Driving Access, Health Equity, and Innovation in Maternal Healthcare through Medicaid

THE PRACTICAL PLAYBOOK III

Working Together to Improve Maternal Health

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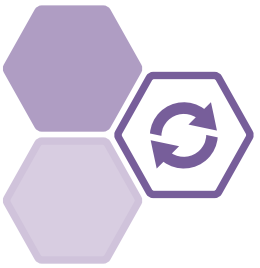

Driving Access, Health Equity, and Innovation in Maternal Healthcare through Medicaid

JESSICA C. SMITH, EMILY HEBERLEIN, ANGELA SNYDER, AND KAREN MINYARD

INTRODUCTION

The Medicaid program covers a large portion of births in the United States (43%). Medicaid pays for an even greater share of births for women in rural areas (50%), Black women (65.9%), and women under age 19 (77.5%).[1] In addition to covering deliveries, Medicaid is an important source of coverage for many women before and after giving birth. Approximately half of women who are uninsured when they become pregnant gain access to insurance coverage through Medicaid or the Children's Health Insurance Program (CHIP).[2] This coverage provides access to the full range of Medicaid benefits, allowing women to receive care in inpatient and outpatient settings, to fill prescriptions, and to receive services from healthcare providers from the time they become pregnant through at least 60 days after delivery. Coverage beyond 60 days varies by state and household income.

Medicaid is funded jointly by the federal government and state governments, and each state operates its own Medicaid program according to federal rules. Because each state is responsible for its Medicaid program, there are variations from state to state in who is covered, length of coverage, what services and provider types are covered, and quality improvement strategies. While this variation can lead to disparities in healthcare access and quality between states, it can also spur innovation, so that state programs can learn from one another and work with their communities to design the most appropriate care for the populations covered.

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Providing insurance coverage and minimizing coverage disruptions are important pieces of the policy puzzle to help reduce maternal morbidity and mortality. Because Medicaid covers so many pregnancies in the United States, finding ways to promote equitable access to quality healthcare through Medicaid is critical to improving maternal health for many low-income women, women in rural areas, and women of color.

MEDICAID BASICS

Variations in Medicaid

Since states run and partially fund their own Medicaid programs, political, ideological, and budgetary considerations influence Medicaid coverage and how care is paid for. Medicaid eligibility limits vary by state, with some states offering generous eligibility and others restricting coverage, and can depend on individuals' health status, age, or whether they are a parent. Disparities exist in who can be covered by Medicaid before, during, and after pregnancy. Medicaid eligibility is primarily tied to a household's income level as it relates to the federal poverty level (100% FPL). For example, in states that expanded Medicaid under the Affordable Care Act (ACA), any individual in a household earning less than 138% FPL qualifies for Medicaid. To illustrate the differences in Medicaid eligibility, different state and individual scenarios for coverage are detailed in Table 41.1.

Table 41.1 State Medicaid Coverage Variation

State Medicaid Coverage Rules	Covered Individual	Covered before Pregnancy	Covered during Pregnancy	Covered after Pregnancy
State A: Expanded Medicaid and covers pregnant women in households earning up to 200% FPL	Childless adult	If income ≤ 138% FPL	If income ≤ 200% FPL	For 60 days if 138% < income ≤ 200% FPL Covered beyond 60 days if income ≤ 138% FPL
	Parent	If income ≤ 138% FPL	If income ≤ 200% FPL	For 60 days if 138% < income ≤ 200% FPL Covered beyond 60 days if income ≤ 138% FPL
State B: Did not expand Medicaid, covers pregnant women in households earning up to 200% FPL, and covers parents earning up to 35% FPL	Childless adult	Not covered	If income ≤ 200% FPL	For 60 days if 35% < income ≤ 200% FPL Covered beyond 60 days if income ≤ 35% FPL
	Parent	If income ≤ 35% FPL	If income ≤ 200% FPL	For 60 days if 35% < income ≤ 200% FPL Covered beyond 60 days if income ≤ 35% FPL

Income Limits and Eligibility Categories

In states that have not expanded Medicaid, able-bodied adults are not eligible for Medicaid coverage unless they are a parent earning less than their state's income eligibility limit for parents. This eligibility limit also varies significantly in states without Medicaid expansion, but it is below the 138% FPL minimum in all non-expansion states. This means that many childless adults in non-expansion states living below 138% of the poverty line may have no access to Medicaid coverage until they become pregnant. Similarly, whether an individual is eligible for Medicaid coverage during pregnancy, and how long coverage lasts after delivery, depends on the state of residence. All states are required to provide Medicaid coverage through 60 days postpartum for women living in households earning below 138% FPL, but eligibility limits beyond that minimum again vary significantly by state, with many states setting much higher income limits. States can decide to increase their income eligibility limits for pregnant women to ensure that more women and infants have access to free perinatal care.

