Medicare & Medicaid Services. (2024, November). *Resource of health equity-related data definitions, standards & stratification practices*. Retrieved 11 January 2025 from https://www.cms.gov/files/document/cms-2024-omh-data-definitions.pdf

75. Daw, J. R., Auty, S. G., Admon, L. K., & Gordon, S. H. (2023, July). Using modernized Medicaid data to advance evidence-based improvements in maternal health. *American Journal of Public Health*, 113(7) 705–824. https://doi.org/10.2105/AJPH.2023.307287

76. Centers for Medicare & Medicaid Services. (2024, July). *CMS framework for health equity*. Retrieved 11 January 2025 from https://www.cms.gov/files/document/cms-framework-health-equity.pdf

77. Burton, D. C., Kelly, A., & Bunnell, R. (2023, December 3). Principles of health equity science for public health action. *Public Health Reports*, 139(3) 277–283. https://doi.org/10.1177/00333549231213162

78. National Partnership for Women & Families. (2024, February). *Maternity care payment reform: Leveraging payment reform to tackle the maternal health crisis*. Retrieved 11 January 2025 from https://nationalpartnership.org/report/maternityapm/

79. *Ibid*.

80. *Ibid*.

81. *Ibid*.

82. —. *Selecting performance measures for maternity care alternative payment models (APMs): Consensus-based maternity care measures recommended for APMs*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/maternityAPM-performance-measures.pdf; —. (2023, March). *Raising the bar for moms & babies: Priority maternity care quality measures to improve outcomes and equity*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/04/rtb-priority-maternity-care-measures.pdf

83. —. (2023, March). *Raising the bar for moms & babies: Designing effective delivery and payment programs to advance maternal and infant health equity and excellence*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/04/rtb-designing-effective-delivery-payment.pdf

84. See Note 40.

85. Maternal Health Hub. (2021, July). *Using alternative payment to transform maternity care, address disparities, and improve outcomes*. Retrieved 11 January 2025 from https://maternalhealthhub.org/wp-content/uploads/2021/07/Using-Alternative-Payment-to-Transform-Maternity-Care-Address-Disparities-and-Improve-Outcomes.pdf

86. See Note 13.

87. See Note 15.

88. See Note 16.

89. See Note 17.

90. See Note 18.

91. See Note 19.

92. See Note 20.

93. Knowles, M., Crowley, A. P., Vasan, A., & Kangovi, S. (2023, April). Community health worker integration with and effectiveness in health care and public health in the United States. *Annual Review of Public Health*, 44 363–381. https://doi.org/10.1146/annurev-publhealth-071521-031648

94. Centering the voices of BIPOC workers: A review of recent data on connecting BIPOC birthworkers. Retrieved 11 January 2025 from https://static1.squarespace.com/static/57126eff60b5e92c3a226a53/t/6189a09bc4bc9603a3bcbe44/1636409513693/BIPOCSurveyReport06.11.21Dist.pdf

95. Nijagal, M. A., Khoong, E. C., Sherwin, E. B., Lance, E., Saleeby, E., Williams, A. P., & Thomas, M. R. (2024, March 12). Perinatal community health workers: Lessons from California. *Health Affairs*. Retrieved 11 January 2025 from https://doi.org/10.1377/forefront.20240306.53450; National Association of Community Health Workers. *Networks and training programs*. Retrieved 11 January 2025 from https://nachw.org/generalresources/networks-and-training-programs/

96. Boyd, L. M., Mehra, R., Thomas, J., Lewis, J. B. & Cunningham, S. D. (2021, October 21). Features and impact of trust-based relationships between community health workers and low-resource perinatal women with chronic health conditions. *Maternal and Child Health Journal*, 25 1866–1874. https://doi.org/10.1007/s10995-021-03242-z

97. See Note 94.

98. Bakst, C., Moore, J. E., George, K. E., & Shea, K. (2020, May). *Community-based maternal support services: The role of doulas and community health workers in Medicaid*. Institute for Medicaid Innovation. Retrieved 11 January 2025 from https://medicaidinnovation.org/wp-content/uploads/2022/09/2020-IMI-Community_Based_Maternal_Support_Services-Report.pdf

99. See Note 96. Mamatoto Village. (2025). Trainings. Retrieved 3 March 2025 from https://www.mamatotovillage.org/trainings/;

100. National Academy for State Health Policy. *State community health worker policies*. Retrieved 11 January 2025 from https://nashp.org/state-tracker/state-community-health-worker-policies/; Cloke, A., Hart, M. Tyus, J., Alley, D., & Kangovi, S. (2024, December). *Medicaid reimbursement for community health worker services: Model state plan amendment & other guidance.* Milbank Memorial Fund. Retrieved 10 April 2025 from https://www.milbank.org/wp-content/uploads/2024/11/Medicaid-CHW-SPA_12.17_Final.pdf

101. *Ibid,* Section 1.

102. See Note 13.

103. See Note 100, Section 2.

104. National Association of Community Health Workers. *How managed care organizations can authentically partner with community health workers*. Retrieved 11 January 2025 from https://nachw.org/wp-content/uploads/2024/01/NACHW-UHCPaperREMedicaid2023-1.pdf

105. National Association of Community Health Workers. (2022). Retrieved March 3 2025 from https://nachw.org/

106. See Note 100, Section 2.

107. See Note 100, Section 1.

108. See Note 13.

109. Policy Center for Maternal Mental Health. (2024, July 26). *Gaps in peer support reimbursement and certification in the United States*. Retrieved 11 January 2025 from https://policycentermmh.org/gaps-in-peer-support-reimbursement-and-certification-in-the-united-states/

110. Kozhimannil, K. B., Interrante, J. D., Fritz, A. H., Sheffield, E. C., Carroll, C., & Handley, S. C. (2024, September). *Information for rural stakeholders about access to maternity and obstetric care: A community-relevant synthesis of research*. University of Minnesota Rural Health Research Center. Retrieved 11 January 2025 from https://rhrc.umn.edu/wp-content/uploads/2024/09/OB_Practical-Implications_9.3.pdf

111. *Ibid*.; See Note 63, Section 2.

112. *Ibid*.

113. Jolles, D., Stapleton, S., Wright, J., Alliman, J., Bauer, K., Townsend, C., & Hoehn-Velasco, L. (2020, December 3). Rural resilience: The role of birth centers in the United States. *Birth Issues in Perinatal Care*, 47(4) 430–437. https://doi.org/10.1111/birt.12516

114. See Note 63, Section 2.

115. *Ibid*.

116. See Note 63, Section 2.

117. Center for Healthcare Quality & Payment Reform. (2024, December). *Addressing the crisis in rural maternity care*. Retrieved 11 January 2025 from https://ruralhospitals.chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf

118. Lamb, E., Merwin, M., Mumford, Q., Thach, S., Fritz, A., & Henning-Smith, C. (2023, February). *Obstetric readiness in rural communities lacking hospital labor and delivery units*. Retrieved 11 January 2025 from https://www.ruralhealth.us/

getmedia/1aade569-b828-41de-96ed-de76e76365f8/NRHA-Policy-Brief-Final-Draft-OB-readiness.pdf

119. Rural Health Information Hub. *Rural Maternal Health Toolkit*. Retrieved 11 January 2025 from https://www.ruralhealthinfo.org/toolkits/maternal-health

120. Centers for Medicare & Medicaid Services. (2022, May). *Advancing rural maternal health equity*. Retrieved 11 January 2025 from https://www.cms.gov/files/document/maternal-health-may-2022.pdf

121. March of Dimes. (2024). *Nowhere to Go: Maternity Care Deserts Across the US; 2024 Report*. Retrieved 11 January 2025 from https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf

122. Centers for Medicare & Medicaid Services. *Improving access to maternal health care in rural communities*. Retrieved 11 January 2025 from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

123. Alliance for Innovation on Maternal Health. (2023, May). *AIM obstetric emergency readiness resource kit*. Retrieved 11 January 2025 from https://saferbirth.org/wp-content/uploads/FINAL_AIM_OERRK.pdf

124. U.S. Health Resources and Services Administration. *Rural maternity and obstetrics management strategies (RMOMS) program*. Retrieved 11 January 2025 from https://www.hrsa.gov/rural-health/grants/rural-community/rmoms

125. —. (2022, May). *Evaluation of the rural maternity and obstetrics management strategies (RMOMS) program: 2019 cohort*. Retrieved 11 January 2025 from https://www.hrsa.gov/sites/default/files/hrsa/rural-health/fy2019-cohort-2nd-evaluation-report-executive-summary.pdf

126. National Partnership for Women & Families. *Blueprint for advancing high-value maternity care through physiologic childbearing: Foster an optimal maternity care workforce composition and distribution*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/02/blueprint-chapter-5.pdf

127. Gilburg, M. L., McDonald, M., & Sullivan, E. E. (2024, September 17). *Innovations in rural obstetrics to maintain access to care*. Milbank Memorial Fund. Retrieved 11 January 2025 from https://www.milbank.org/2024/09/innovations-in-rural-obstetrics-to-maintain-access-to-care/

128. KFF. (2025, January 6). *Medicaid postpartum coverage extension tracker*. Retrieved 26 February 2025 from https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/

129. Druyan, B., Platner, M., Jamieson, D. J., & Boulet, S. L. (2023, May). Severe maternal morbidity and postpartum readmission through 1 year. *Obstetrics & Gynecology*, 141(5) 949–955. https://doi.org/10.1097/AOG.0000000000005150 ; See Note 64.

130. Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2013, June). *Listening to mothers III: New mothers speak out*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/02/listening-to-mothers-iii-new-mothers-speak-out-2013.pdf

131. See Note 130.

132. Daw, J. R., Kozhimannil, K. B., & Admon, L. K. (2021, June 14). Factors associated with postpartum uninsurance among Medicaid-paid births. *JAMA Health Forum*, 2(6). https://doi.org/10.1001/jamahealthforum.2021.1054

133. See Note 128.

134. *Ibid*.

135. Tolbert, J., Bell, C., & Rudowitz, R. (2025, February 12). *Medicaid expansion is a red and blue state issue*. Retrieved 3 March 2025 from https://www.kff.org/medicaid/issue-brief/medicaid-expansion-is-a-red-and-blue-state-issue/

136. *Ibid*.

137. See Note 52, Section 2.

138. *Ibid*.

139. Hasan, A., & Atkeson, A. (2023, September 25). *Optimizing postpartum coverage extension*. National Academy for State Health Policy. Retrieved 11 January 2025 from https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2023/09/NASHP_PostpartumCoverageToolkit_09.2023_FINAL.pdf

140. See Note 52, Section 2.

141. See Note 139.

142. American College of Obstetricians and Gynecologists. (2023, September). *Questions and Answers: Extending Medicaid coverage for pregnant people beyond 60 days postpartum*. Retrieved 11 January 2025 from https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/qanda-extending-medicaid-coverage-for-pregnant-women-beyond-60-days-postpartum.pdf

143. See Note 64.

144. Alliance for Innovation on Maternal Health. Retrieved 11 January 2025 from https://saferbirth.org/

145. Centers for Disease Control and Prevention. (2024, May 15). *Maternal infant health*. Retrieved 11 January 2025 from https://www.cdc.gov/maternal-infant-health/pqc/index.html; Alliance for Innovation on Maternal Health. *Patient safety bundles*. Retrieved 11 January 2025 from https://saferbirth.org/patient-safety-bundles/; https://nnpqc.org/wp-content/uploads/2024/11/ImpactStatement.pdf; Medicaid.gov. *Maternal & Infant Health Care Quality: Medicaid and CHIP Program Collaboration with Hospitals on AIM Bundles, August 20, 2024*. Retrieved 11 January 2025 from https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality#2024WebSeries:~:text=Webinar%20%235%3A%20Medicaid,maternal%20health%20outcomes

146. Centers for Disease Control and Prevention. *Maternal infant health: State perinatal quality collaboratives*. Retrieved 11 January 2025 from https://www.cdc.gov/maternal-infant-health/pqc/state-pqcs.html

147. See Note 145, Section 2.

148. Centers for Disease Control and Prevention. (2016, March 4). *Developing and sustaining perinatal quality collaboratives: A resource guide for states*. Retrieved 11 January 2025 from https://www.cdc.gov/maternal-infant-health/media/pdfs/Best-Practices-for-Developing-and-Sustaining-Perinatal-Quality-Collaboratives_tagged508.pdf

149. —. *Maternal morbidity structural measure*. Retrieved 11 January 2025 from https://www.cms.gov/files/document/maternal-morbidity-structural-measure-specifications.pdf

150. Centers for Medicare & Medicaid Services. *Birthing-friendly hospitals and health systems*. Retrieved 11 January 2025 from https://data.cms.gov/provider-data/birthing-friendly-hospitals-and-health-systems

151. *Ibid*.; Hellmann, J. (2024, May 9). 'Birthing friendly' label requires little effort by hospitals. *Roll Call*. Retrieved 11 January 2025 from https://rollcall.com/2024/05/09/birthing-friendly-label-requires-little-effort-by-hospitals/

152. American Hospital Association. *CMS Care Compare begins displaying birthing-friendly hospital designation*. Retrieved 11 January 2025 from https://www.aha.org/news/headline/2023-11-08-cms-care-compare-begins-displaying-birthing-friendly-hospital-designation

153. See Note 151, Section 2.

154. The White House. *Fact Sheet: Vice President Kamala Harris announces call to action to reduce maternal mortality and morbidity*. Retrieved 25 March 2025 from https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2021/12/07/fact-sheet-vice-president-kamala-harris-announces-call-to-action-to-reduce-maternal-mortality-and-morbidity/

155. See Note 149.

156. American College of Obstetricians and Gynecologists. *Informed consent and shared decision making in obstetrics and gynecology*. Retrieved 11 January 2025 from https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.pdf

157. Stacey, D., Lewis, K. B., Smith, M., Carley, M., Volk, R., Douglas, E. E., … Trevena, L. (2024, January 29). Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews*. Retrieved 11 January 2025 from https://doi.org/10.1002/14651858.CD001431.pub6

158. Dugas, M., Shorten, A., Dubé, E., Wassef, M., Bujold, E., & Chaillet, N. (2012, June). Decision aid tools to support women's decision making in pregnancy and birth: A systematic review and meta-analysis. *Social Science & Medicine*, 74(12) 1968–1978. https://doi.org/10.1016/j.socscimed.2012.01.041; Vlemmix, F., Warendorf, J. K., Rosman, A. N., Kok, M., Mol, B. W. J., Morris, J. M., & Nassar, N. (2012, November). Decision aids to improve informed decision-making in pregnancy care: A systematic review. *BJOG: An International Journal of Obstetrics and Gynaecology*, 120(3) 257–266. https://doi.org/10.1111/1471-0528.12060; Say, R., Robson, S., & Thomson, R. (2011, December). Helping pregnant women make better decisions: A systematic review of the benefits of patient decision aids in obstetrics. *BMJ Open*, 21;1(2):e000261. https://doi.org/10.1136/bmjopen-2011-000261

159. Declercq, E. R., Cheng, E. R., & Sakala, C. (2018, June 22). Does maternity care decision-making conform to shared decision-making standards for repeat cesarean and labor induction after suspected macrosomia? *Birth Issues in Perinatal Care*, 45(3) 236–244. https://doi.org/10.1111/birt.12365

160. Tucker Edmonds, B. (2014, December). Shared decision-making and decision support their role in obstetrics and gynecology. *Current Opinion in Obstetrics and Gynecology*, 26(6) 523–530. https://doi.org/10.1097/GCO.0000000000000120; Shuler, T. O. (2023, January 10). Promoting shared decision-making in maternal health care. *North Carolina Medical Journal*, 84(1). https://doi.org/10.18043/001c.67779

161. Ottawa Hospital Research Institute. *Alphabetical list of decision aids by health topic*. Retrieved 11 January 2025 from https://decisionaid.ohri.ca/AZlist.html

162. Massachusetts General Hospital. *Decision worksheet resource guide*. Retrieved 11 January 2025 from https://

mghdecisionsciences.org/wp-content/uploads/2018/06/decision-worksheet-resource-guide-2018.pdf; —. *Treatment decision worksheet*. Retrieved 11 January 2025 from https://mghdecisionsciences.org/wp-content/uploads/2018/06/sdm-decision-worksheet-template.pdf; —. *A guide to using decision worksheets in the office visit*. Retrieved 11 January 2025 from https://mghdecisionsciences.org/wp-content/uploads/2018/06/a-guide-to-using-decision-worksheets-in-the-office-visit_pcoi.pdf

163. Ottawa Hospital Research Institute. *Ottawa personal decision guide for two*. Retrieved 11 January 2025 from https://decisionaid.ohri.ca/docs/das/OPDGx2.pdf; —. *Ottawa personal decision guide.* Retrieved 3 March 2025 from https://decisionaid.ohri.ca/docs/das/OPDG.pdf

164. Massachusetts General Hospital. *Shared decision making training for clinicians*. Retrieved 11 January 2025 from https://mghdecisionsciences.org/tools-training/clinician-training/; Ottawa Hospital Research Institute. *Ottawa decision support tutorial*. Retrieved 11 January 2025 from https://decisionaid.ohri.ca/odst/

165. Massachusetts General Hospital. *Shared decision making process scale*. Retrieved 11 January 2025 from https://mghdecisionsciences.org/tools-training/sdm-process-survey/

166. Agency for Healthcare Research and Quality. (2024, October) *The SHARE approach*. Retrieved 11 January 2025 from https://www.ahrq.gov/sdm/share-approach/index.html

167. *Ibid*.

168. Ottawa Hospital Research Institute. *What are patient decision aids?* Retrieved 11 January 2025 from https://decisionaid.ohri.ca/index.html

169. Massachusetts General Hospital. *Health Decision Sciences Center.* Retrieved 11 January 2025 from https://mghdecisionsciences.org/

170. Grobman, W. A., Entringer, S., Headen, I., Janevic, T., Kahn, R. S., Simhan, H., … Howell, E. A. (2024, February). *Social determinants of health and obstetric outcomes: A report and recommendations of the workshop of the Society for Maternal-Fetal Medicine*. Society for Maternal-Fetal Medicine. Retrieved 11 January 2025 from https://www.ajog.org/action/showPdf?pii=S0002-9378%2823%2900742-1; National Partnership for Women & Families. (2021, June). *Saving the lives of moms & babies: Addressing racism and socioeconomic influencers of health*. Retrieved 11 January 2025 from https://nationalpartnership.org/momsandbabies; Stuebe, A., Creegan, A., Knox-Kazimierczuk, F., Smith, M. C., Wade, S., & Tully, K. (2024, April). Cultivating vital conditions for perinatal well-being and a sustained commitment to reproductive justice. *Health Affairs*, 43(4) 470–476. https://doi.org/10.1377/hlthaff.2023.01452

171. Maternal Mental Health Leadership Alliance. (2024, May 9). *Maternal mental health conditions: The most common complication of pregnancy and parenting*. Retrieved 11 January 2025 from https://www.mmhla.org/articles/maternal-mental-health-conditions-the-most-common-complication-of-pregnancy-and-parenting

172. See Note 64.

173. Moore, J. E., McLemore, M. R., Glenn, N., & Zivin, K. (2021, October). Policy opportunities to improve prevention, diagnosis, and treatment of perinatal mental health conditions. *Health Affairs*, 40(10). https://doi.org/10.1377/hlthaff.2021.00779; See Note 191.

