



## **Improving Maternal and Child Health Outcomes: A Road Map for States to Integrate Evidence-Based Home Visiting into Medicaid Programs**

This road map offers a framework for state Medicaid programs to scale up and fund evidence-based home visiting (EBHV) programs to improve outcomes for mothers and their children. The road map will outline options and highlight existing state examples for Medicaid programs to fund EBHV services, from small-scale quality improvement efforts to robust value-based purchasing strategies.

### **Key recommendations for states**

Based on the flexibility states have to operate their Medicaid programs, state policymakers should make reasonable efforts in the short term and long term to improve maternal and infant health outcomes for their residents. In the short term, states should update their quality strategies to advance the adoption of evidence-based interventions to improve maternal and child health outcomes. Beyond quality improvement, Medicaid programs should update managed care organization contract language to require coverage for EBHV services and ensure Medicaid recipients are connected to the appropriate EBHV model that best addresses their needs. In the long term, states should focus on using Medicaid as part of a sustainable funding model to pay for a variety of EBHV services. Most importantly, in order to improve maternal and child health outcomes, state Medicaid agencies should include EBHV services in some way as a part of their comprehensive maternal and infant health strategy.

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## Background

Each year in the United States, about 700 women die as a result of pregnancy-related complications, the majority of which are preventable.<sup>1,2</sup> Maternal mortality is highest among Black and Indigenous people, who face about a three times greater risk of a pregnancy-related death than white women.<sup>3</sup> In addition to rising maternal mortality rates, severe maternal morbidity (SMM), which is identified as unexpected outcomes from labor or birth that result in significant short-term or long-term consequences, increased by 200% between 1993 and 2014.<sup>4</sup> The U.S. infant mortality rate is also high, with 5.7 deaths per 1,000 live births,<sup>5</sup> or 1.5 times higher on average than other developed countries.<sup>6</sup> Furthermore, significant inequities exist as babies born to non-Hispanic Black, Alaska Native and American Indian people experience higher mortality rates.<sup>7</sup>

Amidst the many options for interventions to improve outcomes in maternal and child health, EBHV stands apart because of its proven success and its ability to deliver care to those mothers who experience the highest risk for poor health outcomes and a lack of access to care.<sup>8</sup>

Home visiting programs, which may start during the prenatal period, aim to address a broad range of health and developmental outcomes. Collectively, EBHV has demonstrated many benefits. Models vary in their approaches and different outcomes have been achieved with different models. Outcomes from the wide breadth of EBHV models include lower rates of pregnancy-induced hypertension, fewer depressive symptoms for mothers, fewer babies born preterm or with low birth weight, higher rates of achievement of developmental milestones, and reduced rates of child maltreatment and injuries.<sup>9</sup> Additionally, EBHV programs address poverty by promoting economic self-sufficiency by linking families with employment opportunities and community services, and by enhancing capacity for positive parenting and improving the health and function of the family unit. Studies on the Nurse-Family Partnership (NFP) home visiting program, for example, have demonstrated that they can return up to \$5.70 per taxpayer dollar invested with returns being highest for home visiting programs that focus on high-risk populations.<sup>10,11</sup>

Despite its undeniable benefits, EBHV has not been available to serve all of the women, children and families who could benefit from this type of care. In 2018, home visiting programs delivered services to only 286,108 families.<sup>12</sup> While this is a significant number, it represents only 1.6% of the 18 million families who could have benefitted from home visiting services.<sup>13</sup> The need to expand these services in order to improve outcomes is clear, and leveraging the Medicaid program as a source of sustained financing is a critical step toward delivering home visiting services to the families who need them the most.



*Current resources are insufficient to meet the need for EBHV for low-income children and families.*

### **Funding and financing of evidence-based home visiting programs**

In 2010, Congress recognized the success of home visiting programs and the opportunities that they offer, and, on a bipartisan basis, authorized the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, a federal program that provides grants to states to improve outcomes for at-risk children and families through EBHV programs.<sup>14</sup> A decade later, in 2020, MIECHV served almost 140,000 parents and children and provided 925,000 home visits, 70% of which served households with income at or below 100% of the federal poverty level (FPL).<sup>15</sup> MIECHV was reauthorized by Congress in fiscal year 2018 (through fiscal year 2022), providing \$400 million per year for states to implement EBHV programs.

