



# Advancing Equity in Maternal Mental Health: Strategies for State Medicaid Programs

By Dr. Kimá Taylor, Mental Health Advisory Board, and  
Isha Weerasinghe, Senior Policy Analyst, Center for Law and Social Policy (CLASP)  
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## Introduction

The United States is facing tumultuous times amid the coronavirus pandemic, its related economic impact, and racial justice protests. The country is finally reckoning with internal and external anger toward systems that promote and allow racial inequities to persist, even foment. Some of these systems help to perpetuate those racial inequities in maternal and child health, one of many sectors within our health care system rife with deeply rooted issues. The United States' maternal mortality rate has steadily increased over the past few decades; <sup>1</sup> hidden in the U.S. Centers for Disease Control and Prevention's (CDC) aggregate data are enormous racial disparities, especially among Black and Native American women.<sup>2</sup> One example is when Serena Williams, the famous tennis player, had post-birth complications that illustrated the profound biases that lead to poorer outcomes for Black women.<sup>3</sup>

Over the past few years, stark data and merciless community-based advocacy about U.S. maternal mortality and morbidity rates have led to various local, state and national efforts. These initiatives, laws, programs, and practices include legislation to ensure perinatal providers receive implicit bias training, a focus on perinatal and maternal health quality initiatives, and care bundles. Outcome measures must reflect the reality that other social and societal determinants affect women's lives and outcomes, such as employment status, housing instability, and access to transportation.\* System leaders must identify such factors and

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\* The authors prefer to detach social and societal determinants. Social determinants have become a thing you do or give because someone does not have it. Rather, we need to work to change the structural barriers that led to someone not having what they need. The authors use societal determinants to address this gap.

ways to address them through policy and payment reform. Furthermore, providers have little financial incentive to extensively engage with people enrolled in Medicaid who may face the deepest health disparities, given the program's historically low payment. But none of these initiatives, laws, and programs, to date, have managed to deliver equitable outcomes across race and ethnicity.

For the purpose of this paper, "providers" includes a broad range of people working with birthing persons, including OB/GYNs, doulas, midwives, case managers, community health workers, and others who provide care for the mother during the prenatal period.

**This paper aims to offer guidance to state Medicaid offices on the steps needed to advance equity in maternal health, particularly as it relates to people of color.** We outline a framework that employs three specific areas of action. In addition to recommending key agency strategies, we offer effective state and federal models that leaders can look to when taking each approach.

*To effectively develop and implement equity-focused programming, Medicaid and other health systems must lay the groundwork in three critical areas:*

### Step 1:

Medicaid must work with partners including Managed Care Organizations, health and social service providers, and communities representing different jurisdictions to improve the collection, analysis, and use of **stratified** data for equitable quality improvement. Stratified, robust data is needed across all health and social metrics.

### Step 2:

Medicaid systems must endeavor to better understand the people who are enrolled in the program. Agencies can ask themselves and their beneficiaries: which groups are getting what kind of care and why? Where are they receiving care? Is the care they obtain culturally and linguistically appropriate? What are the stratified outcomes, and do they truly reflect the populations eligible for Medicaid in the state? Understanding answers to these questions will require health system staff to identify, recognize, and be held accountable for their own implicit biases as they seek to pinpoint and meet various communities' needs. System leaders must also use an equity lens to identify areas where racial bias is baked into policies, procedures, and engagement in ways that create inequitable and poor health outcomes.

### Step 3:

From the outset, Medicaid must approach these strategies collaboratively. Agencies must work with payer, provider, and community partners to develop the framework, data-sharing relationship, and collaborations needed to launch new or improved value-based frames that incentivize maternal health equity.

## Shortcomings in Our Current Maternal Health System

Even as the physical health causes for maternal morbidity and mortality are widely discussed, behavioral health, mental health, and substance use are often omitted. Maternal Mortality Review Committees and data reports around the world identify behavioral health concerns as significant causes of maternal deaths.<sup>4</sup> The United States conducts much less collection, analysis, and race/ethnicity stratification of this data before, during, or after pregnancy. This lack of integration and focus on behavioral health is troubling.