Postpartum Coverage Limits

While many women gain access to Medicaid coverage during pregnancy, because states are required to cover women only through 60 days postpartum, more than half of the women experience a lapse in insurance coverage within six months of delivery.[2] In states that have not expanded Medicaid, a postpartum coverage gap exists for women living in households earning too much to qualify for Medicaid as low-income parents but earning too little to qualify for support to purchase a healthcare plan on the ACA insurance exchanges (under 100% FPL).[3] Even in states that have expanded Medicaid, mothers in households with incomes just above the expansion income limit (138% FPL) who are able to purchase private coverage on the ACA exchanges may find the out-of-pocket costs unaffordable and often have to change providers, leading to more care disruptions.[4]

Reimbursement Structure

Medicaid programs can use different reimbursement structures to pay for services: fee-for-service, managed care, or a combination of both. Under fee-for-service, state Medicaid programs act as an insurance company, setting payment rates and reimbursing providers for each service they provide. In managed care, states contract with a third-party company and pay a set rate per month for each Medicaid member assigned to the managed-care organization; this is referred to as a per member per month rate. The managed-care organization is then responsible for covering all members in its plan with this pool of money.

Around two-thirds of individuals on Medicaid are covered by a managed-care organization. Some states, like Tennessee, cover all their Medicaid population under managed care.[5] Other states, like Georgia, cover only select

eligibility groups (e.g., pregnant women) under managed care. A smaller number of states use no managed care—covering all members under the fee-for-service structure.

The structure of managed care makes it a useful vehicle for providing non-medical services and supports or enhanced medical services while also providing a predictable level of spending for states. However, proper oversight of managed-care organizations is required to ensure that Medicaid enrollees receive the services they are entitled to.

INNOVATION IN MATERNAL AND CHILD HEALTH THROUGH MEDICAID

States have many opportunities to make changes to their Medicaid programs and to enhance services provided to their maternal and infant populations under existing Medicaid regulations. These changes might include providing eligibility to additional populations, covering optional benefits, or providing coverage through a managed-care delivery system. The most basic tool used to make the changes is a state plan amendment. In effect, the state alters its existing agreement with the federal government to administer its Medicaid program and collect federal matching funds that provide financial support to the program. Additionally, when states seek to innovate Medicaid beyond the rules of the standard federal program, tools like Section 1115 waivers are available to allow states to test and develop new programs and policies to best meet the state's unique needs. Because the waivers are seeking federal funds to demonstrate improvements in care or efficiencies, states need to implement rigorous evaluations and to show that the innovations are cost-neutral to the federal government; therefore, waivers come with more federal oversight and state administrative burden.

Expanding Eligibility

As mentioned above, states are required to provide Medicaid coverage for pregnant women with incomes at or below 138% of the FPL extending to 60 days postpartum. States also have expanded coverage to pregnant women through state plan amendments, waivers, and, in some cases, state-only-funded programs to improve maternal and infant outcomes. These enhancements have included presumptive eligibility, immigrant coverage, postpartum coverage extensions, and place-based coverage in response to environmental exposures.

Presumptive Eligibility

As of 2020, 31 states allowed women to obtain Medicaid-covered prenatal care via presumptive eligibility.[6] Certain qualified state partners, including public health, medical care, and/or social service providers, can screen women for income eligibility and temporarily enroll them in Medicaid, granting them

immediate access to coverage. Presumptive eligibility ensures that providers are paid for any services they deliver during the eligibility period, even if the pregnant woman is not subsequently determined to be eligible.