Despite MIECHV's success in serving children and families and improving outcomes, current resources are insufficient to meet the need for EBHV for low-income children and families. Save for a temporary boost during the COVID-19 pandemic,<sup>16</sup> the MIECHV program has not seen an increase in funds since 2013, making it challenging to grow home visiting programs to serve more families across the nation.<sup>17</sup>

Beyond MIECHV, states across the country have sought to improve access to EBHV by launching programs that blend and braid funding sources, utilizing MIECHV funds, Medicaid funds, other grants and philanthropic funds. This braided financing approach has been successful in extending the reach of existing programs, allowing home visiting to serve a broad array of women and families. Congress is due to reauthorize and renew funding for MIECHV next year. Increased funding and reauthorization of MIECHV in fiscal year 2022 will be essential to continue to improve access to home visiting services.

Complementary to MIECHV, a number of states are covering home visiting services with Medicaid funds — through existing state authorities, state plan amendments or waivers — but because EBHV is not specifically listed as a benefit in the Medicaid statute, home visiting services are not consistently paid for by Medicaid. This means that millions of Medicaid-eligible mothers and children who would benefit from EBHV do not have access to these services. The lack of a federal Medicaid EBHV benefit combined with a shortage of public funding for home

visiting outside of Medicaid presents a significant barrier to getting these services to pregnant mothers and children who need them. A federal Medicaid home visiting benefit would create a clearer pathway for states to cover these essential health services for low-income women and children served by Medicaid. This benefit would also broaden the reach of existing program funding and help scale successful models to serve more at-risk pregnant mothers and young children. Nevertheless, even without an explicit Medicaid home visiting benefit, states have a number of options under current law to expand access to EBHV and improve maternal and child health outcomes.

### **How Medicaid can increase the reach of home visiting to improve maternal and child health outcomes**

Historically, maternal and child health programs (typically run out of state departments of health) and Medicaid programs (which may or may not be housed in departments of health) have been separate despite the fact that they serve overlapping populations. Home visiting programs that are funded through MIECHV are one example of a maternal and child health program serving a largely Medicaid population.<sup>18</sup> Medicaid covers roughly half of all the births that occur in the nation,<sup>19</sup> and if it covered home visiting services, Medicaid could streamline enrollment and increase the number of women, children and families the program serves. As noted above, policymakers across the country have already sought to leverage Medicaid as a vehicle to increase access to home visiting services and help address maternal and infant mortality. In fact, as of 2017, there are 33 states that cover home visiting services in Medicaid; however, there is wide variation in these benefits and their reach.<sup>20</sup> States like New Hampshire, Oregon and South Dakota have used Medicaid's targeted case management (TCM) benefit to finance home visiting.<sup>21</sup> States like New Mexico, New York, and Ohio have used 1115 demonstration waivers to finance home visiting pilots through Medicaid.<sup>22</sup> Other states have used Medicaid Section 1915(b) waivers, Pay for Success and Medicaid managed care to pay for home visiting.<sup>23</sup> States can still go further to incorporate home visiting into their Medicaid programs and serve more families by covering services and making home visiting a regular part of the maternal and child health care continuum.

### **Strategies to integrate home visiting into Medicaid programs**

States have a number of strategies available to them to address maternal health outcomes using a combination of reporting and payment strategies in their Medicaid programs. To significantly improve the health outcomes of mothers and infants in their state, Medicaid agencies should strive to incorporate payment for EBHV services as a part of a value-based purchasing (VBP) model. That being said, there are a range of options state Medicaid programs can adopt that gradually move toward integrating payment to VBP models of care. Identified below are four key strategies that Medicaid programs can implement to achieve this goal.

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### **Strategy 1: Focus on quality improvement efforts**

If states are at the beginning stages of increasing access to home visiting services, they can focus on quality improvement to implement targeted interventions. States should start by looking at their current Medicaid and public health data on maternal and child health outcomes with a particular focus on where disparities exist so that they can identify gaps and build quality improvement plans to address areas where they are falling short. Managed care quality strategies as a part of state managed care quality strategies, Centers for Medicare & Medicaid Services quality plans, care quality strategies and quality measures are all ways states can tie quality measures to maternal and infant health outcomes.