A look at maternal depression and heart disease offers one example of why a new approach is necessary and urgent. Studies have shown that people with depression have worse physical health, and perceived physical health, than others.<sup>5</sup> While many experts know that people with heart disease can have higher rates of depression,<sup>6</sup> there has been less attention focused on how depression can increase the risk of heart disease.<sup>7</sup> The conversation is especially rare in maternal mortality and morbidity research, though heart disease and depression are common causes of poor maternal outcomes during the perinatal period. Maternal health care providers, payers, and advocates must begin to interrogate the intersection of depression, heart conditions, and other chronic diseases, including mental health. They must also examine the role of discrimination to begin eliminating racial and ethnic health disparities. Maternal Mortality Review Committees (MMRCs) and Perinatal Quality Collaboratives (PQCs) look at many of these outcomes, albeit sometimes in siloed ways. These bodies are a great place to mine behavioral health data across race, ethnicity, and other demographics to build a picture of where disparities lie and how they can be addressed.

Unfortunately, COVID-19 has paused or slowed many of these quality and mortality review initiatives like MMRCs and PQCs, shedding light on broader health care shortcomings that create differential outcomes. COVID-19-related isolation, economic and child care stressors, job quality, as well as the disease itself, are likely worsening existing inequities. Absent significant new federal investments, the pandemic is also going to lead to budget cuts that will impact maternal health quality-focused initiatives. For this reason, localities and states must develop new, cost-effective and comprehensive health care delivery and payment changes that incentivize system-wide marches to equity. CLASP believes equity-focused value-based payment structures are one tool to help meet that goal.

## How Medicaid Agencies Can Close Maternal Health Gaps

Some states have initiated pay-for-outcomes models, seeking to hold health systems financially accountable to improve maternal mortality and morbidity outcomes. Using data and lessons from quality, programmatic, and legislative changes, state leaders could also use value-based payment solutions to require and incentivize equity in maternal health. Black and Native American women face the most egregious inequities as compared to white women. However, this may vary depending on location. Eliminating racial inequities of all types requires more than just tinkering with current, ineffective systems. It will take gutting and recreating new ones that look at populations, identify inequities, and immediately address them among any group of people.

While disparities and inequities exist across class, this paper will focus on people enrolled in Medicaid. Broad, thoughtful systemic change will eliminate maternal health inequities among all Black or Native

American women by necessity. But change should also create a platform that will unearth and eradicate gaps confronting other community groups, among and across race, ethnicity, gender identity, sexual orientation, socioeconomic status, and other intersections.

Medicaid departments are in a unique position to lead and ultimately implement these systemic changes. The process will take time, internal reflection, and transformation within the agency. While maternal health could be the first pilot, administrators/stakeholders must develop equity measures across the health continuum. This achievement may not be immediate or easy to do. However, combining new strategies with current maternal health initiatives could provide the partnerships, basic data, and outcome platforms needed to advance equity.

## ***More Effectively Using Data as a Tool to Identify Racial Health Inequities***

### **Step 1:**

Collect and aggregate data across hospital, provider (e.g. Federally Qualified Health Centers), Perinatal and Maternal Quality Collaboratives, clinics, and social sources. Identify gaps in captured demographic groups and in measures of process, perception, and health outcomes. Add these new fields to data collection tables moving forward and ensure the ability to stratify this data.

Currently, states are collecting data within myriad maternal-child health initiatives including Perinatal Quality Collaboratives, as well as in Maternal Mortality Review Committees. Data also exists within payer systems, which have access to medical and pharmacy utilization, hospital outcome data, and more. States must bring this information together and stratify data across race, ethnicity, sexual orientation, gender identity, and other intersections. States must also think about how collective health data compares with other non-health related datasets disaggregated by race/ethnicity to fully capture a picture of the residents of the state. Such disaggregated data will begin to paint a picture of who is receiving services, what they are receiving, and whether the services are having the desired outcomes. Defining the state's data picture will illuminate where measurement gaps exist and inevitably show areas for improvement.

### **Gaps in Medicaid's Measurement Infrastructure**

Some institutions do not collect and/or analyze disaggregated data on people across all federally identified racial groups and ethnicities.<sup>8</sup> Some institutions lack robust stratified behavioral health indicators. This presents missed opportunities for care, as health committees around the world identify behavioral health concerns as a significant cause of maternal deaths.<sup>9</sup>

Furthermore, states that have data may not collect, provide, and house it within the payer system in a way that allows Medicaid to understand, identify, and provide needed services. Measures of maternal health processes and outcomes may differ across initiatives and lack stratification. The first goal must be to bring all of the existing demographic, process, and outcome measures in the state together to understand the current data landscape. Looking at state data differently may even identify areas to strengthen successful initiatives.