174. Wilson, C. A., Finch, E., Kerr, C., & Shakespeare, J. (2020, May 11). Alcohol, smoking, and other substance use in the perinatal period. *BMJ*, Retrieved 11 January 2025 from http://dx.doi.org/10.1136/bmj.m1627; See Note 64.

175. Domestic Policy Council, Office of Science and Technology Policy. (2023, November). *The U.S. playbook to address social determinants of health*. Retrieved 13 January 2025 from https://bidenwhitehouse.archives.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf

176. Avsar, T. S., McLeod, H., & Jackson, L. (2021, March 26). Health outcomes of smoking during pregnancy and the postpartum period: an umbrella review. *BMC Pregnancy and Childbirth*. Retrieved 11 January 2025 from https://doi.org/10.1186/s12884-021-03729-1

177. Chamberlain, C., O'Mara-Eves, A., Porter, J., Coleman, T., Perlen, S. M., Thomas, J., & McKenzie, J. E. (2017). Psychosocial interventions for supporting women to stop smoking in pregnancy. *Cochrane Database of Systematic Reviews*. Retrieved 11 January 2025 from https://doi.org/10.1002/14651858.CD001055.pub5

178. Centers for Disease Control and Prevention. (2023, December 15). Percentage of women who smoked cigarettes during pregnancy, by race and Hispanic origin: National Vital Statistics System, United States, 2016 and 2022. *Morbidity and Mortality Weekly Report*. Retrieved 11 January 2025 from https://pmc.ncbi.nlm.nih.gov/articles/PMC10727141/pdf/mm7250a5.pdf

179. Truven Health Analytics. *The cost of having a baby in the United States*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/02/the-cost-of-having-a-baby-in-the-us.pdf

180. See Note 78.

181. Medicaid. (2023, November). *Coverage of health-related social needs (HRSN) services in Medicaid and the Children's Health Insurance Program (CHIP)*. Retrieved 11 January 2025 from https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf

182. HealthMeasures. *PROMIS (Patient-Reported Outcomes Measurement Information System)*. Retrieved 11 January 2025 from https://www.healthmeasures.net/explore-measurement-systems/promis; Social Interventions Research & Evaluation Network. *Evidence & resource library*. Retrieved 11 January 2025 from https://sirenetwork.ucsf.edu/tools/evidence-library; National Partnership for Women & Families. (2023, May). *Raising the bar for moms & babies: Addressing social drivers of maternal and infant health in maternity care settings*. Retrieved 11 January 2025 from https://nationalpartnership.org/wp-content/uploads/rtb-op-guidance-address-social-drivers-maternal-infant-health.pdf

183. Centers for Medicare & Medicaid Services. *TMaH model frequently asked questions*. Retrieved 11 January 2025 from https://www.cms.gov/tmah-model-frequently-asked-questions; Centers for Medicare & Medicaid Services. (2023, December). *A guide to using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising practices and key insights*. Retrieved 11 January 2025 from https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion

184. Centers for Medicare & Medicaid Services. (2025, February 27). *TMaH model frequently asked questions*. Retrieved 3 March 2025 from https://www.cms.gov/tmah-model-frequently-asked-questions

185. Harrison, J. M. (2024, April). Integrating mental health in perinatal care: Perspectives of interprofessional clinicians. *Health Affairs*, 43(4) 461–608. https://doi.org/10.1377/hlthaff.2023.01427; National Partnership for Women & Families. (2023, May). *Addressing social drivers of health in maternity care settings*. Retrieved 3 March 2025 from https://nationalpartnership.org/wp-content/uploads/rtb-op-guidance-address-social-drivers-maternal-infant-health.pdf

186. See Note 182, Section 1 and Section 2.

187. National Partnership for Women & Families. (2024, February). *Realizing the transformational potential of maternity care payment reform*. Retrieved 13 January 2025 from https://nationalpartnership.org/wp-content/uploads/maternityAPM-report.pdf

188. Hinton, E., & Diana, A. (2024, January 29). Medicaid authorities and options to address social determinants of health. KFF. Retrieved 13 January 2025 from https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/; —. (2024, March 4). Section 1115 Medicaid waiver watch: A closer look at recent approvals to address health-related social needs (HRSN). KFF. Retrieved 13 January 2025 from https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-waiver-watch-a-closer-look-at-recent-approvals-to-address-health-related-social-needs-hrsn/; Vila-Farinas, A., Pérez-Rios, M., Montes-Martinez, A., Ruano-Ravina, A., Forray, A., Rey-Brandariz, J., … Varela-Lema, L. (2024, January). Effectiveness of smoking cessation interventions among pregnant women: An updated systematic review and meta-analysis. *Addictive Behaviors*, 148. https://doi.org/10.1016/j.addbeh.2023.107854; Burak, E. W., Dwyer, A., & Mondestin, T. (2024, January 23). *State Medicaid opportunities to support mental health of mothers and babies during the 12-month postpartum period*. Georgetown University McCourt School of Public Policy, Center for Children and Families. Retrieved 13 January 2025 from https://ccf.georgetown.edu/2024/01/23/state-medicaid-opportunities-to-support-mental-health-of-mothers-and-babies-during-the-12-month-postpartum-period/; Gomez, K. U., Goodwin, L., Jackson, L., Jones, A., Chisholm, A., & Rose, A. K. (2020, October 27). Are psychosocial interventions effective in reducing alcohol consumption during pregnancy and motherhood? A systematic review and meta-analysis. *Addiction*, 116(7), 1638–1663. https://doi.org/10.1111/add.15296; Center for Health Care Strategies. (2024, June). *Designing a health-related social needs strategy in Medicaid: State considerations*. Retrieved 13 January 2025 from https://www.chcs.org/media/Designing-a-Health-Related-Social-Needs-Strategy-in-Medicaid-State-Considerations.pdf; Jantz, K., & Bank, A. (2024, October). *Food for thought: Medicaid nutrition benefit design approaches for equitable implementation*. Center for Health Care Strategies. Retrieved 13 January 2025 from https://www.chcs.org/media/Food-for-Thought-Medicaid-Nutrition-Benefit-Design-Approaches-for-Equitable-Implementation.pdf

189. Dutton, M., Osius, E., Rozario, N., & Segal, J. Z. (2022, November). *Working with community care hubs to address social drivers of health: A playbook for state Medicaid agencies*. Manatt Health. Retrieved 13 January 2025 from https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/1f285a63-b073-4ddf-a2b0-725853bd3dfa/Manatt-CCH-Medicaid-Playbook_Final-11-17-22.pdf

190. Medicaid. *Addressing maternal mental health and substance use care and outcomes*. Retrieved 13 January 2025 from https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/addressing-maternal-mental-health-and-substance-use-care-and-outcomes/index.html

191. See Note 182, Section 1.

192. Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022, May 19). Medicaid coverage of pregnancy-related services: Findings from a 2021 state survey. *Women's Health Policy*. Retrieved 15 January 2025 from https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/

193. See Note 175.

194. See Note 181.

195. See Note 182, Section 2.

196. See Note 185, Section 2.

197. U.S. Department of Health and Human Services. *The Task Force on Maternal Mental Health's report to Congress*. Retrieved 13 January 2025 from https://www.samhsa.gov/sites/default/files/mmh-report.pdf

198. Task Force on Maternal Mental Health. (2024, May). *National strategy to improve maternal mental health care*. Retrieved 13 January 2025 from https://www.samhsa.gov/sites/default/files/mmh-strategy.pdf

199. Alliance for Innovation on Maternal Health. *Perinatal mental health conditions*. Retrieved 13 January 2025 from https://saferbirth.org/psbs/perinatal-mental-health-conditions/

200. Maternal Mental Health Leadership Alliance. *Maternal mental health toolkits*. Retrieved 13 January 2025 from https://www.mmhla.org/maternal-mental-health-toolkits

201. —. *Resource hub*. Retrieved 13 January 2025 from https://www.mmhla.org/resource-hub

202. Policy Center for Maternal Mental Health. *State report cards*. Retrieved 13 January 2025 from https://policycentermmh.org/state-report-cards/

203. Burkhard, J. (2024, April 24). *2023 state maternal mental health legislation report*. Policy Center for Maternal Mental Health. Retrieved 13 January 2025 from https://policycentermmh.org/2023-state-maternal-mental-health-legislation-report/

204. Policy Center for Maternal Mental Health. *2025 pending state maternal mental health legislation*. Retrieved 13 January 2025 from https://policycentermmh.org/state-policy/

205. —. *Maternal mental health nonprofit map*. Retrieved 13 January 2025 from https://policycentermmh.org/nonprofit-nation/

206. —. *Resources for providers*. Retrieved 13 January 2025 from https://policycentermmh.org/resources-for-providers/

207. —. *Certified peer support*. Retrieved 13 January 2025 from https://policycentermmh.org/certified-peer-support/