#### **State example: California**

In California, the [“State of California Department of Health Care Services Comprehensive Quality Strategy” report](#), from 2019, identified seven areas for improvement for managed care plans. The areas were chosen to reflect state priorities, address large performance gaps and leverage shovel-ready interventions. Five of the focus areas were directly linked to quality metrics, including chronic diseases (diabetes and hypertension), services within maternal and child health (postpartum care and immunization of 2-year-olds), and tobacco cessation. The document laid out two objectives to improve Medi-Cal postpartum care where EBHV services could support outcomes: increase the Medi-Cal average number of women receiving postpartum care by 5% and increase the percentage of Medi-Cal managed care reporting units meeting the minimum performance level for timely postpartum care to at least 80%.

#### **State example: Colorado**

In Colorado, the [Department of Health Care Policy & Financing’s “2019 Quality Strategy” report](#) highlighted the state’s efforts to explore how to better utilize benefits included under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) in systems where young children and families interact with benefits. These systems include home visiting along with child welfare, child care and child abuse prevention.

**State example: Ohio**

In Ohio, [“The Ohio Department of Medicaid Managed Care Quality Strategy” report](#), from 2018, highlighted the state’s effort to increase home visiting referrals as part of its overall plan to reduce infant mortality in the state. Ohio’s goals involve streamlining and increasing referrals by integrating data across systems, specifically its pregnancy risk assessment dataset housed in Ohio’s Medicaid program and Department of Health data. The pregnancy risk assessment (PRAF 2.0) system streamlines pregnancy notifications to MCOs to “prevent patients from losing Medicaid coverage during pregnancy and facilitate more efficient linkage to needed services and resources.”<sup>24</sup> Ohio has other quality initiatives underway, and they are related to reducing health disparities and poor health outcomes among mothers and infants. These include: infant mortality reduction initiatives, initiatives targeting opioid use disorder, chronic condition interventions and the promotion of effective behavioral health care.

**Strategy 2: Amend the Medicaid fee schedule/state plan to include EBHV services**

In order to obtain federal reimbursement for health care services, state Medicaid programs must provide what are deemed to be “covered services,” which are approved by the Centers for Medicare & Medicaid Services either in the state plan or in a Medicaid waiver. Understanding what is and what is not covered under the state plan (or in a waiver) is critically important to understand to what extent a Medicaid program can pay for elements of EBHV including registered nurses as well as others types of health care workers or providers that are eligible to be paid for those services. Identifying potential gaps in state plan or waiver language and amending the fee schedule to cover the gaps are key to financing EBHV services. These steps are critical to ensure the suite of services that encompasses a home visit are covered by the Medicaid agency. This strategy is equally important in states that follow a fee-for-service (FFS) model, as well as states that use managed care organizations.

**State example: North Carolina**

In North Carolina, Medicaid beneficiaries are offered [Pregnancy Medical Home](#) services. These services are modeled after enhanced primary care case management programs, which are operated through state Medicaid programs, and include similar services to EBHV. Case managers in this program closely monitor a patient’s pregnancy through regular contact with the physician and patient to promote a healthy birth outcome.



**State example: Ohio**

In Ohio, Gov. Mike DeWine announced the formation of a [pilot program](#) that uses Pay for Success (PFS) incentive payments to increase participation in home visiting programs. This PFS model would be implemented using blended funding sources including from private corporations and government. [Ohio's Help Me Grow program](#) is an example of a home visiting program geared toward first-time parents and their young children, authorized through an [SPA](#).

**State example: Oregon**

In Oregon, [a 2020 state plan amendment \(SPA\)](#) outlined a cost-based methodology where home visiting providers, offering care through targeted case management, submit cost reports to the Medicaid program to establish a rate for payment.

**State example: South Carolina**

In South Carolina, [a Section 1915\(b\) waiver](#) for the Enhanced Prenatal and Postpartum Home Visitation Pilot Project and Managed Care Program created a Nurse-Family Partnership (NFP) pilot program in the state. The pilot opts for a Pay for Success (PFS) approach to home visiting services. This payment model is also an example of how a state can blend its own funding with federal government, private sector and philanthropic funding sources.

**Strategy 3: Improve managed care organization (MCO) contract requirements**

MCOs that contract with state Medicaid agencies to provide Medicaid services must provide all health care services covered under the federally approved Medicaid State Plan or waiver unless “carved out” from managed care into a fee-for-service program managed by the State. Only health care services in the federally approved Medicaid State Plan or waiver can legally be included in the MCO contract for payment under the MCO’s monthly capitation rate, with the exception of in lieu of services. States also have the option under federal regulations to require MCOs to pay a fixed rate to providers for a certain service. This is called a state-directed payment and can ensure payment parity for home visiting programs and increase access to home visiting services across the state.

It is important to note that MCOs can take voluntary action to offer home visiting services to their members and improve perinatal health. There are several ways to do this, including as in lieu of services, or value-added services. In lieu of services (ILOS) allow medically-necessary, non-covered services to be covered as a substitute for similar state plan services, which provides flexibility for MCOs in the services that they offer to their enrollees. ILOS are optional and need to be approved

by the State. Once approved, the ILOS cost can be included in the capitation rate. MCOs can provide additional, non-covered services to Medicaid members as value-added services, and report those costs in the numerator of the plan's medical loss ratio. However, the costs of these additional services, provided at the MCO's discretion, cannot be used to develop their capitation rate. MCOs must use other funds such as profits or accrued savings to pay for these services. As an example, in a January 7, 2021 state health official letter, CMS states that MCOs can provide supportive housing as a value-added service for people with severe mental illness to prevent a cycle of hospitalization and homelessness — although the service may not be included in the capitation rate.<sup>25</sup>

#### **State example: Minnesota**

In Minnesota, the state's [2021 MCO contract](#) requires at-risk pregnant women to be offered enhanced perinatal services, which include home visits. A [SPA](#) also authorized Minnesota to use targeted case management to pay no more than \$140 per visit for a bundled package of services designed to improve outcomes for at-risk mothers and young children.

#### **State example: Pennsylvania**

In Pennsylvania, the state's [2021 MCO contract](#) requires the MCO to implement a home visiting program that is available to all first-time parents of children who have been identified as having additional risk factors, which may include social, clinical, racial, economic or environmental factors. Home visiting programs must be primarily focused on one or more items of a list of 16 criteria, which include maternal and infant health promotion and prevention. In Pennsylvania, the goal of home visiting is explicitly stated to improve maternal and infant health outcomes and reduce maternal and infant morbidity and mortality.

### **Strategy 4: Adopt value-based purchasing (VBP)**

This integrated strategy would require states to tie perinatal health payments to health outcomes as opposed to volume of services as a way to shift away from an FFS model. However, it is important to note that this approach often still requires an established rate in the fee schedule (outlined in strategy 2). VBP is often adopted in combination with quality improvement efforts, like those detailed in the quality improvement section (strategy 1).



*State Medicaid directors and state advocates should look to Medicaid to provide funding and policies for innovative and proven programs like EBHV.*

**State example: Ohio**

In Ohio, Medicaid uses [perinatal bundles](#) to pay for perinatal health care services. These are not, in fact, bundled payments but rather care coordination payments that are part of a greater VBP payment model. Ohio also has the comprehensive [Maternal and Infant Support Program](#), which includes the development of reimbursement for home visiting.

**State example: Pennsylvania**

In Pennsylvania, contract negotiation with MCOs has included consideration of the following measures for additional payments per metric met: breastfeeding initiation, depression screening completion, newborn well visit and obstetric care in the postpartum period. These are in addition to an established per member per month (PMPM) rate for active participants of the Nurse-Family Partnership EBHV program.

**Conclusion**

Maternal and infant health outcomes across the nation are dire, particularly among Black and Indigenous people. The COVID-19 pandemic has exacerbated the already devastating trends in Black women's health.<sup>26</sup> Some states are working to implement strategies and programs that can help improve these outcomes. In particular, they are leveraging the evidence-based intervention of home visiting for those individuals at highest risk for adverse health outcomes, including death. Unfortunately, current financing structures are not consistently covering innovative programs, nor ensuring the right intervention is targeted to the right population. State Medicaid directors and state advocates should look to Medicaid to provide funding and policies for innovative and proven programs like EBHV.

*Ensuring that EBHV is a part of the regular prenatal and post-delivery care regimen is critical.*



Key strategy recommendations for states to integrate EBHV into their Medicaid programs

- » Update quality strategies to better address gaps in outcomes.
- » Update MCO contract language to include specific mention of EBHV as a tool to improve maternal health outcomes and language to ensure the right services will be covered to meet the desired outcomes and needs.
- » Engage EBHV models on their data and evaluation needs to understand what data they will be collecting and what data the state is already collecting. Data collection should be coordinated between EBHV models and the state departments working on home visiting to ensure that the right data is captured without unnecessary and burdensome data collection requirements.
- » Tie payment to EBHV services in order to ensure that these efforts are implemented widely in the state and that they have a sustainable funding source to keep them up and running.
- » Include EBHV services as a part of a comprehensive maternal and infant health strategy.

States should work to operationalize quality and payment strategies ([Appendix A](#)) and determine how their Medicaid program can best incorporate EBHV into the available benefits for their beneficiaries. Ensuring that EBHV is a part of the regular prenatal and post-delivery care regimen is a critical opportunity with high reward for mothers and infants as well as state Medicaid programs and MCOs. Integrating EBHV programs into Medicaid will allow states not only to improve outcomes and reduce long-term costs, but also, most importantly, to provide mothers and infants with the care and services they need while building a foundation for the health and well-being of generations to come.

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This road map is part of a two-year project funded by the W.K. Kellogg Foundation. The overarching vision for our project is to improve maternal and child health outcomes for low-income mothers and children with a focus on those insured by Medicaid. To achieve this vision, we are identifying and spreading promising strategies for how Medicaid programs can elevate, expand and pay for community-based programs that focus on improving maternal and child health outcomes and reducing health disparities, while continuing to preserve the fidelity of a community-based model. By doing this work and building actionable tools, we hope to enable Medicaid programs to more easily bring to scale evidence-based, community-based models of care.

## Appendix A

### Strategies to integrate home visiting into Medicaid programs

#### *Purpose*

The Medicaid Operationalization Chart was created to provide state Medicaid agencies, using Washington, D.C., as an example, with options to integrate home visiting into the Medicaid benefits offered to mothers and children. This chart can and should be replicated for use in other states. It should be viewed as a way to provide a digestible and clear indication of how state Medicaid programs can take the most immediate steps to improve maternal health outcomes, as well as help to envision the long-term policy changes that should be made in order to sustainably include home visiting as a part of the maternal and infant health care continuum.

#### *Overview*

The vision and execution of the chart is based on four strategies that a state Medicaid program could use to incorporate home visiting. In the chart, the strategies are labeled from left to right in order of least integrated (quality) to most integrated (value-based purchasing (VBP)) into the Medicaid financing structure. For each strategy, there are two or three state examples, a snapshot of the current landscape in the District of Columbia and key policy suggestions of how the District's Medicaid program could implement each strategy. It is important to note that the strategies are not mutually exclusive. They can be built upon and set the groundwork for more advanced and integrated forms of payment, and they can and should be pursued simultaneously.

	<b>QUALITY</b> Use Centers for Medicare and Medicaid Services (CMS) quality strategies, MCO quality improvement plans, and/or the selection of quality measures to prioritize quality improvement for maternal/child health.	<b>FEE SCHEDULE/STATE PLAN</b> Pay for both clinical and wraparound services for perinatal health services from the fee schedule on a fee-for-service (FFS) basis.	<b>MANAGED CARE ORGANIZATION (MCO) CONTRACT REQUIREMENTS</b> Modify the contract to allow voluntary or mandatory action to improve perinatal health.	<b>VALUE-BASED PURCHASING (VBP)</b> Tie perinatal health payments to outcomes as part of a shift away from FFS (Importantly, this approach often still requires an established rate in the fee schedule.)
<b>State Examples</b>	<p><b>Ohio</b> – 2018 Managed Care Quality Strategy report highlighted the state’s effort with home visiting (HV) referrals as part of its overall plan to reduce infant mortality in the state. (See <a href="#">pages 60-62</a>)</p> <p><b>Colorado</b> – The state’s 2019 Quality Strategy highlighted the state’s efforts under a technical assistance opportunity to explore how to better utilize benefits included under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) in systems where young children and families interact with benefits such as HV. (See <a href="#">page 56</a>.)</p>	<p><b>Oregon</b> – A cost-based methodology, HV providers submit cost reports to establish a rate. (See <a href="#">approved State Plan Amendment (SPA)</a>; <a href="#">extension, pending approval</a>.)</p> <p><b>North Carolina</b> – Pregnancy Medical Home under primary care case management offers: exemption from prior approval on ultrasounds, \$50 for completing a high-risk screening tool at initial visit, \$150 incentive for the postpartum visit. (See this <a href="#">North Carolina Medicaid webpage</a>).</p>	<p><b>Pennsylvania</b> – Contract requires the MCO to establish a HV program that is available to all first-time parents of children who have been identified as having additional risk factors which may include social, clinical, racial, economic or environmental factors. Home visiting programs must be primarily focused on one or more of a list of sixteen items, which includes maternal and infant health promotion and prevention. The contract includes requirements of topics to be covered: referrals including to evidenced based HV for members with risk factors, reporting requirements of MCO to the Department of Human Services (DHS) (<a href="#">see pages 239-244</a>).</p>	<p><b>Ohio</b> – Ohio utilizes perinatal <a href="#">bundles</a> to help pay for perinatal health services through <a href="#">value-based purchasing</a>. Ohio also has the Maternal and Infant Support Program, which includes the development of reimbursement for HV. (See <a href="#">Page 138</a>.)</p> <p><b>Pennsylvania</b> – Contract negotiation in Pennsylvania with MCOs has included consideration of the following measures for additional payments per metric met: breastfeeding initiation, depression screen completion, newborn well visit, OB care in postpartum period. This is on top of an established per member per month (PMPM) rate for active NFP participants.</p>

	QUALITY	FEE SCHEDULE/STATE PLAN	MANAGED CARE ORGANIZATION (MCO) CONTRACT REQUIREMENTS	VALUE-BASED PURCHASING (VBP)
<b>State Examples Continued</b>	<p><b>California</b> – 2018 managed care quality strategy highlighted seven areas for improvement. The areas were chosen to reflect state priorities, address large performance gaps, and leverage shovel-ready interventions; one focus area highlighted was maternal/ child health (postpartum care and immunization of two-year-olds). (See pages <a href="#">37,40-41</a>)</p>	<p><b>South Carolina</b> – This state uses a “pay for success” approach to pay for HV services under a Section 1915(b) waiver; blended funding from state and federal government and philanthropic sources. (See Section <a href="#">1915(b)</a> waiver proposal.)</p> <p><b>Ohio</b> – This state uses “<a href="#">Pay for success</a>” incentive payments by way of <a href="#">blended</a> funding. (See SPA, pages <a href="#">15-20</a>; <a href="#">MCO</a> contract, page <a href="#">52</a>.)</p>	<p><b>Minnesota</b> – MCO contract requires at-risk pregnant women to be offered enhanced perinatal services, which includes home visits. (See page <a href="#">115</a>.) Minnesota also uses targeted case management to pay no more than \$140 per visit for a bundled packaged of services. (See <a href="#">SPA</a>).</p> <p><b>Ohio</b>—MCO contract allows for the managed care provider to arrange for home visiting services for high-risk populations. These services are required to be culturally-competent and meet the member’s needs. (See page <a href="#">150</a>)</p>	<p><b>Rhode Island</b>—The state recently received approval for an 1115 waiver which will cover EBHV under the Nurse-Family Partnership (NFP) and Healthy Families America (HFA). (See pages <a href="#">36-38</a>)</p> <p><b>New Jersey</b>—The state is piloting the Nurse Family Partnership and Healthy Families America programs under 1115 waiver authority. (See page <a href="#">40</a>)</p> <p><b>Maryland</b>—<a href="#">The Maryland Department of Health (MDH)</a> expanded their 1115 HealthChoice waiver to include Nurse Family Partnership as a part of their Home Visiting Services (HVS) Pilot. (See page <a href="#">23</a>; and this <a href="#">protocol attachment</a>).</p>



	QUALITY	FEE SCHEDULE/STATE PLAN	MANAGED CARE ORGANIZATION (MCO) CONTRACT REQUIREMENTS	VALUE-BASED PURCHASING (VBP)
<b>Current Landscape in the District of Columbia</b>	<ul style="list-style-type: none"> <li>• <b>Perinatal measures:</b> The district measures MCOs and providers on three perinatal measures: <ul style="list-style-type: none"> <li>• Timeliness of prenatal care.</li> <li>• Postpartum care.</li> <li>• Contraceptive care (new).</li> </ul> </li> <li>• <b>Perinatal performance:</b> Overall, the district's MCO performance on Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal and Postpartum Care did not compare favorably to national averages.</li> <li>• <b>Performance improvement:</b> The district is developing a new Maternal Health Performance Improvement Project (PIP).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Fee schedule:</b> In the district, 27 of the 44 codes that support evidence-based home visiting (EBHV) are on the fee schedule.</li> <li>• <b>Health Homes:</b> Health Homes provide some of the nonclinical wraparound services but can miss early enrollment of pregnant women.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>High-risk pregnancies:</b> Contract has no specific language addressing high-risk pregnancies.</li> <li>• <b>High-risk newborns:</b> Each high-risk newborn receives a HV from a registered nurse (RN) within 48 hours of discharge. If need assessed, contract provides ongoing follow-up through child's first year, including additional HV, specialist coordination, and community support.</li> <li>• <b>Case management:</b> Contract specifies enrollment of at least 3% of the eligible enrollment in case management. There are both tiered and complex case management (requires RN).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>VBP:</b> The District of Columbia requires that 25% of medical loss ratio (MLR) be tied to VBP by end of Option Year 1 and 50% by Option Year 3.</li> </ul>

	QUALITY	FEE SCHEDULE/STATE PLAN	MANAGED CARE ORGANIZATION (MCO) CONTRACT REQUIREMENTS	VALUE-BASED PURCHASING (VBP)
<b>What Could be Done in the District of Columbia</b>	<ul style="list-style-type: none"> <li>• Quality strategy update: Update the state Medicaid quality strategy to include a perinatal health focus.</li> <li>• Provide guidelines for approvable, effective interventions: Specify (or provide guidance) regarding effective interventions (i.e., EBHV).</li> <li>• Accountability: Tie performance to payment.</li> <li>• Align quality measures: Increase perinatal health outcome measures in the MCO contracts that align with the Department of Health Care Finance's goals.</li> </ul>	<ul style="list-style-type: none"> <li>• Update fee schedule: Update the fee schedule to reflect the full range of the EBHV model.</li> </ul>	<ul style="list-style-type: none"> <li>• EBHV for high-risk pregnancy: Require EBHV for high-risk pregnancies.</li> <li>• Case management (CM) for high-risk pregnancy: Target complex CM to high-risk pregnant women and define parameters for interventions.</li> <li>• "Carve in" EBHV: Cover EBHV services in the contract.</li> <li>• EBHV as "value-added": Build out the "value-added" to add EBHV.</li> <li>• EBHV as "in lieu of": Build out the "in lieu of" to add EBHV.</li> <li>• EBHV as a PMPM: MCOs could explore PMPM models with EBHV models.</li> </ul>	<ul style="list-style-type: none"> <li>• Directed payments: Require MCOs to pay EBHV providers specific rates in VBP arrangements.</li> <li>• Perinatal care-specific VBPs: Develop perinatal care models in VBP (e.g., bundles).</li> <li>• Payment withholds: Withhold a portion of the MCO capitation payment tied to perinatal measures.</li> <li>• Section 1115 pilot: Build a perinatal health demonstration program using the Section 1115 waiver.</li> </ul>

## Endnotes

- <sup>1</sup> Emily E. Peterson et al., “Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017.” *Morbidity and Mortality Weekly Report* 68, no. 18 (May 10, 2019): 423–429, <https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm>.
- <sup>2</sup> Centers for Disease Control and Prevention (CDC), “Severe Maternal Morbidity in the United States,” last reviewed February 2, 2021, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>.
- <sup>3</sup> Peterson, “Vital Signs.”
- <sup>4</sup> CDC, “Severe Maternal Morbidity.”
- <sup>5</sup> Centers for Disease Control and Prevention (CDC), “Infant Mortality,” last reviewed September 8, 2021, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>.
- <sup>6</sup> America’s Health Rankings, “Health of Women and Children: Infant Mortality,” [https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR\\_MCH/state/ALL](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/ALL).
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