Immigrant Coverage

Legal permanent residents of the United States entering after August 1996 typically must wait five years before they can receive full Medicaid benefits, but states can cover lawful residents during pregnancy before the five-year waiting period ends. States also have the option to provide coverage to other immigrants, but they may only use state funds to do so. As of 2020, 27 states provided coverage to immigrant pregnant women.[7]

Postpartum Coverage

When the 60-day Medicaid postpartum period expires, some postpartum women may qualify for Medicaid through another pathway; others may not. To address maternal health equity and decrease morbidity and mortality in the postpartum period, several states have extended coverage to all, or a targeted population of, pregnant women. In July 2021, Georgia implemented a Medicaid 1115 waiver that extends full Medicaid coverage from 60 to 180 days postpartum for all pregnant women. Beginning in April 2022, the American Rescue Plan Act of 2021 gives states the option to extend postpartum Medicaid coverage to 12 months via a five-year state plan amendment.[8]

Geographic Coverage

Using the 1115 waiver, Michigan provides full Medicaid coverage to pregnant women and children in Flint, Michigan, who were affected by that city's water crisis. Coverage is available to all income levels with no cost-sharing for those under 400% of the FPL.

Coverage for Different Services under Medicaid

In addition to variation in eligibility rules, states vary in their benefits and coverage policies that affect maternal health. While states must provide core inpatient and outpatient medical care under federal law, they have considerable flexibility in determining the scope for pregnancy-related support services and other nonhospital services.[9]

Midwifery Services and Birth Centers

States vary in coverage, licensing, and credentialing rules for Medicaid coverage of midwives and free-standing birth centers. Particularly suitable for women with low-risk pregnancies, midwifery-led care is an evidence-based maternity model that includes prenatal, intrapartum, and postpartum services, with a philosophy of shared decision-making and supporting "watchful waiting and nonintervention in normal processes." Different types of midwives have different

training, certification, and scopes of practice. When care is needed beyond the midwifery scope, midwives may consult with physicians, manage care with physicians, or transfer the patient for medical management. Practices have developed varied staffing models for physicians and midwives. The number of midwife-attended births in the United States has steadily increased, with most births occurring in hospitals, including "alongside" birth centers housed on a hospital campus (98.5%).

Free-standing birth centers are physically separate from a hospital and comprise a small part of the US maternity care system. Between 2010 and 2020, the number of birth centers grew by 97%, to a total of 384. Strong evidence supports positive outcomes and increasing access to birth centers; these settings are much more common and well-integrated into healthcare systems in European countries. Medicaid reimbursement requires that birth centers be licensed, with regulations varying by state, and states that license birth centers must cover birth center deliveries under Medicaid. The Institute for Medicaid Innovation's 2020 report, "Improving Maternal Health Access, Coverage, and Outcomes in Medicaid," is a comprehensive guide to the midwifery-led model of care opportunities and policy landscape under Medicaid.[10]

Doula Care

A doula is a "trained professional who provides continuous physical, emotional and informational support to a mother before, during, and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible."[11] Multiple research studies have demonstrated that pregnant women who receive doula services are more likely to have healthy birth outcomes and a more positive birth experience, and Medicaid-funded doula programs could experience a significant return on investment.[12] As of 2020, six states had state-level Medicaid doula reimbursement programs (Indiana, Oregon, Minnesota, Nebraska, Washington, and New Jersey) and New York was piloting a program in several counties; 13 state Title V Maternal and Child Health Block Grant programs also had long-standing doula services. In 2019, 13 state legislatures were considering Medicaid reimbursement for doula services.[12] Payment strategies include using Title V block grant funds for services for Medicaid-enrolled women and adding doula services as an optional pregnancy care benefit, where doulas work under the supervision of a Medicaid-enrolled provider (Minnesota) or enroll as Medicaid providers (Oregon). In Nebraska, one managed-care organization has selected doula services as a value-added service for pregnant females involved in the foster care system.

Group Prenatal Care

Group prenatal care models, usually serving women with low-risk pregnancies, integrate health assessment, health education, and peer support. Group sessions are facilitated by a healthcare provider and follow a curriculum; women

with similar due dates participate in two-hour sessions every two to four weeks. Partners and support people are welcome to attend. CenteringPregnancy (Centering Healthcare Institute) is the most researched of these models and has approximately 350 sites across 40 states.[13] Women participating in group prenatal care are more likely to receive adequate care and to breastfeed; some evidence suggests that participants, particularly Black women, may experience better birth outcomes. Group prenatal care can be more costly and logistically challenging for providers to implement.