## Successful Models Using Data to Boost Racial Equity in Health Care

**Massachusetts** (MA) does a good job of collecting and aggregating multiple data sources as part of its **Population Health Information Tool Data Directory**.<sup>10</sup> It collects health outcomes for different populations, including physical and behavioral health and social determinant outcome measures. This includes non-MA solicited data sources, such as the Pregnancy Risk Assessment Monitoring System (PRAMS). The data directory will tell users what race, ethnicity, age, sex, and geography data is available for the data set. Massachusetts also puts together a Health Systems and Health Care tool that captures all available data, including disparities in each category, and includes a guide for providing Culturally and Linguistically Appropriate Services (CLAS) standards within different public health settings.

**California's** Maternal Mortality Quality Initiative used its data to recognize the difference between improving outcomes and removing inequities; this led to the creation of the **California Birth Equity Collaborative**. California's maternal quality collaborative is one example of a program collecting and analyzing stratified data as a tool to close health gaps.

The **California Birth Equity Collaborative** grew out of the California Maternal Quality Care Collaborative (CMQCC). While the use of quality initiatives led to a 55 percent decline in maternal mortality from 1999-2006, racial disparities remained. This reality forced the Maternal Quality Care initiative to begin the Birth Equity Collaborative and start addressing structural racism as a root cause of disparities. The Birth Equity Collaborative is a quality improvement initiative to enhance birth care, experiences, and outcomes for Black mothers and birthing people in California. The partnership consists of local, state, and national experts, local communities, and hospitals, as well as the Maternal Quality Care Collaborative and its **maternal data center**. This work was possible because its stratified data collection and analysis revealed continued disparities along racial lines.

**At the federal level**, the U.S. Center for Medicare and Medicaid Services' (CMS) Office of Minority Health has a massive collection of stratified Medicare Advantage data. While it is not used for contracting or payment purposes, this work demonstrates such data collection is both important and viable, even when working with private payers.

The U.S. Center for Medicare and Medicaid Services (CMS) has collected National Medicare Advantage data by race and ethnicity. The data cuts across various health conditions, including behavioral health, an area that needs buttressing when looking at maternal health needs and outcomes. The stated purpose of the data collection is to "comprehensively address and eliminate health disparities," and that, to do so, "it is necessary to measure and publicly report – in a standardized and systematic way – the nature and extent of health care disparities. Stratified reporting provides useful information for targeting quality improvement activities and resources, monitoring health and drug plan performance, and advancing the development of culturally and linguistically appropriate quality improvement interventions and strategies." **CMS** demonstrates the need and ability to collect data in a way that states can emulate. States can apply this method in the maternal health field to equitably improve outcomes.



The health care sector, among other systems, only recently started to analyze stratified intersectional data that patients self-identify. Health systems have often used “other” as a catchall for races and ethnicities that are not “white” or where systems did not provide patients the opportunity to self-identify; instead staff would assign race, ethnicity and other intersectional identifiers. Many Medicaid offices are just starting to enlarge these types of data fields, build better collection infrastructures, and teach staff to allow for patient self identification. Such infrastructure development will establish a baseline against which Medicaid can judge whether payers improve health outcomes equitably, determine subsequent incentives or penalties, and get more accurate data from patients. The baseline must include areas where disparities exist to identify ways to achieve equitable outcomes across race, ethnicity, and other intersections. Medicaid offices must also be able to assess whether the benchmark (usually measured among white women) rates are acceptable.

The lack of data, while frustrating, can be an opportunity for shared learning and creating innovative ways to collect it, within the privacy constraints of the law. As a first step, states can work to provide comprehensive, stratified measures of health processes and outcomes to providers and communities. These partners can then identify targeted policy and program improvements to end inequities.

## ***Internal and External Strategies to Shift the Medicaid System toward Equity***

### **Step 2:**

Medicaid must embark on internal implicit bias work. This includes assessing its infrastructure to identify policies and payment and program structures that promote or mitigate inequities--and then altering them as appropriate. With this new awareness, staff must meet with community stakeholders, including people enrolled in Medicaid, to identify health and social services that could be included in a Medicaid maternal care bundle designed to achieve equity.