208. Medicaid. (2024, June). *Maternal & infant health care quality: Maternal mental health screening, treatment and improvement strategies* and *Decreasing fragmentation in maternal substance use disorder screening and treatment*. Retrieved 13 January 2025 from https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/index.html#2024WebSeries:~:text=Webinar%20%232%3A%20Maternal,collaborating%20across%20systems

209. Alliance for Innovation on Maternal Health. *Care for pregnant and postpartum people with substance use disorder*. Retrieved 13 January 2025 from https://saferbirth.org/psbs/care-for-pregnant-and-postpartum-people-with-substance-use-disorder/

210. Roberts, T., Frederiksen, B., Saunders, H., & Salganicoff, A. (2023, September 19). *Opioid use disorder and treatment among pregnant and postpartum Medicaid enrollees*. KFF. Retrieved 13 January 2025 from https://www.kff.org/medicaid/issue-brief/opioid-use-disorder-and-treatment-among-pregnant-and-postpartum-medicaid-enrollees/

211. American Diabetes Association. Management of diabetes in pregnancy: Standards of medical care in diabetes – 2020. *Diabetes Care*, 43(S1). https://doi.org/10.2337/dc20-S014; Horgan, R., Hage Diab, Y., Fishel Bartal, M., Sibai, B. M., & Saade, G. (2024, February). Continuous glucose monitoring in pregnancy. *Obstetrics and Gynecology*, 143(2) 195–203. https://doi.org/10.1097/AOG.0000000000005374

212. Centers for Disease Control and Prevention. *Births data summary: Natality records 2016–2023*. Retrieved 14 January 2025 from https://wonder.cdc.gov/wonder/help/natality-expanded.html

213. Tran, K., Padwal, R., Khan, N., Wright, M.-D., & Chan, W. S. (2021, June 15). Home blood pressure monitoring in the diagnosis and treatment of hypertension in pregnancy: A systematic review and meta-analysis. *CMAJ Open*, 9(2). https://doi.org/10.9778/cmajo.20200099; Albadrani, M., Tobaiqi, M., & Al-Dubai, S. (2023, August 1). An evaluation of the efficacy and the safety of home blood pressure monitoring in the control of hypertensive disorders of pregnancy in both pre- and postpartum periods: A systematic review and meta-analysis. *BMC Pregnancy and Childbirth*, 23. https://doi.org/10.1186/s12884-023-05663-w; Lewkowitz, A., & Hauspurg, A. (2024, September). Perinatal remote blood pressure monitoring. *Obstetrics & Gynecology*, 144(3) 339–345. https://doi.org/10.1097/AOG.0000000000005690

214. Horgan, R., Hage Diab, Y., Fishel Bartal, M., Sibai, B. M., & Saade, G. Continuous glucose monitoring in pregnancy.

Obstetrics & Gynecology, 143(2) 195–203. https://doi.org/10.1097/AOG.0000000000005374; García-Moreno, R. M., Benítez-Valderrama, P., Barquiel, B., González Pérez-de-Villar, N., Hillman, N., Pablos, D. L., & Herranz, L. Efficacy of continuous glucose monitoring on maternal and neonatal outcomes in gestational diabetes mellitus: A systematic review and meta-analysis of randomized clinical trials. (2022) *Diabetes Medicine*, https://doi.org/10.1111/dme.14703; Alexopoulos, A.-S., Blair, R., & Peters, A. L. (2019, May 14). Management of preexisting diabetes in pregnancy: A review. *Journal of the American Medical Association*, 321(18) 1811–1819. https://doi.org/10.1001/jama.2019.4981; Levy, C. J., Galindo, R. J., Parkin, C. G., Gillis, J., &. Argento, N. B. All children deserve to be safe, mothers too: Evidence and rationale supporting continuous glucose monitoring use in gestational diabetes within the Medicaid population. *Journal of Diabetes Science and Technology*, 18(5). https://doi.org/10.1177/19322968231161317

215. American College of Obstetricians and Gynecologists. (2019, January). *Chronic hypertension in pregnancy*. Retrieved 14 January 2025 from https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy; —. (2018, February.) *Gestational diabetes mellitus. Obstetrics & Gynecology*, 131(2) 406-408. https://doi.org/10.1097/AOG.0000000000002498 [paywall]

216. See Note 192; American Medical Association. (2024, October). *SMBP coverage insights: Medicaid*. Retrieved 13 January 2025 from https://www.ama-assn.org/system/files/smbp-coverage-medicaid.pdf; Center for Health Care Strategies. (2023, July). *Continuous glucose monitor access for Medicaid beneficiaries living with diabetes: State-by-state coverage*. Retrieved 13 January 2025 from https://www.chcs.org/media/CGM-Access-for-Medicaid-Beneficiaries-Living-with-Diabetes-State-By-State-Coverage.pdf

217. See Note 192.

218. *Ibid*.; see Note 216, Section 3.

219. See Note 192.

220. *Ibid*.

221. See Note 216, Section 2.

222. See Note 192.

223. Medicaid. *Improving maternal hypertension control and cardiovascular health*. Retrieved 13 January 2025 from https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/improving-maternal-hypertension-control-and-cardiovascular-health/index.html; Million Hearts. *Hypertension in pregnancy change package*. Retrieved 13 January 2025 from https://millionhearts.hhs.gov/tools-protocols/action-guides/hypertension-pregnancy-change-package/index.html; Medicaid. (2024, July 16). *Maternal & infant health quality: Addressing hypertension before, during, and after pregnancy*. Retrieved 13 January 2025 from https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality#2024WebSeries:~:text=Webinar%20%234%3A%20Addressing,and%20care%20coordination.

224. Alliance for Innovation on Maternal Health. *Maternal Early Warning System Implementation Resource Kit*. Retrieved 13 January 2025 from https://saferbirth.org/maternal-early-warning-system-implementation-resource-kit/

225. —. *Severe Hypertension in Pregnancy*. Retrieved 13 January 2025 from https://saferbirth.org/psbs/severe-hypertension-in-pregnancy/

226. Centers for Disease Control and Prevention. *Hear Her campaign*. Retrieved 13 January 2025 from https://www.cdc.gov/hearher/index.html

227. American College of Obstetricians and Gynecologists. (2018, March). *Group prenatal care*. Retrieved 11 January 2025 from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care

228. Carter, E. B., Temming, L. A., Akin, J., Fowler, S., Macones, G. A., Colditz, G. A., & Tuuli, M. G. (2016). Group prenatal care compared with traditional prenatal care: A systematic review and meta-analysis. *Obstetrics and Gynecology,* 128(3) 551–561. https://doi.org/10.1097/AOG.0000000000001560; Sheeder, J., Yorga, K. W., & Kabir-Greher, K. (2010, November 19). A review of prenatal group care literature: The need for a structured theoretical framework and systematic evaluation. *Maternal and Child Health Journal*, 16 177–187. https://doi.org/10.1007/s10995-010-0709-1; Centers for Medicare & Medicaid Services. *Strong Start for mothers and newborns: Evaluation of full performance period (2018).* Retrieved 11 January 2025 from https://www.cms.gov/priorities/innovation/files/reports/strongstart-prenatal-fg-finalevalrpt.pdf; Centering Healthcare Institute. (2022, December). *CenteringPregnancy and CenteringParenting annotated bibliography*. Retrieved 11 January 2025 from https://www.centeringhealthcare.org/uploads/files/Centering-Healthcare-Institute-Annotated-Bibliography.docx-16.pdf

229. Byerley, B. M., & Haas, D. M. (2017, September 29). A systematic overview of the literature regarding group prenatal care for high-risk pregnant women. *BMC Pregnancy and Childbirth*. Retrieved 11 January 2025 from https://doi.

org/10.1186/s12884-017-1522-2; Robinson, K., Garnier-Villarreal, M., & Hanson, L. (2018, April/June). Effectiveness of CenteringPregnancy on breastfeeding initiation among African Americans: A systematic review and meta-analysis. *Journal of Perinatal & Neonatal Nursing*, 32(2) 116–126. https://doi.org/10.1097/JPN.0000000000000307; Lewis, J. B., & Ickovics, J. R. (2024, June 8). Expect with me: Group prenatal care to reduce disparities. *New England Journal of Medicine*, 390(22) 2039–2040. https://doi.org/10.1056/NEJMp2400482; Embrace. Retrieved 11 January 2025 from https://embraceblackcare.org/; Nguyen, D. (2023, December 4). Maternity group care for and by Black people is improving outcomes in Oakland. KQED. Retrieved 11 January 2025 from https://www.kqed.org/news/11968835/maternity-group-care-for-and-by-black-people-is-improving-outcomes-in-oakland; Alameda Health System. *Black Centering is a new kind of care made for you and your baby*. Retrieved 11 January 2025 from https://www.alamedahealthsystem.org/family-birthing-center/black-centering/; Liese, K., Stewart, K., Pearson, P., Lofton, S., Mbande, T., Patil, C., … Geller, S. (2022, November). Melanated Group Midwifery Care: Centering the voices of the Black birthing community. *Journal of Midwifery & Women's Health*, 67(6) 696–700. https://doi.org/10.1111/jmwh.13438; Carter, E. B., EleVATE Women Collaborative & Mazzoni, S. E. (2021, April). A paradigm shift to address racial inequities in perinatal healthcare. *American Journal of Obstetrics and Gynecology*, 224(4) 359–361. https://doi.org/10.1016/j.ajog.2020.11.040

230. Mays, M., Oklan, T., Acevedo, G. & Mungalez, S. N. (2021, September 14). *EMBRACE perinatal care for Black families: Reclaiming health, wellness, and self-determination for Black birthing*. Zero to Three. Retrieved 11 January 2025 from https://www.zerotothree.org/resource/journal/embrace-perinatal-care-for-black-families-reclaiming-health-wellness-and-self-determination-for-black-birthing/#chapter-3527; See Note 175, Part 4; See Note 175, Section 3; Masters, C., Carandang, R. R., Lewis, J. B., Hagaman, A., Metrick, R., … Cunningham, S.D. (2024, March 4). Group prenatal care successes, challenges, and frameworks for scaling up: A case study in adopting health care innovations. *Implementation Science Communications*, 5(1) 20. https://doi.org/10.1186/s43058-024-00556-1; Health Management Associates. *Issue brief: How CenteringPregnancy can support birth equity*. Retrieved 11 January 2025 from https://centeringhealthcare.org/uploads/downloads/BirthEquity_IssueBrief__Oct9th2019.pdf

231. See Note 192.

232. Centering Healthcare Institute. *CenteringPregnancy*. Retrieved 11 January 2025 from https://centeringhealthcare.org/what-we-do/centering-pregnancy

233. March of Dimes. *Supportive Pregnancy Care*. Retrieved 11 January 2025 from https://www.marchofdimes.org/our-work/health-professionals/continuing-education-courses/supportivepregnancycare

234. See Note 229 and Note 230. Masters, C., Carandang, R. R., Lewis, J. B., Hagaman, A., Metrick, R., Ickovics, J. R., & Cunningham, S. D. (2024). Group prenatal care successes, challenges, and frameworks for scaling up: A case study in adopting health care innovations. *Implementation Science Communications,* 5(20). Retrieved 11 January 2025 from https://doi.org/10.1186/s43058-024-00556-1

235. Centering Healthcare Institute. *Aligning value-based payment with CenteringPregnancy*. Retrieved 11 January 2025 from www.centeringhealthcare.org/uploads/files/Aligning-Value-Based-Payment-with-CenteringPregnancy.pdf

236. South Carolina Department of Health and Human Services. (2017, May 26). *Coverage for CenteringPregnancy group prenatal care*. Retrieved 11 January 2025 from https://www.scdhhs.gov/communications/coverage-centering-pregnancy-group-prenatal-care

237. Prenatal-to-3 Policy Impact Center. (2023, September). *State policy lever checklist: Group prenatal care.* Retrieved 11 January 2025 from https://pn3policy.org/wp-content/uploads/2023/09/PN3PIC_StatePolicyLeverChecklist_GPNC.pdf; Ohio House of Representatives. (2020, June 22). Rep. Howse announces bill to improve prenatal and maternal health outcomes signed into law. Retrieved 11 January 2025 from https://ohiohouse.gov/news/democratic/rep-howseannounces-bill-to-improve-prenatal-and-maternal-healthoutcomes-signed-into-law-103308

238. See Note 232.

239. See Note 233.

240. See Note 237, Section 1.

241. —. (2021, October 5). *Resources for group prenatal care*. Retrieved 11 January 2025 from https://pn3policy.org/resources-for-group-prenatal-care/

242. Pekkala, J., Cross-Barnet, C., Kirkegaard, M., Silow-Carroll, S., Courtot, B., & Hill, I. (2019, October 23). Key considerations for implementing group prenatal care: Lessons from 60 practices. *Journal of Midwifery & Women's Health*, 65(2) 208–215. https://doi.org/10.1111/jmwh.13047

243. Health Resources and Services Administration. *Maternal, infant, and early childhood home visiting (MIECHV) program*. Retrieved 15 January 2025 from https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-

early-childhood-home-visiting-miechv-program; —. *Healthy start: Nurturing health, preventing disparities*. Retrieved 15 January 2025 from https://mchb.hrsa.gov/programs-impact/healthy-start

244. See Note 63, Section 2.

245. Weigel, G., Frederiksen, B., & Ranji, U. (2020, February 26). Telemedicine and pregnancy care. *Women's Health Policy*. Retrieved 15 January 2025 from https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/

246. Tormen, M., Toniolo, B., Pecci, L., Soraci, G., Taliento, C., Greco, P., & Salvioli, S. (2024, November). Exploring the impact of integrating telehealth in obstetric care: A scoping review. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 302, 242–248. https://doi.org/10.1016/j.ejogrb.2024.09.031; M2 Health Care Consulting. (2021, August). *Telehealth & maternity care: Strategies and resources for state policymakers and payers to improve access to telematernity.* Retrieved 15 January 2025 from https://m2hcc.com/wp-content/uploads/2021/08/M2-%E2%80%93-Telehealth-and-Maternity-Care-A-COVID-19-Policy-Crossroad-%E2%80%93-August-2021.pdf

247. Cantor, A. G., Jungbauer, R. M., Totten, A. M., Tilden, E. L., Holmes, R., Ahmed, A., … McDonagh, M. (2022, July). *Telehealth strategies for the delivery of maternal health care.* Patient-Centered Outcomes Research Institute. Retrieved 15 January 2025 from https://www.pcori.org/sites/default/files/PCORI-Rapid-Review-Telehealth-Strategies-for-the-Delivery-of-Maternal-Healthcare.pdf

248. Li, W. Z.-M. (2023, April 13). *Advancing health equity and value-based care: A mobile approach*. Harvard Medical School Center for Primary Care. Retrieved 15 January 2025 from https://info.primarycare.hms.harvard.edu/perspectives/articles/mobile-clinics-in-the-us-health-system

249. Health Resources and Services Administration. (2024, June). *The Maternal, Infant, and Early Childhood Home Visiting Program*. Retrieved 15 January 2025 from https://mchb.hrsa.gov/sites/default/files/mchb/about-us/program-brief.pdf

250. —. *Healthy start*. Retrieved 15 January 2025 from https://mchb.hrsa.gov/sites/default/files/mchb/about-us/mchb-healthy-start-factsheet.pdf

251. Movitz, S., Ediger, R. M., Dingwall, A., & Tobah, Y. B. (2023, November 15). Telehealth for equitable obstetric care: Addressing gaps for patients, providers, and payers. *Telehealth and Medicine Today*, 8(5). https://doi.org/10.30953/thmt.v8.443

252. Mobile Health Map. Retrieved 15 January 2025 from https://www.mobilehealthmap.org/clinics/

253. Centers for Medicare and Medicaid Services. (2024, February). *State Medicaid & CHIP telehealth toolkit.* Retrieved 15 January 2025 from https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf

254. See Note 243.

255. March of Dimes. *Mom & baby mobile health centers*. Retrieved 15 January 2025 from https://www.marchofdimes.org/our-work/mobile-health-centers; https://southernbirthjustice.org/mobile-midwife-clinic

256. See Note 253.

257. U.S. Department of Health and Human Services. *Telehealth for maternal health services*. Retrieved 15 January 2025 from https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-maternal-health-services

258. See Note 245.

259. Mobile Healthcare Association. Retrieved 15 January 2025 from https://mobilehca.org/

260. Mobile Health Map. *Looking for a place to start?* Retrieved 15 January 2025 from https://www.mobilehealthmap.org/resources/start-a-mobile-health-clinic/

261. Barranca-Enríquez, A., & Romo-González, T. (2022, September 14). Your health is in your mouth: A comprehensive view to promote general wellness. *Frontiers in Oral Health*, 3. https://doi.org/10.3389/froh.2022.971223

262. American Dental Association. (2024, May 13). *Medicaid: Dental coverage for pregnant & postpartum women*. Retrieved 15 January 2025 from https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/medicaid/medicaid_postpartum_coverage_050124.pdf

263. Lieneck, C., Connelly, E., Ireland, D., Jefferson, A., Jones, J., & Breidel, N. (2023, August 10). Facilitators and barriers to oral healthcare for women and children with low socioeconomic status in the United States: A narrative review. *Healthcare*, 11(16) 2248. https://doi.org/10.3390/healthcare11162248

264. CareQuest Institute for Oral Health. (2024, September). *Medicaid adult dental benefits offered to specific beneficiary groups as of December 2023*. Retrieved 4 March 2025 from https://www.carequest.org/system/files/CareQuest_Institute_Medicaid-Adult-Dental-Benefits_10.9.24.pdf

265. National Academy for State Health Policy. 2022, October 20). *State Medicaid coverage of dental services for general adult and pregnant populations*. Retrieved 15 January 2025 from https://nashp.org/state-tracker/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/

266. See Note 192.

267. National Maternal and Child Oral Health Resource Center. Retrieved 15 January 2025 from https://www.mchoralhealth.org/

268. CareQuest Institute for Oral Health. *Pregnancy and oral health*. Retrieved 15 January 2025 from https://www.carequest.org/system/files/CareQuest_Institute_The-Role-Medicaid-Adult-Dental-Benefits-During-Pregnancy_4.10.23.pdf

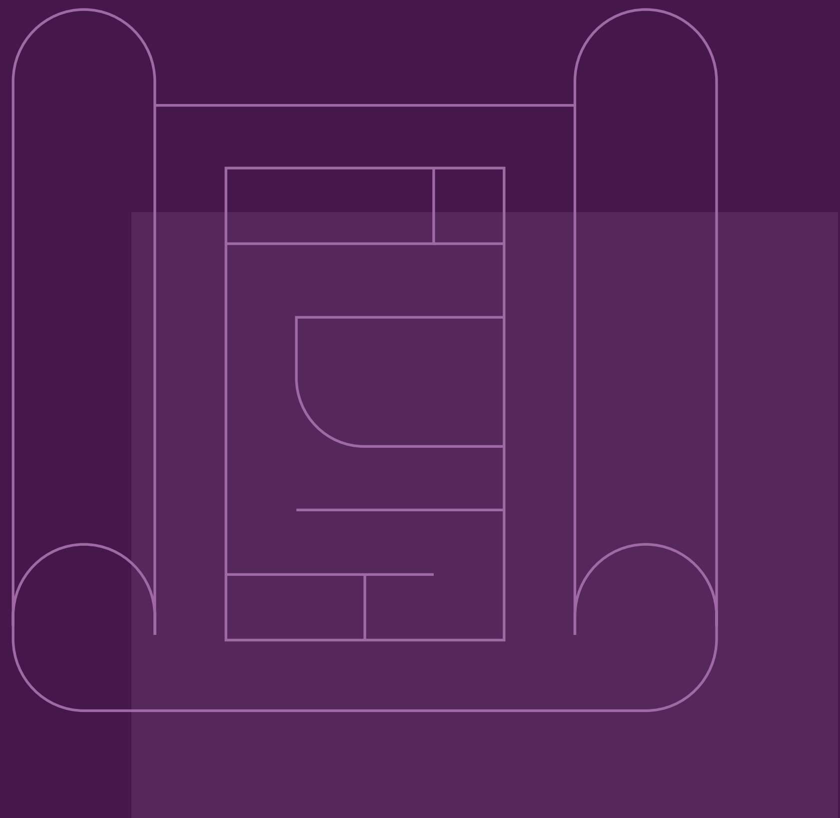
269. Consortium for Oral Health Systems Integration and Improvement. (2023). *Capacity inventory for integrating oral health care and primary care for pregnant women*. Retrieved 15 January 2025 from https://www.mchoralhealth.org/PDFs/capacity-inventory-brief.pdf

270. American Academy of Pediatrics. *Oral health campaign toolkit*. Retrieved 15 January 2025 from https://www.aap.org/en/news-room/campaigns-and-toolkits/oral-health/

SECTION 3

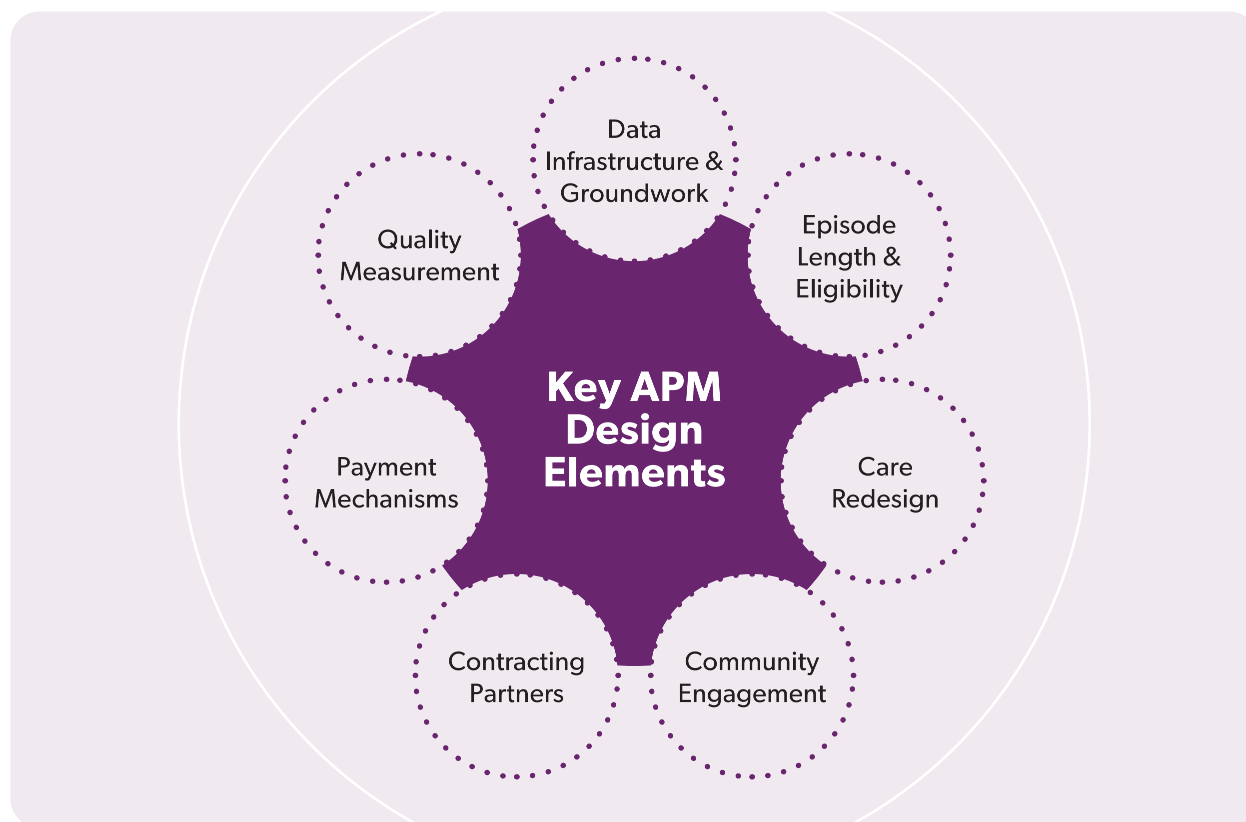
Effective Maternity Care

Alternative Payment Model Design Guide



The authors of this playbook recently carried out a landscape study of existing and developing maternity care alternative payment model (APM) programs. We found that few such programs have been offered, few providers have been participating, and program managers were unable to point to improvements in maternal health, either overall or in reducing outcome gaps.[1] The failure to effectively leverage payment to meet urgent needs of childbearing families is a major missed opportunity. This section summarizes that study's extensive design recommendations for more impactful maternity care APMs. The recommendations are relevant to all state Medicaid agencies, whether participating in the Transforming Maternal Health (TMaH) model, separately operating a maternity care APM program, or contemplating advancing beyond fee-for-service payment to a program for alternative payment and delivery reform.

During the three-year TMaH pre-implementation period, awardees will engage with the CMS Innovation Center to design a single value-based APM, with flexibility for state-specific circumstances. TMaH states will offer gainsharing to higher-performing providers in model year four and will implement the full payment model in the final six program years. Lessons summarized here from legacy and more recent maternity care APM programs can inform a TMaH payment model that will drive meaningful improvements in care, experiences, and outcomes. By strengthening data collection and reporting and other aspects of maternal health infrastructure during the pre-implementation period, participating SMAs can prepare for effective implementation during and beyond the TMaH model.



1. DATA INFRASTRUCTURE AND GROUNDWORK

APMs need high-quality data about provider performance and the experiences and well-being of childbearing families to understand baseline status and track and measure progress toward program goals. Also critical for these programs are data linkages and exchange between different data sources with information on maternal health, infant health, and social drivers of health.

- ☐ Implement data mechanisms that allow for near real-time collection, assessment and evaluation of the progress of the maternity APM, and feedback to participating providers.
- ☐ Establish data agreements and other data infrastructure requirements to link infant and childbearing woman data, and use the information to assess provider performance.
- ☐ Establish mechanisms to collect full and accurate self-identified data on demographic attributes of interest to measure, set targets, and improve care and outcomes for all.
- ☐ Build capacity to support providers through technical assistance, infrastructure development, and timely and actionable progress reports that enable and foster improvement.

2. EPISODE LENGTH AND ELIGIBILITY[i]

When establishing a maternity APM, payers must specify the time period and patient eligibility. The relatively long childbearing episode spans pregnancy, birth, and the postpartum period. The postpartum period presents many opportunities to enhance maternal health. This period is increasingly recognized as a year or more after birth, and nearly all states have extended Medicaid eligibility to one year postpartum. However, systems need to address the challenges that longer time frames can pose for timely reporting, model evaluation, and model adjustment/refinement.

Designs for which the great majority of childbearing women and newborns are eligible maximize model reach and prevent confusion about changing eligibility when maternal and infant conditions change across the episode of care.

- ☐ Initiate episodes upon initial presentation of pregnant women for care; include maternal care and outcomes in the episode through 12 months postpartum, with mechanisms for rapid-cycle data collection and management, continuous provider feedback, and regular refinement of the model and strengthening of benchmarks in the context of learning health systems.

i Maternity care APMs are often based on “episode” payments, but in the context of this design element this term references the duration of focus, when participants enter and leave the program.

- ☐ Limit ineligibility for inclusion in APMs to a small set of serious complications that are beyond the control of clinicians, to enable the great majority of families to benefit from participation. Ensure that payments and performance metrics are adjusted to support providers in caring for patients with higher acuity needs.
- ☐ Include the newborn, including the quality of care, birth outcomes, and costs, in the APM, if feasible from the start, and otherwise through an expeditious glide path.[ii] This needs to be coupled with data linkages and other infrastructure improvements and contracting with multiple providers across the episode. (See "Data Infrastructure and Groundwork" section, above, and "Contracting Partners," below.)

3. CARE REDESIGN

Standard maternity care is not achieving the better results that childbearing families need. Maternity care must be redesigned to eliminate avoidable harm and reliably provide respectful upstream whole-person care that enables families to thrive.

- ☐ Ensure that providers and health systems have access to supports such as perinatal quality collaboratives and patient safety bundle training that avert catastrophic harm and are also supported and incentivized to offer upstream preventive and health promoting care that enables families to thrive.
- ☐ Require care settings to screen for physical health, mental and behavioral health, and social needs, and help with needed services, as desired and in a respectful manner that prioritizes confidentiality.
- ☐ Provide technical assistance to help contracting providers understand how high-performing care models can support childbearing families and participating provider success. Require providers to create teams providing access to high-performing underused care models (and community-based forms of these, when possible). These include midwifery, community birth settings, doula support, and support and care from community-based perinatal health worker groups.
- ☐ Require providers to support and connect families with community-based and -led organizations that offer trusted, respectful, and often culturally congruent support and care.
- ☐ Develop and test methods to reduce the inappropriate overuse of NICUs by lower-risk infants,[2] including the use of stand-by payments, while providing access to NICU care for babies who may be expected to benefit.[3]

ii Maternal-newborn care and well-being are deeply intertwined and many standard maternity-care outcomes (e.g., preterm birth) are newborn outcomes. Including the baby in maternity APMs is an opportunity for care teams to be accountable to, and improve care for, both individuals. The baby makes a later appearance but is associated with about 37 percent of all payments made on behalf of mother and baby across the episode. https://nationalpartnership.org/wp-content/uploads/2023/02/the-cost-of-having-a-baby-in-the-us.pdf]

- ☐ Care teams or other entities should advance maternal-infant health by reliably informing participating childbearing families about health-promoting benefits beyond the APM program for which they may be eligible and how to secure benefits. These include state Medicaid doula programs, state paid leave programs, temporary disability benefits, WIC and SNAP programs, workplace pregnancy and breastfeeding accommodations, diaper banks, and home visiting and Early Head Start programs.

4. COMMUNITY ENGAGEMENT

Meaningful and sustained community engagement is central to learning health systems, improving the quality and experiences of care, and achieving better maternal and infant health outcomes for all.[4]

- ☐ Across the APM cycle – from planning to implementation, evaluation, and refinement – center the feedback, concerns, solutions, and other guidance from maternal health leaders, community-based organizations, birth workers, and childbearing families who are most adversely affected by the underperforming maternity care system. Mechanisms include Perinatal Community Advisory Boards, experience of care surveys, local hiring and procurement, and supporting and providing access to services of community-based organizations.
- ☐ Implement best practices for respectful, inclusive processes, collaborative problem-solving, good communication and feedback, and appropriate support for participants to help design, implement, and scale impactful community engagement programs.
- ☐ Prioritize access to culturally concordant care of both clinicians and community-based services, and pathways for building community power through education and recruitment, as well as contracting with and supporting community organizations.
- ☐ Ensure that providers and health systems understand the importance of meaningful community participation in all aspects of governance, receive feedback from community members, and engage in processes to track and address identified concerns.

5. CONTRACTING PARTNERS

Effective maternity APMs need to include all entities providing care and support within the model across the maternity care episode, including community-based partners.

- ☐ Develop, or require Medicaid managed care organizations to develop, contracts with teams that include physicians, midwives, support personnel (e.g., lactation, community-based organizations), hospitals, birth centers, and federally qualified health centers.
- ☐ Incentivize ob-gyn and family physicians and care settings to collaborate with high-performing care providers, such as midwives, birth centers, doulas, and community-based perinatal health workers, as a strategy to achieve success on performance metrics under risk-based contracting.

- ☐ Incentivize team-based approaches that link the prenatal, intrapartum, and postpartum phases of care, including when the contracting provider is not employed or affiliated with the birth facility. This may be done, for example, by requiring the majority of shared savings to reach those providing care and incentivizing care team members in all phases of care to work toward shared performance targets.

6. PAYMENT MECHANISMS

Use payment mechanisms as a tool to drive delivery system reform and incentivize performance improvement. Avoid ineffective design elements of legacy APM programs.

- ☐ Explore a combination of episode payment programs for improving clinical care and maternity care home programs for addressing nonclinical needs that impact health outcomes. Consider including both standby payments that compensate for the fixed costs of having services available as well as payments for provided services. Standby payments can support sustainability and access in low-volume settings, access to underused high-performing care models, and appropriate use of NICU services.[5]
- ☐ Ensure coverage and optimal incentives for high-performing maternal care models[6] to improve maternal-infant health, reduce outcome gaps, and succeed in APM participation. Reward contracting providers for their baseline high performance and welcome improvement.
- ☐ Provide payment levels commensurate with a whole-person care model, with the expectation that care teams will be responsible for preventing, assessing, and addressing physical health, mental and behavioral health, and social needs as key drivers of maternal and infant outcomes. Provide adequate, reliable Medicaid payment for separately reimbursed nontraditional pregnancy-related services.[7]
- ☐ Pay providers prospectively with adjustments to account for higher-acuity physical health, mental health, and social needs of individual patients or their overall maternity patient population. Consider using place-based indices for risk adjustment such as the Area Deprivation Index[8] or the Maternal Vulnerability Index,[9] to adequately support higher-acuity patients and the providers caring for them.
- ☐ Provide infrastructure support (both funding and technical assistance) for data collection and sharing and integration of demographic information, whole-person care screening and follow-up, performance measurement, and quality improvement initiatives into clinical practices. Ensure that smaller, safety-net, and rural practice providers, as well as providers who lack the resources of larger health systems, are supported to integrate APM functions into their practices and successfully participate in APMs.

- [ ] Set APM budgets using a blended rate for cesarean and vaginal birth for both professionals and facilities rather than projecting historical fee-for-service rates forward. Payments should compensate for small and steady year-over-year cesarean rate reductions as providers and systems learn how to safely implement evidence-based cesarean reduction practices in the context of current levels of overuse and unwarranted variation.[10] Provide technical assistance for providers and health systems about the many practices associated with averting unneeded cesareans.[11]
- [ ] Investigate how maternity episode payment and maternity care home APMs could be incorporated into larger population-based APMs with strong design elements for impacting maternal-newborn care and outcomes, and evaluate the impact of Accountable Care Organizations (ACOs) on maternal-newborn care, health, and costs.
- [ ] Require a substantial portion of any incentive payment or shared savings to be distributed to all care team members, including nonclinical members, to encourage those providing care to work together toward shared goals. Limit shared savings flowing to the contracting entity to administrative costs and a smaller proportion of overall savings.
- [ ] Prioritize adequate targeted investment in urgently needed maternal-infant improvements in quality and outcome gap reduction over short-term cost savings. Recognize that such improvements as reduced rates of cesarean birth, preterm birth, perinatal mental health conditions, and low-value NICU admissions and increased rates of vaginal birth, vaginal birth after cesarean, and breastfeeding generate considerable cost savings. Design analytical model frameworks and actuarial models that capture and support such improvements as well as spillover effects, system learnings, and other valuable contributions.[12]

7. QUALITY MEASUREMENT

Performance measurement is central to holding professionals and health systems accountable for care delivery reform. However, many legacy maternity APMs have poorly leveraged the great potential of performance measurement. Reasons include poor data infrastructure, selection of low-impact measures, unavailability of consensus-developed measures for key measure concepts, inconsistent measure stratification, inadequate technical assistance, and failure to make performance goals and incentives progressively more stringent over time.

- [ ] Create and implement an interoperable data system for respectfully collecting participants' self-identified demographic data, as well as clinical data, health-related social needs and mental health screening results and follow-up, and performance measure results. (See "Data Infrastructure and Groundwork," above.)
- [ ] Select fit-for-purpose high-impact maternal-infant performance measures developed through consensus processes that apply to a large segment of this population and have the potential to improve quality, reduce outcome gaps, and drive meaningful preventive upstream population-level improvements. The Partnership for Quality Measurement

(successor to the National Quality Forum), the National Committee for Quality Assurance, and the Agency for Healthcare Research and Quality use widely respected consensus processes to endorse or otherwise recommend measures. Eschew measures that cannot be expected to lead to meaningful improvement (for example, because they are topped out or focus on infrequent phenomena and are thus difficult to interpret).[13]

- [ ] While awaiting consensus-based measures for crucial topics (e.g., person-reported experience of maternity care), adapt generic measures (e.g., social needs screening and follow-up), adapt maternity measures (e.g., depression measures for anxiety), or use interim indicators developed and validated for research purposes (e.g., experience of maternity care tools).[14]
- [ ] Include priority infant measures, even when newborn care and costs are not yet included in the model. Create a glide path to ensure newborn care and costs are eventually included. (See “Episode Length and Eligibility.”)
- [ ] As appropriate, stratify performance measures by relevant subgroups to ensure outcomes are improving for all.
- [ ] Measure performance results, set benchmarks for better care and financial incentives, track results over time, and progressively adjust benchmarks for steady improvement.
- [ ] Implement mechanisms to avoid penalizing high-performing providers, those working in under-resourced settings, and those working with high-acuity patients.
- [ ] Implement quality improvement processes in tandem with performance measurement, including improvement plans, rapid-cycle provider feedback, technical assistance, and support of perinatal quality collaboratives.

Endnotes

1. National Partnership for Women & Families. (2024, February). *Maternity care payment reform*. Retrieved 10 January 2025 from https://nationalpartnership.org/maternityAPM

2. Goodman, D. C., Little, G. A., Harrison, W. N., Moen, A., Mowitz, M. E., Ganduglia Cabazan, C., … Doherty, J. R. (2019). *The Dartmouth atlas of neonatal intensive care*. Dartmouth Institute for Health Policy & Clinical Practice. Retrieved 10 January 2025 from https://www.dartmouthatlas.org/Neonatal_Atlas_090419.pdf

3. Center for Healthcare Quality & Payment Reform. *An alternative payment model for maternity care*. Retrieved 13 October 2023 from https://www.dartmouthatlas.org/Neonatal_Atlas_090419.pdf

4. National Partnership for Women & Families. (2023, March). *Raising the bar for moms & babies: Engage with individuals and organizations in the community to achieve maternal health equity*. Retrieved 10 January 2025 from https://nationalpartnership.org/health-justice/raising-the-bar/report/#community-partner

5. See Note 3; —. *Addressing the crisis in rural maternity care*. (2024, December). Retrieved 10 January 2025 from https://ruralhospitals.chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf

6. National Partnership for Women & Families. *Improving our maternity care now.* Retrieved 10 January 2025 from https://nationalpartnership.org/health-justice/maternal-health/improving-our-maternity-care/

7. Mondestin, T. (2024, September 10). *As more states allow Medicaid reimbursements for new pregnancy-related services, promoting access remains a challenge*. Georgetown University McCourt School of Public Policy, Center for Children and Families. Retrieved 10 January 2025 from https://ccf.georgetown.edu/2024/09/10/as-more-states-allow-medicaid-reimbursements-for-new-pregnancy-related-services-promoting-access-remains-a-challenge/

8. Center for Health Disparities Research, University of Wisconsin School of Medicine and Public Health. *Neighborhood atlas*. Retrieved 10 January 2025 from https://www.neighborhoodatlas.medicine.wisc.edu/

9. Surgo Ventures. *Maternal vulnerability in the US: A shameful problem for one of the world's wealthiest countries*. Retrieved 10 January 2025 from https://mvi.surgoventures.org/

10. Pacific Business Group on Health. (2015, October). *Case study: Maternity payment and care redesign pilot*. Retrieved 10 January 2025 from https://www.pbgh.org/wp-content/uploads/2020/12/TMC_Case_Study_Oct_2015.pdf; Kozhimannil, K. B., Graves, A. J., Ecklund, A. M., Shah, N., Aggarwal, R., & Snowden, J. M. (2018, August). Cesarean delivery rates and costs of childbirth in a state Medicaid program after implementation of a blended payment policy. *Medical Care*, 56(8), 658–664. https://doi.org/10.1097/MLR.0000000000000937; Kozhimannil, K. B., Law, M. R., & Virnig, B. A. (2013, March). Cesarean delivery rates vary tenfold among US hospitals; reducing variation may address quality and cost issues. *Health Affairs*, 32(3). https://doi.org/10.1377/hlthaff.2012.1030

11. California Maternal Quality Care Collaborative. *Support vaginal birth and reduce primary cesareans toolkit*. Retrieved 10 January 2025 from https://www.cmqcc.org/VBirthToolkit

12. Sheingold, S., Ghosh, K., & Samson, L. W. (2024, September 24). How to evaluate the Innovation Center's impact on delivery system transformation. *Health Affairs*. Retrieved 10 January 2025 from https://www.healthaffairs.org/content/forefront/evaluate-innovation-center-s-impact-delivery-system-transformation; Health Care Payment Learning & Action Network. (2024, November). *Value of health care redefined: Social return on investment understanding the landscape and opportunities for applying social return on investment to health care*. Retrieved 10 January 2025 from https://hcp-lan.org/wp-content/uploads/2024/11/CMS-HEAT-Social-ROI.pdf

13. National Partnership for Women & Families. (2024). *Selecting performance measures for maternity care alternative payment models (APMs): Consensus-based maternity care measures recommended for APMs*. Retrieved 10 January 2025 from https://nationalpartnership.org/wp-content/uploads/maternityAPM-performance-measures.pdf; —. (2023, March). *Priority maternity care quality measures to improve outcomes and equity operational guidance*. Retrieved 10 January 2025 from https://nationalpartnership.org/wp-content/uploads/2023/04/rtb-priority-maternity-care-measures.pdf

14. Bernheim, S. M., Rudolph, N., Quinton, J. K., Driessen, J., Rawal, P., & Fowler, E. (2024, May). Elevating quality, outcomes, and patient experience through value-based care: CMS Innovation Center's quality pathway. *NEJM Catalyst*, 5(5). Retrieved 10 January 2025 from https://catalyst.nejm.org/doi/pdf/10.1056/CAT.24.0132

Acronyms

Acronym	Definition
AABC	American Association of Birth Centers
AAP	American Academy of Pediatrics
AIAN	American Indian or Alaska Native
ACNM	American College of Nurse-Midwives
ACOG	American College of Obstetricians and Gynecologists
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
AIM	Alliance for Innovation on Maternal Health
APM	Alternative Payment Model
CDC	Centers for Disease Control and Prevention
CHCS	Center for Health Care Strategies
CHIP	Children's Health Insurance Program
CHQPR	Center for Healthcare Quality and Payment Reform
CHW	Community Health Worker
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CM	Certified Midwife
CNM	Certified Nurse-Midwife
CPM	Certified Professional Midwife
HHS	Department of Health and Human Services
HRSN	Health-Related Social Needs

KFF	Kaiser Family Foundation
MACPAC	Medicaid and CHIP Payment and Access Commission
MMHLA	Maternal Mental Health Leadership Alliance
NASHP	National Academy of State Health Policy
NEMT	Non-Emergency Medical Transportation
NGA	National Governors Association
NHeLP	National Health Law Program
NICU	Neonatal Intensive Care Unit
NOFO	Notice of Funding Opportunity
NPWF	National Partnership for Women & Families
OHRI	Ottawa Hospital Research Institute
PBGH	Purchaser Business Group on Health
PQCs	Perinatal Quality Collaboratives
RHIhub	Rural Health Information Hub
SAMHSA	Substance Abuse and Mental Health Services Administration
SMA	State Medicaid Agency
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
SUD	Substance Use Disorder
WIC	The Special Supplemental Nutrition Program for Women, Infants, and Children

About the Authors

Carol Sakala, PhD, MSPH, is a nationally recognized thought leader in maternal health and maternity care, with expertise in maternity care system transformation and high-performing maternal care models. She is the Senior Director for Maternal Health at the National Partnership for Women & Families, a founding member of the Health Care Payment Learning & Action Network (LAN) and the Health Care Transformation Task Force (HCTTF). Dr. Sakala served as a member of the LAN Clinical Episode Payment Workgroup that developed guidance on maternity care episode payment, and on the Strategy Team that led the LAN's Maternity Multi-stakeholder Action Collaborative. Additionally, she has supported the HCTTF Maternal Health Hub. In collaboration with Megan Burns, she carried out the 2024 landscape study of maternity care alternative payment programs in the United States, *Realizing the Transformational Potential of Maternity Care Payment Reform*. She also served as co-chair of the National Quality Forum's Perinatal and Women's Health Standing Committee for many years and contributes to numerous other performance measurement-related advisory bodies. She is the lead author of recent major reports on several high-performing care models – midwifery care, community birth settings, and doula support – and works to delineate health care's role in meeting the social, mental health, and physical health needs of childbearing families. She is the principal investigator of the Fourth National *Listening to Mothers* Survey.

Megan Burns, MPP, is an independent health policy consultant and lecturer at Brandeis University. Ms. Burns has more than two decades of experience in health policy and the health care industry. As a consultant, Ms. Burns has supported dozens of organizations, including state Medicaid agencies, state regulatory agencies, health-related foundations, nonprofit and advocacy organizations, commercial and Medicaid health plans, provider organizations, and other health policy-engaged stakeholders. She has facilitated many public bodies focused on health care improvement and has performed both research and applied work on maternity payment reform, including designing and developing the content for the Health Care Payment Learning & Action Network (LAN) Maternity Multi-Stakeholder Action Collaborative (MAC). Ms. Burns also designed a maternity episode payment model for an Oregon Medicaid Coordinated Care Organization. Alongside Carol Sakala, she co-authored the 2024 landscape study of maternity care alternative payment programs in the United States, *Realizing the Transformational Potential of Maternity Care Payment Reform* and its technical supplement. She also serves as a Board Member of Accompany Doula Care, a Massachusetts-based nonprofit doula organization focused on providing culturally concordant continuous perinatal birthing support in Eastern Massachusetts.

Acknowledgments

We are deeply grateful to the Innovation Center at the Centers for Medicare and Medicaid Services for developing its Transforming Maternal Health (TMaH) model, which provides a framework, policy signal, and resources with the potential to demonstrate, scale, and spread impactful maternity care delivery and payment reform.

We applied lessons from our recent research to describe and learn from the landscape of maternity care alternative payment programs in the United States and are grateful to the many people acknowledged in our main report, *Realizing the Transformational Potential of Maternity Care Payment Reform* (2024).

We wish to thank the following individuals who provided subject matter expertise for this playbook:

- **Jill Alliman**, American Association of Birth Centers
- **Cassaundra Jah**, National Association of Certified Professional Midwives
- **Karen Jefferson**, American College of Nurse-Midwives

Thanks for the invaluable support of colleagues at the National Partnership for Women & Families:

- **Sinsi Hernández-Cancio**, Vice President for Health Justice
- **Erin Mackay**, Managing Director for Health Justice
- **Lorena Bonet Velazquez**, Health Justice Policy Associate
- **Mettabel Law**, Senior Digital Communications Specialist

We also acknowledge the following professionals who helped make this report a reality:

- **Evan Potler**, Factor3 Digital
- **Arielle Zoeller**, Factor3 Digital
- **Jorge Morales**, Editor

The Skyline Foundation provided generous support for this work.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting access to quality, affordable health care; reproductive health and rights; fairness in the workplace; and policies that help all people meet the dual demands of work and family.