A handful of states (Maryland, Montana, New Jersey, Ohio, and South Carolina) lead in offering group prenatal care, providing enhanced Medicaid reimbursement, investing state funds to improve access (e.g., grants to support start-up or pilot programs), and reaching a greater proportion of pregnant women. States may also include group prenatal care in alternative payment method initiatives. Prior to COVID-19, only 10% of states had at least 5% of pregnant women access CenteringPregnancy, and the pandemic significantly curtailed this type of group care.[13]

Home-Visiting Services

Although they cover a range of models, home-visiting services generally tend to offer screening, case management, health education, parenting support, and other interventions to improve a combination of health outcomes, skills, and child development. Case management is a broad term for activities that link families to needed services and supports. Research has demonstrated a range of positive health and developmental effects and a return on investment for home visiting, depending on the program's focus (e.g., education, justice system involvement, healthcare costs, public assistance reliance).[14] The home-visiting workforce may include nurses, social workers, early childhood educators, lactation counselors, and others.

As of 2018, 20 states were using a variety of approaches under Medicaid to fund home visiting. Some initiatives are decades-old, state-level policies; others are pilots, localized, or more recently developed. Most commonly, states use the targeted case-management benefit under a Medicaid state plan amendment or finance home visiting as a demonstration or pilot program under a larger Medicaid waiver (e.g., Section 1115 or 1915b waiver). Some states use existing benefits. Blending/braiding with Title V funds is a strategy to expand capacity. Because most pregnant women are covered under Medicaid managed care, home-visiting services often are incorporated into state contracts with managed-care organizations.[14]

Community Health Workers

A community health worker (CHW) is a trusted community member or has a very close understanding of the community and uses these relationships to connect health and social services with the community, facilitating access and

improving quality and cultural competence.[15] CHWs support women in following recommended care and health screenings, accessing child vaccinations, and improving nutrition. The Affordable Care Act officially recognized CHWs as an important resource for improving care and population health and reducing costs. States vary in training and certification standards for CHWs.

States have used Medicaid waivers to fund CHW programs and to reimburse for CHW services. Healthcare providers use waiver funds to pay CHWs to work with patients to enroll in Medicaid, to manage their health, to connect to community resources, and to navigate health services. Some states (including Massachusetts) use the designation "medically necessary early intervention" to allow Medicaid reimbursement to CHW-like providers directly through fee-for-service or within a managed-care contract structure.

Maternity Medical Homes

Maternity medical homes are enhanced models of prenatal care that track patients over time, coordinate services and supports, and aim to be more patient-centered, providing additional psychosocial support and health education.[16] These models are relatively new and vary in their implementation.[17] North Carolina's Pregnancy Medical Home initiative is one example, where Medicaid pays a primary care case-management organization a per member per month bundled payment. Other states, including Texas and Wisconsin, have implemented these models.

Optional Services

When states expand eligibility to additional populations, they can provide full Medicaid coverage, a limited package of services, or innovative benefits not currently available to beneficiaries. Home visiting, doula services, and models of care delivery like pregnancy medical homes and group prenatal care are described above. Additionally, states have added behavioral healthcare, substance use disorder services, and family planning to their Medicaid plans to improve the array of services available to women during pregnancy and their childbearing years. Although most states provide full Medicaid benefits to all pregnant women, five states (Arkansas, Idaho, New Mexico, North Carolina, and South Dakota) cover only pregnancy-related services.

Maternal Depression Screening

In 2016, the Centers for Medicare & Medicaid Services issued a bulletin clarifying that state Medicaid agencies may allow maternal depression screenings to be claimed as a service for the child as part of the well-child benefit, in effect expanding screenings to women who lose Medicaid coverage after 60 days postpartum.[18] For example, North Dakota Medicaid covers maternal depression screening as a separate service when performed in conjunction with a Health

Tracks (EPSDT) screening or any other pediatric visit. Providers are allowed to bill the child's Medicaid ID when using one of the standardized screening tools up to three times in the child's first year.