To successfully build a process to develop, contract, and measure value-based payment, Medicaid systems must examine racial bias in their internal practices, procedures, and thought processes.

### **Acknowledging Racism Embedded in America’s Health Care Institutions**

It is valuable to start by acknowledging longstanding health inequity in America and Medicaid’s place within that history. Unequal treatment was built into the U.S. health care system; it was intentionally designed to provide separate care to people of diverse racial and ethnic backgrounds. Medicaid was instituted in 1965, nine years after the U.S. Supreme Court’s ruling in *Brown v. Board of Education* that “separate” was in fact “unequal.” This was also only one year after the Civil Rights Act—a time when legal segregation and explicit racism were alive and well across the entire country.

States originally had the choice whether to implement Medicaid, and it took many years before all states did so. Arizona was the last holdout, not providing Medicaid until 1982. In addition, states were only required to provide coverage to families receiving cash assistance, and many states with large Black populations used low benefit levels and caseworker discretion to limit Black women's access to both cash aid and Medicaid. Medicaid’s implementation was inauspicious from the start.

During subsequent years, Medicaid was unjustly used as a tool to blame and vilify people with low incomes, especially for people of color. Such misuse was perhaps best demonstrated by President Ronald Reagan, who promoted an exaggerated image of a Black woman as a “welfare queen.” This offensive label remains in use today. The stereotype ignores the fact that the majority of people using Medicaid are white. States continue to have the power over coverage, payment levels, and the administrative burden involved in applying for and continuing to receive Medicaid.

With such deeply rooted bias, this system will need more than tinkering around the edges to achieve health equity. Medicaid agency officials must work internally to understand how the program’s historic policies and practices influence inequities. They must also be intentional about talking with, listening to, and understanding the people they serve. The internal work will allow Medicaid to develop RFP and contracting processes that will help pay for and incentivize access to culturally and linguistically effective services that people enrolled in Medicaid have cited as necessary to improve their health.

### **Approaches to Undo Racial Bias within Medicaid**

Understanding the people whom Medicaid serves and the communities in which they live is important for programs to meet their overall health needs, including the particular needs of people during pregnancy and after giving birth. To do so, Medicaid staff and leadership must understand the biases they bring to the table. To develop knowledge about people enrolled, offices can create diverse community advisory boards and/or host community focus groups and town halls. These advisory boards must be created with humility; ensuring that those who agree to come to the table are respected, heard, and that their time is valued. This includes working with communities to set agendas, and determine meeting days/times. These spaces can allow Medicaid officials to listen to the community’s health realities and needs, and build trust with communities.

For effective community engagement, such actions will require Medicaid personnel to leave their own biases at the door. Preparing leadership and staff for this type of work will require efforts such as: ongoing implicit bias workshops; education about myths upheld by the health care system (e.g., the myth that Black people have a higher pain tolerance than their white peers); and focused work to look at current policies, programs, and practices and how they facilitate, mitigate, or eradicate inequities.

Medicaid can offer implicit bias training with a proactive equity lens that would help promote the provision of culturally and linguistically appropriate services. Implicit bias, as defined by the Kirwan Institute for the Study of Race and Ethnicity, is “the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.”<sup>11</sup> Providing an approach of implicit bias training would also ultimately hold system partners accountable to ensure its sustainability. **Ohio tried just such an undertaking.**

Ohio Medicaid has engaged in interesting, system-wide implicit bias training work. Several years ago, Medicaid launched the **Ohio State University (OSU) Medicaid Equity Simulation Project**. Through trainings that include virtual reality and simulated patient experiences, the project seeks to increase Medicaid providers' ability to deliver culturally effective care and increase their awareness of equity. The project is a partnership between the Ohio Department of Medicaid and Ohio's academic medical and health sciences colleges. It is based on the reality that decreasing implicit bias among health care professionals "can reduce health disparities, improve patient care, and health outcomes." Pregnancy and infant mortality are but two of their simulation areas. This is an example of taking a systems approach to changing the way care is provided and assessed. It is led and endorsed by Medicaid itself, and was funded using Medicaid Technical Assistance and Policy Program (MEDTAPP) funding.

### Analyzing Health Data with an Equity Lens

Part of understanding the community's needs requires assessing health data in the context of existing biases and social determinants of health. Following bias training, Medicaid should look at the population's stratified health data and consider the following questions:

- *What is the risk prevalence for adverse outcomes?*
- *What chronic conditions exist prior to pregnancy?*
- *Are people being treated for their unique health concerns and, if not, why not?*
- *Have people been screened for behavioral health concerns and/or are they in care if they have such concerns?*
- *What types of medications are prescribed, and are patients adherent?*
- *What types of providers are serving pregnant and postpartum women?*
- *Are collaborative care models being used before, during, and after pregnancy?*

Medicaid staff can further investigate the reason behind any existing gaps. Community members can provide critical information on where and why health systems fall short. Agencies need such on-the-ground knowledge to create or scale up practices that will improve community members' health.

For example, if people enrolled in Medicaid are eligible for a depression screening, but Black and Latina women are not engaging with the tool, Medicaid staff must evaluate why. Health officials might ask: has anyone created a strategy to increase engagement among women of color? What are some other population health management strategies that can be implemented? Understanding what is driving such gaps allows states to identify possible remedies, either through innovation, scaling existing models, or borrowing solutions from other states. This knowledge is key to ascertaining what services and resources are needed, and what must be covered, as part of a bundled payment to improve community members' health outcomes.

### Listening to Community Members to Locate Health Gaps and Successes

Once Medicaid has looked at its own policies, practices, and stratified health outcomes data, staff should provide an internal evaluation of policies and practices that promote inequitable outcomes to the communities served. Ongoing communication is important as the agency seeks to work with and better understand the people who are its beneficiaries, including their needs, their social realities, how



structural racism affects their lives and their health, and the service capacities where they live. Medicaid leaders need to ask: are current policies having the intended affect? Has the agency identified the correct problems and appropriate remedies?

Myriad articles identify the negative impact that racism and bias have on health. Systemic inequities especially harm the health of Black people. Medicaid leaders can act to remove health-based biases especially if they work with communities of color who can often easily identify which biases and barriers have the greatest effect on their outcomes. Often health care payers and providers identify social determinants they would like to address based on national research, without talking to members of the community about the health barriers they find insurmountable. To be most effective, Medicaid must ensure it fully understands the communities it serves. That means listening to the unique needs of people of diverse races, ethnicities, immigration status, sexual orientations, gender identities, socioeconomic status, and more. One single employed birthing person may require child care support, while another may live with their family and not need child support but has food insecurity. Even within socially identified groups, people may have distinct needs; no defined community is monolithic. In addition, federalism implies that each state has different laws, practices, support systems, and income thresholds that affect work with varying racial and ethnic groups. The variability in care for different groups due to inequitable access and service provision detracts from the main aim of Medicaid programs to serve all populations with low incomes.

Assessing one's own racial biases and listening to/collaborating with the community may be new and difficult. This work often requires outside expertise and collaboration to help staff comfortably look at, critique, and change work that has created racial and ethnic inequities. It is a worthwhile investment. Gathering an understanding and building a compendium of community-identified culturally and linguistically appropriate interventions is an important piece of a service platform that Medicaid can use and pay for within a value-based construct.

Listening to communities share what health resources they desire and will use can help Medicaid shift to reimbursing services that are cost effective and improve outcomes. For instance, many states including New York and New Jersey are covering doula services.<sup>12</sup> Doulas have long provided culturally responsive pregnancy care in many communities. Yet until policymakers began to ask people enrolled in Medicaid about their needs, these culturally effective services were not reimbursed.

## ***Creating Payment Models that Value Maternal Health Equity***

### **Step 3:**

With stakeholder input and partnership, state Medicaid offices must develop the maternal care bundle payment model, an implementation timeline, and the desired implementation process. State offices must also designate the perception and health outcome measures against which they will assess providers and payers. Medicaid officials must do this in partnership with a range of key stakeholders, such as payers, birthing facilities, diverse providers, birthing persons, and community members. Having a stakeholder board can help to facilitate ongoing conversations and oversight.

Once a state Medicaid office gathers baseline information, system leaders must develop value-based payment models that hold the agency accountable for equity in maternal and child health outcomes. Such payment models can inadvertently lead to cherry picking where providers turn away people they envision having more risk factors and who may ultimately have poorer outcomes—and higher costs to the system. Having an equity framework for all birthing persons is imperative if the system seeks to eliminate such actions; ensuring providers have the best possible infrastructure to provide effective care. Without this frame, populations impacted by social and societal determinants of health, including racism, may have worse health prior to pregnancy, which leaves them at risk for poorer maternal health outcomes. Providers serving patients at higher risk would be unduly punished by pay-for-performance schemes that do not incentivize equity. The program should pay providers more if they are ending racial health inequities and penalize those that stall progress or whose care worsens such gaps. This step requires partnership between payers, providers, consumers, and social service groups. Having an infrastructure to collect and analyze stratified data, carry out system reviews for bias, adjust for different risk levels, and conduct community health assessments will help partners develop a value-based payment contract rooted in incentivizing equity for the long term.

### How Data Can Inform Value-Based Payment Efforts

The steps to create a value-based package targeting equity are not vastly different than those used to develop contracts in other realms. However, such a system will have some unique features. Building a payment contract that seeks to truly achieve equity will require input from community, provider, and payer partners. Each of these players will have to dismantle the racist systems embedded in their fields or institutions –which is not currently done for many value-based plans.

Partners must work together to create data dashboards identifying key measures on perinatal, maternal, and infant health processes and outcomes. The data systems must capture information across different ages, races, ethnicities, socioeconomic statuses, and other intersections. Partners must be willing to share the data with strict adherence to privacy. Data sharing will allow providers and payers to identify any inequities, consider how they can be mitigated, and determine where/whether payment should be positively or negatively affected. Where Medicaid finds that areas of data are limited, it must create, collect, and share new data fields. The goal of equity is for systems to recognize that all populations should be able to achieve the best outcomes based on current information and services, while still striving for more. This takes away some of the counter arguments about not addressing equity because of the lack of data on any particular ethnicity over five years; the best outcome is the interim goal based on current data, while still working to continuously improve as more data is gathered.

### Collaborating with Payers, Providers, and Community Members to Incentivize Equity

For work done in the payment space to be successful, it has to involve listening to the realities facing each stakeholder, including payers and providers.

**Payers** are looking for ways to improve health while doing so in a cost-effective manner. When developing a value-based plan, payers will consider what the most expensive underlying conditions are that lead to poor health outcomes. For maternal and child health, these issues include hypertension,

behavioral health concerns, and infections. Any plan that seeks to improve maternal and child health, and manage costs, must focus on these top conditions. Providers, including hospitals and payers, must be held accountable for equitable outcomes. These stakeholders need time and education to understand how to transform racist structures and to import or scale culturally and linguistically effective health care practices.

**Providers** know health care interventions alone will not immediately lead to their patients having perfect engagement and health outcomes. Providers want to and should be compensated for the range of services they deliver, such as: providing team-based care, including collaborative care models with a care manager; attending trainings on implicit bias and its remedies; working with social service providers; and taking the time to revamp clinic processes to allow for screening and referrals for patients' needs regarding physical, behavioral, and social concerns, including social and societal determinants. Improvement will occur slowly and will require providers having the data and time to assess and rethink strategies that are not working as desired. Providers will need to ramp up both time and funding before they can share risk for basic outcomes, much less use an equity lens for outcomes. Medicaid should offer providers examples of programming that has promise to promote equitable outcomes and that they can realistically implement and assess within their clinic. Examples of this include **Centering Pregnancy**, as well as **the ROSE Study** and **Mothers and Babies initiative** cited in the **United States Preventive Services Taskforce recommendations on preventive interventions for perinatal depression**.

**Members of the community** should have access to disaggregated data to understand how Medicaid providers, including hospitals and payers, are caring for people who are like them. Medicaid agencies can take steps to help community members learn more than, for example, the names of USA Today's "Best Hospitals." Rather, the program can publicize more granular data showing which hospitals work best for Black women with perinatal concerns and which are providing equitable care, among other factors.

One such program is **Centering Pregnancy**, a group prenatal care team-based initiative that was started in the 1990s and is now in locations across the country with support of the Centering Healthcare Institute. However, there are many other group-based care programs. Another type of group program targets moms with newborns. One such program started by Oakland's Joan Jeung is called the **Empowering Mothers Initiative**. It was formed explicitly to address the needs of and to bring culturally and linguistically appropriate services to low-income Asian American immigrant and refugee communities. These patient-centered programs bring together women from the community who are at similar stages of pregnancy for joint health, social, and educational visits. The group has access to longer visits, team-based care, referral for health and social concerns, and the wisdom, support, and encouragement of their peers.

According to its own research, Centering Pregnancy has been shown to nearly eliminate preterm birth disparities for African American women. Other group prenatal programming like the **ROSE Study** and **Mothers and Babies** are recognized as preventive interventions for perinatal depression, particularly for mothers from communities of color. While such programming is not a panacea, it could be one of the programs that Medicaid incentivizes providers to implement within their practice. Medicaid could give providers a value-based payment based on equitable outcomes.

## Developing Value-Based Care Bundles to Drive Maternal Health Equity

From all of this, partners must create contracting that reflects payment for equitable outcomes. Medicaid must create a menu of value-based contracting options. Contracts will differ if Medicaid is working with a payer like a Medicaid Care Organization (MCO) versus a provider, but the tenets are similar. When Medicaid is contracting with a payer, more of an onus is on the payer to work with providers to achieve equity; contracting guidelines should be framed as such. Some state Medicaid programs may need to tweak current value-based bundled prenatal programs to ensure payment and ensure risk share is based on equitable outcomes across race and ethnicity.

Value-based contracts always recognize different risk categories within payer or provider panels. Equity-focused contracts can consider inequitable starting points and include agreements that reward improvements while dis-incentivizing continued health gaps. Medicaid may use different tools for different payers and providers. However, the program would ultimately hold providers financially accountable for moving toward high-quality, equitable health outcomes for people during the pre-, peri- and postnatal period. This approach could be taken through a bundled payment that includes process, engagement, and outcome measures collected within a data report card. It could contain diverse, stratified demographic information that identifies inequities and measures improvements. Patients, not providers or payers, should declare their race, ethnicity, gender identity, sexual orientation, and other personal information. Medicaid would need to provide education to staff in provider and payment offices on data collection and describe why the data is important for health outcomes.

Like current bundles, providers would receive a certain amount of funding for this set of services. It would take into account their costs, the risk stratification, what needed services they expect to provide, and other externalities. However, there would be an additional weight for decreasing inequities. It could take shape as an added incentive payment or a withholding if disparities do not decrease. Stratified outcomes could include all current maternal mortality and perinatal quality measures, among others. In a world with equity as its target, the desired health goals will not necessarily change. Rather, each outcome would be stratified and evaluated across race, ethnicity, and other intersectional characteristics.

Outcome report cards would also include patient-centered survey measures as important tools to assess patient experience. They also give providers and health systems real-time knowledge of practices in need of change. A strong example is the Mother's Autonomy in Decision Making scale (MADM),<sup>13</sup> which looks at mothers' perceptions around discrimination. Another patient-centered tool is a birthing persons advisory board, where health care system stakeholders work in partnership with community birthing persons of various ages, race/ethnicities, sexual orientations, and relationship statuses, to listen and understand community realities and needs in an effort to improve health care engagement, delivery, and outcomes. To be truly equitable, community members are compensated for their work.

## ***Effectively Addressing Challenges to Equity-Focused Changes***

The steps this paper recommends are crucial if we are to better support people during and after pregnancy. Like any worthwhile solution to a longstanding problem, taking action to end maternal health inequities will likely present challenges. Systems resist change; none more so than the health care system. That is why shared learning and up-front work to promote buy-in is so important. Previous obstacles to advancing equity have included the absence of key data and limited interest in developing new data collection strategies. These hurdles cannot continue to perpetuate inequitable outcomes and can be overcome. It is important and helpful to create a shared baseline that considers the reality of each player's starting point but speaks to higher expectations in the future. Each of these steps takes time, leadership, and fortitude.

### **Managing Providers' Financial Incentives**

The first hurdle Medicaid leaders must grapple with is the limited value the system places on clinicians. Providers, not payers, deliver and are at the frontlines of value-based care. Payments must compensate providers' insight, with reimbursements that are sufficient to support high-quality care and innovation. Medicaid must also work with providers and payers to identify who else needs to be reimbursed for providing care within these bundles. For example, in obstetric care, the bundle should pay the health workers who perform the birth and also consider the prenatal and postnatal team (if they are different). Many providers will have to reimagine how they are giving care. They may need to add behavioral health staff, provide onsite translation, hire a more diverse staff, or reimagine how they engage patients. Incentives should truly reflect the value of health equity.

A related obstacle revolves around how Medicaid treats the non-medical barriers that influence maternal health equity. Developing reimbursement relationships will be complicated, and Medicaid must avoid perverse incentives that could inadvertently lead providers to cherry-pick their patients. Risk adjustment of this type has occurred in other health settings and can be done for maternal health care. Medicaid can use those models as examples to establish similar financing practices in maternal health.

