Promising Approaches to Reducing Disparities in Birth-Related Health Outcomes in Medicaid

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Introduction

States are at different stages in their efforts to confront institutionalized and structural racism in the healthcare system. Many states are beginning to address the resulting inequities in health outcomes, such as birth outcomes, which are rooted in structural racism and the related policies and practices that result in inequitable distribution of social and economic resources. Birth-related mortality rates among Black, American Indian, and Alaska Native people are two to three times the rate experienced by White people.[1] Certain subgroups of Latina birthing people also have higher rates of maternal mortality compared to non-Latina White people. Black birthing people have the highest rate of severe maternal morbidity (SMM) compared to non-Latina White people, and data show Black birthing people are at an increased risk for pregnancy-related complications.[2] For Black birthing people, these risk factors are present across all age groups and education levels and have persisted for more than a century.[3] Research estimates that more than one half of cases of maternal mortality and SMM are preventable.[4]

An extensive body of research reports on poor birth-related outcomes and disparities in maternal mortality and morbidity in the United States, particularly for individuals enrolled in Medicaid. Importantly, Medicaid provides healthcare coverage to individuals who may otherwise not be eligible for coverage until pregnancy, until which time they may have been uninsured or under-insured and have untreated health conditions or lack access to routine care. As states start to tackle institutionalized racism in the healthcare system, they are considering approaches to center health equity by addressing disparities in birth outcomes. This issue brief describes the drivers of birth-related health disparities and identifies purchasing and payment strategies to support state efforts to reduce disparities in birth outcomes. The brief focuses specifically on actions Medicaid agencies can pursue through their managed care programs or directly with provider organizations to promote health equity and improve birth outcomes.

The brief is organized into two primary sections. The first identifies state approaches to target systemic drivers of birth-related health disparities and the second describes specific actions states can take at each stage of the reproductive cycle. While this brief does not focus on implementing approaches to dismantle institutionalized and systemic racism in the healthcare system and its impact on SMM, each section highlights interventions and collaborations states may consider that demonstrate promising outcomes to mitigate disparities and begin to center equity in maternal health policies.

Throughout the brief, examples of state approaches and promising practices are represented using this icon.

Systemic Drivers of Birth-Related Health Disparities

Medicaid covers nearly half of all births in the United States. Medicaid programs play an important role in directing and influencing payment and delivery system policies and reforms to improve care for pregnant and birthing people and reduce related health disparities. This section includes actions Medicaid agencies can take to target systemic drivers of birth-related disparities with specific attention to strategies around purchasing, payment, and delivery system reforms. (*Additional strategies, including Medicaid coverage and benefits, enrollment processes, models of care, and quality improvement initiatives can be found in SHVS's issue brief, Medicaid's Crucial Role in Combating the Maternal Mortality and Morbidity Crisis*.[5])

Institutionalized Racism in Healthcare

Structural racism, discrimination, explicit and implicit bias, and other forms of past and present mistreatment of Black, American Indian, Alaska Native, and other pregnant people of color increase the risk of poor health outcomes.[6,7,8,9] A survey of people who gave birth in California hospitals in 2016 found that Black and Asian/Pacific Islander individuals were more likely to report unfair treatment (for example, harsh language and rough handling from hospital personnel) based on their race or ethnicity during their stay.[10] Implementing and ensuring adherence to standardized evidence-based clinical protocols and integrating cultural humility training for clinicians and staff are ways in which institutions can target disparate experiences in care and disparate outcomes.[11]

State Medicaid agencies can take the following actions to begin to address institutionalized racism in healthcare:

- Require hospitals, managed care organizations, and contracted accountable care organizations to implement birth-related clinical pathways, such as maternity safety bundles, and demonstrate evidence of implementation, including through reports generated by electronic medical records (EMRs) on pathway compliance rates. (States and managed care organizations can also offer incentives for the adoption of these pathways.)
- Establish accreditation standards as a condition for contracting and payment. For example, the Joint Commission has developed standards for maternal hemorrhage and hypertension/eclampsia.[12]
- Provide training, learning opportunities and funding to hire and foster a diverse and inclusive workforce so that pregnant and birthing people receive care from individuals who speak their language, share their culture, and live in their communities.[13] Medicaid agencies should engage individuals enrolled in Medicaid and care team members, such as doulas and midwives, in the design and implementation of workforce initiatives.
- Require managed care organizations, hospitals, and providers to educate their staff about implicit bias and its contribution to disparate health outcomes and patient experience and provide them with meaningful ways to change their practice to counter such biases.

The Colorado Medicaid agency, the Department of Health Care Policy & Financing (CO HCPF) implemented a voluntary Maternity Bundled Payment Program to hold participating providers accountable for the cost and quality of care.[14] The state designed the program, in part, to promote the quality and efficiency of services that reduce health disparities. Participating providers are required to complete cultural competency training, which must include "the importance of racial congruence between patients and providers and hiring and retention strategies for maintaining a diverse staff."

The Minnesota Department of Human Services asked respondents to the state's Medicaid managed care request for proposals to describe their experience with and/or plans for reducing implicit, explicit, and institutional bias experienced by Black and Indigenous people during pregnancy, delivery, and postpartum care. Respondents were also asked to describe their plans for monitoring and sustaining their actions and identify how their actions would reduce disparities in health outcomes for Black and Indigenous people during and after pregnancy.[15]

Payment for Pregnancy and Birth-Related Services

Value-based payment models that reimburse for outcomes or quality of care can spur changes to birth-related care delivery to improve outcomes. For example, a payment bundle through which providers are accountable for the total cost of birth-related care may mitigate financial incentives for Cesarean deliveries (C-sections) for individuals at low risk.[16] Research shows Cesarean delivery has been estimated to be associated with a larger proportion of SMM than any other risk factor.[17] In addition, value-based payment models can encourage better coordination among clinicians and other members of an individual's care team. States that pursue value-based payment strategies for pregnancy and birth-related care should include mechanisms in their models to guard against adverse consequences, such as provider non-referral to specialty care outside of the payment bundle.

State Medicaid agencies can take the following actions to reform pregnancy and birth-related payment models:

- Implementing or requiring the implementation of pregnancy and/or birth-related value-based payment models to encourage care delivery changes and improvements and increase provider accountability for birth outcomes. Such models include:
    - Maternity payment bundles
    - Blended payments for vaginal and C-sections
    - Hospital/provider incentives for performance on nationally endorsed metrics such as C-section rates, elective delivery before 39 weeks, exclusive breastfeeding, and unexpected complications in term newborns
    - Incentives for operationalizing birth-related safety bundles and achieving maternity honor roll status if designated by the state
- Providing reimbursement for programs and practitioners that have shown to improve birth outcomes, including pregnancy medical homes, home visits, community health workers, midwives, and doulas.[18,19] Medicaid agencies should support new Medicaid providers with the transition to managed care, for example, by offering assistance with Medicaid billing processes.[20]
- Stratify relevant quality measures by race and ethnicity to identify disparities in performance, evaluate the impact of efforts to address these, and inform quality improvement requirements.

The Ohio Department of Medicaid (ODM) implemented a Maternal and Infant Support Program (MISP) with an explicit focus on reducing racial disparities in maternal and infant health outcomes. ODM is engaging birthing persons enrolled in Medicaid, community members, and maternal healthcare providers to inform the design of the program. Through the program, providers, including gynecologists and community-based providers, are reimbursed for completing and submitting a pregnancy assessment form to ODM. The purpose of the assessment is to support early engagement in prenatal care. ODM shares information with managed care plans to facilitate member connection and referral to providers and resources

The Virginia Department of Medical Assistance Services (DMAS) convened a working group of managed care plans and doulas to discuss integrating and enrolling doula providers and services into their care delivery models and processes, with a specific focus on reducing racial disparities in birth-related health outcomes. In addition, DMAS has streamlined and standardized the credentialing process for doulas, eliminating the need for each health plan to apply its own credentialing on the new Medicaid provider group.

Monitoring Disparities in Birth-Related Health Outcomes to Inform Care Delivery Improvements

Maternal Mortality Review Committees (MMRCs) and Perinatal Quality Collaboratives (PQCs)[21] review cases of maternal mortality, perform root cause analyses, and stratify analyses using demographic data. The committees can identify delivery system changes, recommend improvements, develop pregnancy and birth-related care standards and toolkits, and offer technical support to providers. The committees promote evidence-based clinical protocols to improve quality of care and reduce variation. Generally, these committees include officials from Medicaid, managed care organizations, and providers. To date, 48 states, the District of Columbia, New York City, Philadelphia, and Puerto Rico have MMRCs, but only six states and New York City require the committee's reports to address racial disparities.[22,23]

State Medicaid agencies can take the following actions to leverage MMRCs and/or PQCs to inform and improve care delivery:

- Require active participation of the Medicaid medical director on MMRCs and PQCs and focus attention of committees on examining and reducing racial disparities.
- Establish formal processes for reviewing findings and reports from MMRCs and PQCs to identify needed care delivery reforms and opportunities for improvement that target racial health disparities.
- Contractually mandate that Medicaid health plans require contracted hospitals to participate in PQCs or similar bodies to improve the quality of care in hospitals.
- Encourage Medicaid MCOs to support PQCs, including potentially in-kind and financial support such as through community needs investment strategies.

Based on findings in a report from the state's MMRC,[24] the Louisiana Department of Health is leveraging the state's PQC to identify and champion strategies to improve and standardize clinical processes in pregnancy and birth-related care. Through the *Reducing Maternal Morbidity Initiative*, the Louisiana Perinatal Quality Collaborative (LaPQC) has been working with 42 birthing facilities, including hospitals, using quality improvement science to create sustainable change that improves outcomes.[25] In 2019, LaPQC convened birthing facility teams for a learning session devoted entirely to health equity citing a need for "a common understanding of the antecedents and consequences of health disparities."[26] In addition, the Louisiana legislature directed the creation of a Healthy Moms, Healthy Babies Advisory Council "to ensure that state initiatives addressing maternal mortality and severe maternal morbidity include an equity focus informed by the community."[27] Two staff members from LDH sit on the Advisory Council.

The Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) will require contracted Medicaid managed care organizations to contribute a percentage of annual pre-tax profits to community reinvestment strategies, such as PQCs, through which the state has indicated it could pursue health equity strategies.[28,29]

Specific Approaches by Reproductive Stage

Preconception Care

It is widely acknowledged that preconception care is essential to improving outcomes and reducing pregnancy and birth-related health disparities.[30] It also represents optimal care. Black, American Indian, and Alaska Native people experience disproportionately high prevalence of chronic conditions—such as hypertension and diabetes—associated with adverse birth outcomes.[31]

State Medicaid agencies can take the following actions to promote comprehensive preconception care:

- Expand the full scope of Medicaid to foster engagement with the healthcare system prior to pregnancy, to promote continuity of healthcare coverage, and to facilitate access to primary care, behavioral healthcare, and connection with non-medical social supports.
- Define family planning programs[32] in Medicaid contracts to include health education and promotion, testing and treatment for sexually transmitted infections, contraception, and other services to optimize people's health regardless of pregnancy status.

Prenatal Care and Supports

Heart conditions and bleeding are leading causes of mortality during the prenatal period. Engaging people early and often in prenatal care helps to identify risk factors and manage chronic conditions that increase risk of adverse outcomes and mortality. Group prenatal care programs provide peer and social support, including stress management, and critical prenatal care services, such as identification and management of chronic or other conditions that can increase risk of poor health outcomes. Participation in group prenatal care programs has been associated with significant reductions in preterm birth, particularly among Black pregnant people.[33] Maternity medical homes are comprehensive, whole person/family-centered, and multidisciplinary and have shown early evidence of positive impact on birth outcomes.[34] The maternity medical home can serve as an anchor for integrated care and multidisciplinary interventions to improve perinatal care.

State Medicaid agencies can take the following actions to improve prenatal care:

- Implement value-based payments to reward high quality prenatal care.
- Implement purchasing strategies that include group prenatal care and home care, require that managed care contractors pay for those services, and ensure members have access to them for prenatal care.
- Support pilots of new care delivery models like maternity medical homes.[35]
- Stratify MCO prenatal care quality measure rates to identify disparities in performance, evaluate efforts to address inequities, and inform quality improvement requirements.

North Carolina implemented a Pregnancy Medical Home (PMH) model of care to improve birth outcomes and maternity care for Medicaid enrollees. PMH model clinical pathways standardize care for specific conditions, including obesity, hypertensive disorders, substance use, and progesterone treatment. Care managers are available to support pregnant people by telephone, during a prenatal office visit, at home, or in the community and help with medication management, transportation, and referrals to childbirth and breastfeeding classes. Since the launch of the program in 2011, North Carolina has seen a nearly 7 percent decrease in the rate of low-birthweight babies in the Medicaid population.[36] The state also reported a decrease in racial disparities in mortality, however, an increase in mortality among White birthing individuals contributed to the disparities reduction.[37]

South Carolina Medicaid pays for group prenatal care through the Centering Pregnancy model. An evaluation of the model found that participation reduced the risk of premature birth, low birthweight, and neonatal intensive care unit (NICU) utilization.[38] Another study found a significant association between participation in the Centering Pregnancy group prenatal care model and lower premature birth rates among Black birthing people.[39]

Labor and Delivery

Hospital quality is a significant contributor to pregnancy-related mortality and morbidity, and research shows that Black people are more likely to deliver at hospitals of lower quality. Even in hospitals of higher quality, pregnancy-related disparities persist.[40] Safety bundles and clinical pathways to standardize care can promote improvements and reduce variation. Maternity safety bundles for hypertension and postpartum hemorrhage are standards for the Joint Commission, the hospital accreditation body, as well as the focus of many statewide maternal quality collaboratives.[41] The midwifery model of care and doula services have shown to reduce C-sections, which increase the risk of hemorrhage and SMM. Rates of C-section deliveries are disproportionately high among Black people.

State Medicaid agencies can take the following actions to improve and optimize care during labor and delivery:

- Adjust Medicaid reimbursement to hospitals to blend rates for vaginal and cesarean deliveries or reduce payment for non-medical C-sections to mitigate a financial incentive for C-section deliveries. (Implementation of payment models to promote improved care delivery should include: mechanisms to monitor for negative impact or unintended consequence on quality and utilization of care; and exclusions of certain subpopulations, for example, individuals who are at a higher risk of birth-related health complications.)
- Require Medicaid health plans to contract with hospitals that have demonstrated high quality pregnancy and birth care, adherence to standards of delivery and birth-related safety bundles, and commitment to transparency in outcomes and quality.
- Require Medicaid health plans to offer enrollees access to midwifery and doula services that are integrated with both hospital-based delivery teams and birthing centers.[42]

Colorado Medicaid administers a performance-based incentive program for hospitals which includes assessment of performance on a group of birth-related quality measures, such as C-section rates. Beginning in 2022, participating hospitals will begin reporting on the current state of and plans for identifying and reducing racial and ethnic disparities. Hospitals with labor and delivery services will be required to provide their plans for reducing peripartum racial and ethnic disparities.[43]

Postpartum Care

The postpartum period is a critical time for continued care to reduce adverse health outcomes and mortality. Cardiovascular and mental health conditions are primary causes of SMM and mortality postpartum, and birthing people of color are at higher risk of death due to postpartum cardiovascular conditions.[44] Identifying risk factors and coordinating with providers before hospital discharge to secure timely postpartum care is critical to ensuring continued monitoring for complications and treatment of chronic conditions. Screening for postpartum depression and other mental health conditions is also a critical aspect of postpartum care. Integrated care models such as maternity medical homes augmented by doula services and other postpartum supports for breastfeeding and infant care can be leveraged to support new parents and identify and address conditions leading to morbidity and mortality in the postpartum period.

State Medicaid agencies can take the following actions to improve care for women during the postpartum period:

- Expand reimbursement to extend postpartum services for up to one year after birth.
- Continue to pay for services in maternal medical homes and with doulas through the postpartum period.
- Provide reimbursement for depression screening performed during well-child visits, consistent with the recommendations of the American Academy of Pediatrics (AAP).
- Implement financial incentive programs with managed care plans that hold them accountable for postpartum care, including timeliness of care and provision of screening for depression and other behavioral health conditions and referral to treatment.
- Stratify postpartum care quality measure rates to identify disparities in performance, evaluate efforts to advance equity, and inform quality improvement requirements.

New York's Medicaid program reimburses pediatric providers (e.g., physicians, nurse practitioners, physician assistants) for postpartum maternal depression screening using a validated screening tool. The state requires practices (pediatric or other) to have an established referral process for individuals who screen positive for depression and require further evaluation and treatment if those practices do not have the capacity to diagnose and treat.[45]

Conclusion

There are many factors that contribute to disparities in pregnancy and birth outcomes that are rooted in institutionalized and systemic racism. Maternal mortality and SMM are multifaceted and complex problems requiring significant investment, focus, and attention on how to achieve measurable improvements. As states consider approaches to dismantling racism within their healthcare systems, Medicaid agencies can play a role. They have the opportunity to leverage their purchasing and convening powers to inform strategies and interventions across the healthcare system,[46,47] and at different stages in the reproductive lifecycle, with an intentional focus on reducing disparities and improving outcomes for birthing people.

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ABOUT BAILIT HEALTH

This brief was prepared by Erin Taylor, Jennifer Sayles, M.D., and Michael Bailit. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see *www.bailit-health.com*.

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