Substance Use Disorder (SUD) Services

Under a Section 1115 waiver, Massachusetts Medicaid managed-care organizations must provide acute treatment services, structured outpatient addiction programs, clinical support services, residential rehabilitation services, recovery coaches, and recovery-support navigators for people with SUDs. Pregnant women receive specialized services to ensure coordination between their obstetrical care, acute addiction treatment, and clinical support services. Structured outpatient addiction and residential rehabilitation programs may also include specialized services and staffing for pregnant women.[6]

Family Planning

Family planning services must be provided without cost-sharing to individuals of childbearing age who qualify for Medicaid. Many states also extend eligibility for family-planning-only services through waivers or under their state plan. Through these stand-alone benefit packages, 31 states have a payment policy specifically designed to encourage long-acting reversible contraception insertion immediately postpartum. Multiple studies have found that these programs prevent unintended pregnancies and abortions, thus improving women's health and saving money for federal and state governments.[19] The Healthy Texas Women program started in 2016 as a non-Medicaid-funded program and provides women's health and family planning services at no cost to eligible low-income Texas women.

IMPROVING QUALITY THROUGH VALUE-BASED PURCHASING

Because Medicaid covers many people, the program can drive quality improvement for specific populations, including pregnant women, by linking payments to quality metrics or other policies that can improve patient care. In 2016, changes to federal rules around managed care gave states and managed-care organizations greater flexibility to pilot value-based payment (VBP) programs, to cover a broader scope of services, including services that address social determinants of health, and to implement payment reforms. Money that is not spent by managed-care organizations on providing care or administering services to Medicaid members can be used for other purposes, such as investing in care-coordination services or providing value-added services (e.g., covering breast pumps and infant car seats to new mothers). More than half of states have managed-care quality initiatives in place that are tied to perinatal outcomes.[5]

Pay for Performance

As of 2020, the most popular VBP program was the pay-for-performance model.[20] In this model, financial incentives are used to increase the quality of care. Providers or health systems are given quality targets and are rewarded for meeting or exceeding the targets. For example, Medicaid could provide bonus payments to managed-care organizations that increase by 5% the number of Black women who have a prenatal care visit during their first trimester. Managed-care organizations can also develop and implement their own programs to meet the goals, such as offering OB-GYNs in their provider network $100 bonus payments for each delivering mother who attends a postpartum visit within six weeks of delivery.

Episode of Care

For perinatal services, Medicaid programs can utilize an episode-of-care approach to reimburse providers for bundles of services. This model essentially sets acceptable costs for providing a service or set of perinatal services. It is designed to control costs by rewarding providers who deliver services for less than the set acceptable cost and by penalizing providers who deliver services for more than the acceptable cost.

Medical Homes

As mentioned above, states can support a holistic approach to perinatal healthcare using the maternity medical home model. This model encourages care coordination across providers and services, in both clinical and behavioral care, as well as social supports.[20] Medical homes may be supported by offering financial incentives for activities like completing risk assessments or through the creation of other payment approaches, such as shared savings programs that encourage coordination across provider types and care settings.

CONCLUSION

Medicaid is an essential tool for building and sustaining maternal and child systems of care at the state and local levels. Mapping what populations and services are currently covered by state Medicaid programs to determine the current context and to identify gaps is one place stakeholders can begin a process of comprehensive system planning and improvement. Complementary steps in the planning process involve identifying other relevant funding streams, grants, and demonstration projects to test and fill the gaps, sometimes through additional blending and braiding of funds. Home-visiting programs are an example of how multiple federal and state funding streams, including Medicaid and the Maternal, Infant, and Early Childhood Home Visiting Program, can be successfully combined to target women and their families.

One place stakeholders can get data to inform system effectiveness and planning is the state maternal mortality review committee (MMRC). MMRCs are multidisciplinary teams that conduct comprehensive reviews of women's deaths during, or within a year of, pregnancy. The committees often include representatives from the maternal and child health practitioner community, public health and behavioral health professionals, and advocacy or community-based organizations. Reports from MMRCs can identify opportunities to address system shortcomings related to hospital protocols, payment mechanisms, and gaps in clinical and preventive services. Stakeholder engagement is crucial in driving system improvements, with each member playing a unique role in the policy change process.

This chapter describes the basics of the Medicaid program, how Medicaid funding can be leveraged for innovation, and how some states have used Medicaid to improve maternal and child outcomes in their unique contexts. While Medicaid plays an important role in covering many pregnant women and their children, variation in eligibility rules and covered services by state can make the program difficult to navigate for patients, providers, and community-based organizations. Like many policies, Medicaid policies in some states are more progressive than in others. Having a clear understanding of a state's Medicaid income eligibility rules, reimbursement structure, and scope of covered services is the first step in identifying who the program can cover now and who could benefit from more generous coverage requirements or policies.