### **Breaking the Wall Between Maternal and Mental Health**

Another hurdle that Medicaid can overcome is the disconnect between mental health and maternal health. Mental health and substance use services are essential, but they are often siloed from other areas of health care. Moreover, some behavioral health providers do not offer evidence-informed or culturally responsive/effective care. This sector also faces a workforce shortage. In the short term, Medicaid can help create or identify provider education tools to help primary care and obstetric clinicians learn how to better support the people they serve by teaching them to provide basic mental health services or to partner with effective existing community-based services. Such education should focus on building responsive and linguistically effective behavioral health practices that are informed by evidence, community, and culture. Medicaid could also make connections between behavioral and somatic providers, especially those who are rooted in, partner with, and understand their communities. Medicaid can also lead conversations with payers and providers on consent and privacy and about how health care inequities intersect with the justice and child welfare systems, among others. For example, community members may be afraid to engage with health care providers because they fear their



diagnoses could lead to punitive justice outcomes or child welfare intervention, or because of patronizing interactions with providers in the past.

### **Prioritizing a Diverse Health Workforce**

In the longer term, Medicaid could lead efforts to grow and diversify the future workforce. Medicaid makes the final decision on which payers to include; it can assess the payer's network and if it is not diverse can help lead the organization to tools to help it build a broader network. In addition, Medicaid can help collect stratified health care workforce data to bring to state administrators and legislators involved in building workforce pipelines and student loan repayment strategies. Such data must include all areas of the health workforce from the lowest- to highest-paid jobs. Many times, efforts focus on diversifying lower-paid jobs without any career ladder, implying that people of color may not be interested in all areas of the health care workforce. Studies show providers who are members of underrepresented communities are more likely to work in and provide for their communities. A diversified workforce is essential, not just for justice and economic reasons, but to improve health outcomes.<sup>14</sup> Still, studies show that physicians from communities of color are more likely to practice in underserved areas and have a higher percentage of patients of color than their white counterparts.<sup>15</sup>

### **Supporting Community-led Solutions**

We truly do not have enough program models for integrated, evidence-informed, culturally relevant, and effective somatic and behavioral health services for people who are pregnant and who have given birth. Medicaid must support innovation and promote work that has already been implemented on the community level. Communities often create solutions out of necessity because larger systems, like Medicaid, ignore them. Their efforts should be elevated, evaluated, and incorporated into Medicaid payment as applicable. The agency can also encourage and provide resources for community-based organizations to innovate.

### **Building Capacity for Meaningful Measurement**

Finally, in advancing strategies to achieve equity, Medicaid will confront data collection and accuracy concerns. Some Electronic Health Records are not designed to collect and integrate maternal physical and behavioral health data, much less stratify it across race. Networks must be taught to accurately collect patient-directed information about race and ethnicity, instead of allowing for staff to guess or have patients self-identify.

## ***Moving Forward: The Urgency to Adopt Strategies for Maternal Health Equity***

This paper lays out the basic framework for identifying and addressing disparities in mental and behavioral health services in maternal health. Future reports could provide additional concrete solutions to some of the challenges of closing those gaps. They may also offer strategies from other health sectors or geographic areas that have begun to tackle health inequity using value-based arrangements.

The time to address such issues is now.

Rising maternal mortality rates among Black women and other people of color were in the news and

prompting federal attention before the coronavirus pandemic. Maternal health inequities have been complicated by COVID-19. The virus is disproportionately harming communities of color and has imposed unique behavioral health concerns on people nationwide. As this public health and economic crisis remains in the news, Medicaid leaders have a window of political will it can seize to propel meaningful action.

This opportunity is also urgent because, post-COVID, states will confront budget holes that will force all public systems to develop ways to deliver more cost-effective services.

Value-based payment arrangements are one tool that could help Medicaid meet this unique moment. If designed with an equity focus, this strategy could provide cost-effective care while also ensuring diverse populations—including Black, Native American, LGBTQ+, LatinX, Asian American, Native Hawaiian, Pacific Islander, and white women—have equitable outcomes. In driving equity forward, the system would truly serve its patients. CLASP seeks to work with forward-thinking Medicaid programs to build such an improved system.

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## Endnotes

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