REFERENCES

1. MACPAC. Medicaid's role in financing maternity care: fact sheet. 2020:16. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf. Accessed November 19, 2021.
2. Daw JR, Hatfield LA, Swartz K, Sommers BD. Women in the United States experience high rates of coverage 'churn' in months before and after childbirth. *Health Aff*. 2017;36(4):598–606. doi:10.1377/hlthaff.2016.1241.
3. Garfield R, Damico A, Orgera K. *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*. National Library of Medicine Digital Collections. 2016. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101717244-pdf.
4. Ranji U, Gomez I, Salganicoff A. Expanding postpartum Medicaid coverage. https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/. Published 2020.
5. Hinton E, Rudowitz R, Stolyar L, Singer N. 10 Things to know about Medicaid managed care. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/. Published 2020.
6. Medicaid and Chip Payment and Access Commission. Inventory of state-level Medicaid policies, programs, and initiatives to improve maternity care and outcomes. https://www.macpac.gov/publication/inventory-of-state-level-medic

aid-policies-programs-and-initiatives-to-improve-maternity-care-and-outcomes/. Published 2020.

7. MACPAC. Report to Congress on Medicaid and CHIP. 2020:99–132. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf.
8. H.R.1319 - 117th Congress (2021-2022): American Rescue Plan Act of 2021, Congress (Yarmuth JA 2021). March 11, 2021. https://www.congress.gov/bill/117th-congress/house-bill/1319.
9. Gifford K, Walls J, Ranji U, Salganicoff A, Gomez I. Medicaid coverage of pregnancy and perinatal benefits: results from a state survey. 2017:38. https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/. Accessed December 20, 2021.
10. Moore JE, George KE, Bakst C, Shea K. Improving maternal health access, coverage, and outcomes in Medicaid: a resource for state Medicaid agencies and Medicaid managed care organizations. https://www.medicaidinnovation.org/_images/content/2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report.pdf. Published 2020.
11. DONA International. What is a doula? https://www.dona.org/what-is-a-doula/.
12. Platt T, Kaye N. Four state strategies to employ doulas to improve maternal health and birth outcomes in Medicaid. https://www.nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/. Published July 13, 2020. Accessed December 20, 2021.
13. Prenatal-to-3 State Policy Roadmap. Group Prenatal Care. https://pn3policy.org/pn-3-state-policy-roadmap-2021/us/group-prenatal-care/.
14. Johnson K. Medicaid financing for home visiting: the state of states' approaches. https://ccf.georgetown.edu/wp-content/uploads/2019/01/Medicaid-and-Home-Visiting.pdf. Published January 2019. Accessed December 20, 2021.
15. Association of State and Territorial Health Officials. Utilizing community health workers to improve access to care for maternal and child populations: four state approaches. Issue brief. Association of State and Territorial Health Officials. https://www.astho.org/Maternal-and-Child-Health/AIM-Access-CHW-Issue-Brief/. Published 2016. Accessed December 20, 2021.
16. Rakover J. The maternity medical home: the chassis for a more holistic model of pregnancy care? [Blog post]. Institute for Healthcare Improvement. http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=222. Published 2016.
17. Hill I, Benatar S, Courtot B, Dubay L, Blavin F. *Strong Start for Mothers and Newborns Evaluation: Year 4 Annual Report*. Vol 1. *Cross-Cutting Findings*. Urban Institute. 2018:204. https://downloads.cms.gov/files/cmmi/strongstart-snhancedprenatalcaremodels_evalrptyr4v1.pdf. Accessed October 13, 2020.
18. U.S. Dept. of Health and Human Services Guidance Portal. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. Published May 11, 2016. https://www.hhs.gov/guidance/document/maternal-depression-screening-and-treatment-critical-role-medicaid-care-mothers-and

19. Walls J, Gifford K, Ranji U, Salganicoff A, Gomez I. Medicaid coverage of family planning benefits: results from a state survey. 2016:44. https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey.
20. MACPAC. Value-based payment for maternity care in Medicaid: findings from five states. 2021:16. https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf.