Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC SUBMISSION

January 30, 2024

Office on Women's Health
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Suite 18E01
Rockville, MD 20857

Re: Solicitation for Public Comments on Questions from the Task Force on Maternal Mental Health

Dear Task Force on Maternal Mental Health,

Thank you for the opportunity to provide comments regarding maternal mental health including issues concerning the context, policies, effectiveness, promising practices, and limitations and gaps related to prevention and treatment of maternal mental health conditions and substance use disorders. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes through Medicaid and the Children's Health Insurance Program (CHIP).

Medicaid plays a vital role as the predominant payer of U.S. births and coverage source for low-income infants. Medicaid finances approximately 40% of births. Notably, national birth data from the Centers for Disease Control and Prevention show that more than two-thirds (64%) of Black mothers and more than half (58%) of Hispanic mothers had Medicaid coverage reported on birth certificates in 2021.[1] This means that Medicaid plays a particularly important role in reducing disparities in maternal[2] and infant health outcomes.

At the same time, untreated perinatal mental health challenges are among the leading causes and drivers of the U.S. maternal mortality crisis, which disproportionately affects

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[1] Centers for Disease Control and Prevention, "National Vital Statistics Reports," Vol, 72, No. 1 (January 2023), available at https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-01.pdf.

[2] With focus nationally and in states on "maternal" health, CCF uses the term "mother" herein to distinguish covered individuals following their pregnancy. We aim to use more inclusive terms when able in recognition that not all individuals who become pregnant and give birth identify as women. Georgetown CCF also uses the term "women" when referencing statute, regulations, research, or other data sources that use the term "women" to define or count people who are pregnant or give birth.

Black and Indigenous mothers.[3] Many such pregnancy-related deaths are preventable.[4] A survey of postpartum women and people in six states and New York City from January 2021 to March 2022 found that, compared to those with commercial insurance, Medicaid enrollees were less likely to have a usual source of care and use of care in the postpartum year.[5] Those in Medicaid experienced significantly higher rates of depression and anxiety symptoms, social risks (e.g., financial strain, food insecurity, intimate partner violence), and delays in getting needed care.[6] Untreated depression in parents is also associated with delays in cognitive and social-emotional development for children as early as infancy.[7] The cost of these untreated conditions is high.[8]

For mothers and babies, access to care across the continuum, from health promotion to screenings and treatment, is vital to ensure that no mother or infant falls through the

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[3] J. Beauregard et al., "Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019" (Centers for Disease Control and Prevention, September 2022), available at https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/datammrc.html#table4; Estriplet, T., Morgan, I., Davis, K., Crear Perry, J., & Matthews, K. Black, "Perinatal Mental Health: Prioritizing Maternal Mental Health to Optimize Infant Health and Wellness," Frontiers in Psychiatry 13 (April 2022), available at https://doi.org/10.3389/fpsyt.2022.807235; Hoyert, D. L., "Maternal mortality rates in the United States, 2021" (National Center for Health Statistics, Health E-Stats, March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternalmortality/ 2021/maternal-mortality-rates-2021.htm.

[4] Centers for Disease Control and Prevention (CDC), "State Strategies for Preventing Pregnancy-Related Deaths: A Guide for Moving Maternal Mortality Review Committee Data to Action" (Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, June 2022), available at https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-relateddeaths/state-strategies.html; J. Beauregard et al., "Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019" (Centers for Disease Control and Prevention, September 2022), available at https:// www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/datammrc.html#table4.

[5] Daw, J.R., Underhill, K., Liu, C., Allen, H.L., "The Health and Social Needs of Medicaid Beneficiaries In The Postpartum Year: Evidence From A Multistate Survey," Health Affairs 42, no. 11 (November 2023):1575-85, available at https://doi.org/10.1377/hlthaff.2023.00541.

[6] Bellerose, M., Collin, L., & Daw, J. R., "The ACA Medicaid Expansion and Perinatal Insurance, Health Care Use, And Health Outcomes: A Systematic Review," Health Affairs 41, no. 1 (January 2022):60-68, available at https://doi.org/10.1377/hlthaff.2021.01150.

[7] A. Rogers et al., "Association Between Maternal Perinatal Depression and Anxiety and Child and Adolescent Development: A Meta-analysis," JAMA Pediatrics 174, no. 11 (September 2020):1082-1092, available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2770120; Engelhard, C., Hishinuma, E., & Rehuher, D., "The impact of maternal depression on child mental health treatment and models for integrating care: a systematic review," Archives of Women's Mental Health 25, no. 6 (November 2022):1041–1065, available at https://doi.org/10.1007/s00737-022-01272-2.

[8] Brown, C. C., Adams, C. E., George, K. E., & Moore, J. E., "Mental Health Conditions Increase Severe Maternal Morbidity By 50 Percent and Cost $102 Million Yearly in The United States," Health Affairs 40, no. 10 (October 2021):1575–1584, available at https://doi.org/10.1377/hlthaff.2021.00759; Pollack, L. M., Chen, J., Cox, S., Luo, F., Robbins, C. L., Tevendale, H. D., Li, R., & Ko, J. Y., "Healthcare Utilization and Costs Associated with Perinatal Depression Among Medicaid Enrollees," American Journal of Preventive Medicine 62, no. 6 (February 2022):e333-e341, available at https://doi.org/10.1016/j.amepre.2021.12.008; Margiotta, C., Gao, J., O'Neil, S., Vohra, D., & Zivin, K., "The economic impact of untreated maternal mental health conditions in Texas," BMC Pregnancy and Childbirth 22, no. 1 (September 2022):700, available at https://doi.org/10.1186/s12884-022-05001-6.

cracks—prior to conception and continuing through the first year postpartum.[9] Effective mental health[10] interventions are available, yet challenges with workforce, finance, and socio-cultural issues impede access and progress.[11] Related concerns exist about the numbers of pregnant and birthing people who need substance use disorder interventions.[12] While states are making efforts to address perinatal substance use, they report challenges in using Medicaid financing.[13]

Accordingly, we encourage the Task Force on Maternal Mental Health ("Task Force") to examine the full array of tools available to advance maternal mental health and improvements and coordination for Federal activities, including with and within Medicaid and CHIP. Below are CCF's comments in response to the Task Force's request.

Improving Access, Parity, and Transparency

As noted in our recent comments[14] submitted in response to the Center for Medicaid and CHIP Services request for comments on process for assessing compliance with mental health parity and addiction equity in Medicaid and CHIP, the nation remains in a maternal mortality crisis with Medicaid (alongside CHIP) playing a key role in covering pregnant and postpartum individuals in whom mental health conditions remain a leading cause of pregnancy-related maternal mortality. Yet even though Medicaid serves as the primary financing mechanism for maternity care for low-income individuals in the U.S.

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[9] Admon, L. K., Zivin, K., & Kozhimannil, K. B., "Perinatal insurance coverage and behavioral health-related maternal mortality," International Review of Psychiatry (England) 33, no. 6 (June 2021):553–556, available at https://doi.org/10.1080/09540261.2021.1903843.

[10] Use of "mental" herein aims to be inclusive of the full range of mental health, substance use disorder and behavioral health interventions.

[11] O'Connor, E. et al., "Interventions to Prevent Perinatal Depression: A Systematic Evidence Review for the U.S. Preventive Services Task Force," (Rockville: Agency for Healthcare Research and Quality, February 2019), (Evidence Synthesis, No. 172.), available at https://www.ncbi.nlm.nih.gov/books/NBK537819/; Burak, E. W., & Wachino, V., "Promoting the Mental Health of Parents and Children by Strengthening Medicaid Support for Home Visiting," Psychiatric services 74, no. 9 (March 9, 2023):970–977, available at https://doi.org/10.1176/appi.ps.20220608; Hart, J., Crear-Perry, J., Stern, L., "US Sexual and Reproductive Health Policy: Which Frameworks Are Needed Now, and Next Steps Forward," American Journal of Public Health 112, no. S5 (May 2022):S518-22, available at https://doi.org/10.2105/AJPH.2022.306929.

[12] Choi, S., Stein, M. D., Raifman, J., Rosenbloom, D., & Clark, J. A., "Motherhood, pregnancy and gateways to intervene in substance use disorder," Health & social care in the community 30, no. 4 (August 2021):e1268–e1277, available at https://doi.org/10.1111/hsc.13534.

[13] Akbarali, S., Dronamraju, R., Simon, J., Echols, A., Collins, S., Kaeberle,B., & Chaudhry, A., "PromotingInnovation in State and Territorial Maternal and Child Health Policymaking," Maternal and Child Health Journal 27,no. Suppl 1 (October 2023):5–13, available at https://doi.org/10.1007/s10995-023-03779-1; Shepherd-Banigan, M., Domino, M. E., Wells, R., Rutledge, R., Hillemeier, M. M., & Van Houtven, C. H., "Do Maternity Care Coordination Services Encourage Use of Behavioral Health Treatment among Pregnant Women on Medicaid?," Women's Health Issues 27, no. 4 (July 2017):449–455, available at https://doi.org/10.1016/j.whi.2017.02.006.

[14] Georgetown Center for Children and families, "Re: Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP," (December 2023), available at https://ccf.georgetown.edu/wp-content/uploads/2023/12/CCF-comments_CMCS-Medicaid-and-CHIP-parity-request-for-comment_12042023.pdf.

and the majority of pregnant individuals are enrolled in Medicaid managed care, states vary considerably in the amount and type of information they make publicly available regarding the performance of Medicaid managed care plans on maternal health. According to a CCF review of 12 states, *none* of the states' Maternal Mortality Review Committee reports examined the role of individual Medicaid managed care plans in managing pregnant or postpartum enrollees.[15]

As noted throughout our response to the Medicaid/CHIP mental health parity request for comments, additional oversight is needed to ensure individuals covered by Medicaid and CHIP - including those at increased risk such as pregnant or postpartum individuals given their unique mental health needs - have timely access to high-quality and affordable mental health services. For example, we support many of the Administration's proposals to improve access to care in Medicaid and CHIP including in managed care such as proposed waiting time standards and requirements for conducting secret shopper surveys and enrollee experience surveys as included in "Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality; Proposed Rule" (CMS-2439-P).

As federal agencies work to advance network adequacy in Medicaid and CHIP, we also support requiring Medicaid managed care plans, alternative benefit plans and CHIP to conduct regular parity compliance analyses that mirror the requirements for individual marketplace and employer-based plans set forth in the Administration's recently proposed rule including requirements around assessing provider networks as a non-quantitative treatment limit (NQTL). Ensuring regular parity compliance analysis and assessing Medicaid and CHIP provider networks as an NQTL along with appropriate data collection and evaluation as part of Medicaid and CHIP parity efforts would advance the Administration's larger ongoing efforts to ensure sufficient access to needed services throughout Medicaid and CHIP.

We also encourage the Task Force to review and identify opportunities to improve prior authorization processes, including for maternal health services. Prior authorization is a time-consuming process that can burden providers, divert valuable resources away from direct care, and cause delays in access to needed services and treatment. According to a recent study by the Office of the Inspector General, individuals enrolled in Medicaid managed care may not be receiving necessary health services due to the high number and rates of denied prior authorization requests, limited oversight of prior authorization denials, and limited access to external medical reviews.[16] While we were disappointed

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[15] Schneider, A, et al., "Medicaid Managed Care, Maternal Mortality Review Committees, and Maternal Health: A 12-State Scan," Georgetown Center for Children and Families (October 2023), available at https://ccf.georgetown.edu/2023/10/16/medicaid-managed-care-maternal-mortality-review-committees-and-maternal-health-a-12-state-scan/.

[16] Department of Health and Human Services, Office of Inspector General, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care," OEI-09-19-00350 (July 2023), available at https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

that CCF's recommendations[17] to exempt maternity care services (including perinatal, labor and delivery, and postpartum services and prescription drugs) from prior authorization were not included in the recently released Advancing Interoperability and Improving Prior Authorization Process Final Rule, we encourage the Task Force to review CCF's comments on improving prior authorization when examining opportunities to support maternity and mental health care.

Supporting State Opportunities to Improve Maternal and Infant Mental Health

As part of CCF's work to support maternal and infant mental health, in October 2023 CCF convened a group of maternal and child health practitioners and Medicaid policy experts to help generate actionable steps states could take to support mental health for moms and babies during the postpartum year. CCF was honored to learn from some of the country's leading experts with a passion for improving maternal and child health and closing persistent health inequities based on race and ethnicity.

As a follow up to the convening, we released a final report on "State Medicaid Opportunities to Support Mental Health of Mothers and Babies During the 12-Month Postpartum Period".[18] Beginning with context on recent federal actions with implications for state work, the report makes recommendations for state Medicaid programs, accompanied by detailed action steps, including:

1. Enhancing Primary Care to Serve More Effectively as a Care Hub for Families
2. Monitoring and Rewarding Successful Connections to Timely Care
3. Financing and Removing Barriers to Appropriate Services
4. Supporting Expanded Workforce Capacity
5. Prioritizing Maternal Mental Health and Infant-Early Childhood Mental Health in Medicaid

Taken together, these recommendations hold the potential to accelerate use of best practices, advance equity, improve health outcomes for all Medicaid-financed births, and ensure the extended postpartum coverage period works as intended to improve the health and mental health of mothers and babies. We have included a copy of the report herein and encourage the Task Force to review the recommendations when examining

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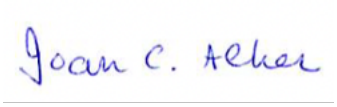
[17] Georgetown Center for Children and families, "Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program; Proposed Rule - CMS-0057-P," (December 13 2023), available at https://ccf.georgetown.edu/wp-content/uploads/2023/03/Georgetown-CCF-Prior-Auth-NPRM-Comment-03.13.2023.pdf.

[18] Burak, E.W., et al., "State Medicaid Opportunitites to Support Mental Health of Mothers and Babies During the 12-Month Pospartum Period" Georgetown Center for Children and Families (January 23, 2024), available at https://ccf.georgetown.edu/2024/01/23/state-medicaid-opportunities-to-support-mental-health-of-mothers-and-babies-during-the-12-month-postpartum-period/.

opportunities to advance maternal mental health including opportunities to better support state Medicaid programs advance mental health for moms and babies during the postpartum year.

We appreciate your efforts to improve maternal mental health and thank you for considering CCF's comments. If you need more information, please contact Anne Dwyer (Anne.Dwyer@georegetown.edu) or Elisabeth Wright Burak (Elisabeth.Burak@georgetown.edu).

Sincerely,



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State Medicaid Opportunities to Support Mental Health of Mothers and Babies During the 12-Month Postpartum Period

Summary

Most states have moved to adopt a new state option to extend Medicaid coverage to all enrolled pregnant people from 60 days to 12 months following a pregnancy. As the predominant payor of U.S. births and health care to postpartum people and young children, Medicaid is key to any effort to improve mental health among mothers and babies in the consequential year following a pregnancy.

This report recommends concrete steps state Medicaid agencies can take to address mental health among mothers and infants in the postpartum year highlighting recent federal actions with implications for state action. Recommendations were vetted, revised, and prioritized during an October 2023 meeting between Medicaid policy and maternal and child health practice experts hosted by Georgetown University Center for Children and Families (CCF) with a dedicated objective of advancing health equity at the community and state levels. Taken together, recommendations hold the potential to accelerate best practice, advance equity, improve health outcomes, and ensure the extended postpartum coverage period works as intended to improve the health and mental health of mothers* and their infants.

* With focus nationally and in states on "maternal" health, this paper uses the term "mother" to distinguish covered individuals following their pregnancy. We aim to use more inclusive terms when able in recognition that not all individuals who become pregnant and give birth identify as women. Georgetown CCF uses also the term "women" when referencing statute, regulations, research, or other data sources that use the term "women" to define or count people who are pregnant or give birth.

State recommendations, accompanied by detailed action steps, include:

1. Enhance Primary Care to Serve More Effectively as a Care Hub for Families
2. Monitor and Reward Successful Connections to Timely Care
3. Finance and Remove Barriers to Appropriate Services
4. Support Expanded Workforce Capacity
5. Prioritize Maternal Mental Health and Infant-Early Childhood Mental Health in Medicaid

Introduction

Medicaid has a vital role to play in ensuring that postpartum parents and their infants get the right care at the right time during a sensitive period of family change, maternal health, and early childhood development. Many federal and state officials want to address widespread concerns about the mental health of mothers with newborns and to increase access to and utilization of maternal and infant-early childhood mental health services. The relatively new state option to extend postpartum coverage for twelve months in Medicaid provides a unique chance for states to consider how the health system should be leveraged to ensure mental health, behavioral health, and substance use issues are identified and addressed as soon as possible to ensure postpartum parents, their infant, and the parent/child relationship are set up to thrive in the long term.

Untreated perinatal mental health challenges are among the leading causes and drivers of the U.S. maternal mortality crisis, which disproportionately affects Black and Indigenous mothers.[1,2,3] Many such pregnancy-related deaths are preventable.[4,5] A survey of postpartum people in six states and New York City from January 2021 to March 2022 found that, compared to those with commercial insurance, Medicaid beneficiaries were less likely to have a usual source of care and use of care in the postpartum year.[6] Those in Medicaid experienced significantly higher rates of depression and anxiety symptoms, social risks (e.g., financial strain, food insecurity, intimate partner violence), and delays in getting needed care.[7] Untreated depression in parents is also associated with delays in cognitive and social-emotional development for children as early as infancy.[8,9] The cost of these untreated conditions is high.[10,11,12]

For mothers and babies, access to care across the continuum, from health promotion to screenings and treatment, is vital to ensure that no mother or infant falls through the cracks—prior to conception and continuing through the first year postpartum.[13] Effective mental health* interventions are available, yet challenges with workforce, finance, and socio-cultural issues impede access and progress.[14,15,16] Related concerns exist about the numbers of pregnant and birthing people who need substance use disorder interventions.[17] While states are making efforts to address perinatal substance use, they report challenges in using Medicaid financing.[18,19]

Why Medicaid?

Medicaid covers about half of all children (including the majority of low-income infants and toddlers), pays for more than 40 percent of all births in the U.S. and is the single largest payer of behavioral health care, encompassing mental health and substance use treatment services. The program's role and reach is critical to both financing care and spurring needed health systems changes.[20] Studies of several states' early efforts to expand or extend Medicaid postpartum coverage point to the value of extended coverage in addressing mental health needs.[21, 22, 23, 24, 25, 26, 27, 28, 29] As of November 2023, all but four states have or are in the process of taking up a new state option to extend the postpartum Medicaid coverage period from 60 days to a full year—states have seized this opportunity with unprecedented speed.[30, 31] U.S Department of Health and Human Services (HHS) estimates that more than 720,000 additional women will gain coverage if all states adopt this option.[32] In total, Medicaid reaches as many as 2 million mother-infant pairs annually through enrollment of the infant, mother, or both.[33, 34] The large majority of postpartum women and infants in the U.S. are enrolled in Medicaid managed care organizations (MCOs).[35] These families and their providers must navigate care needs through the additional filter of managed care plan implementation of Medicaid requirements.

> *"States need to have a rigorous approach to capturing the impact of postpartum extension—using both quantitative and qualitative data to monitor implementation and outcomes."*
> *– Gretchen Hammer*

* Use of "mental" and "social emotional" health throughout this paper and during the October 2023 meeting discussion aimed to address the full range of mental health, substance use disorder and behavioral health interventions with the acknowledgement that more intentionality is necessary to fully integrate substance use treatment into these and related conversations.

With a large majority of postpartum mothers and infants enrolled in Medicaid managed care,[36] having clear and effective contract specifications is critical for ensuring that coverage achieves the triple aim of improving population health, improving individual outcomes, and reducing costs. Equally important is having transparency and accountability, including collection and reporting of data on maternal and infant health outcomes, by race and ethnicity.[37, 38]

The time is now to keep the spotlight on Medicaid's role in assuring the extended postpartum coverage works efficiently and effectively, fulfilling its potential to help improve maternal and infant outcomes. Intentional state policy development and program implementation, especially in Medicaid, can help to ensure that parents and infants get their mental health needs addressed promptly, appropriately, effectively, and without bias. More equitable and effective programs are one of the steps toward reducing the impact of historical and structural barriers to mental health care for mothers.[39, 40, 41, 42, 43, 44, 45, 46]

This paper recommends concrete steps state Medicaid agencies can take to address mental health among mothers and infants in the postpartum year. Collectively, they hold the potential to accelerate best practice, advance equity, and ensure the extended postpartum coverage period works as intended to improve the health and mental health of mothers and their infants. Recommendations were vetted, revised, and prioritized during an October 2023 meeting of Medicaid policy and maternal and child health practice experts with a dedicated objective of advancing health equity at the community and state levels. Participants included community-based mental health practitioners, OBGYNs, pediatricians, current and former state Medicaid agency leaders, public health leaders, and mental health and substance use disorder policy experts (see Appendix I for a full list of meeting participants and advisors). Recommendations reflect general group consensus on the Medicaid approaches based on meeting discussions and recommendation prioritization by perceived impact and feasibility. However, Georgetown CCF takes responsibility for the full list of recommendations and details presented here.

Recent Federal Actions Create New Opportunities for States

Recent bipartisan Congressional and Biden Administration efforts in Medicaid offer a number of opportunities for states to anchor and advance maternal and infant mental health.[47] Because these opportunities are sprinkled across many different pieces of legislation awareness may be low, and those working on Medicaid policy have been necessarily consumed by the unwinding of continuous coverage protections, more education is needed.

The new state option to extend the postpartum coverage period from 60 days to a full year following the end of a pregnancy in Medicaid and the Children's Health Insurance Program (CHIP) is an important foundation for recommendations in this brief.

Recent Federal Actions

- ☑ American Rescue Plan Act, 2021
- ☑ Bipartisan Safer Communities Act, 2022
- ☑ Consolidated Appropriations Act, 2023
- ☑ Recent CMS guidance
- ☑ CMS regulatory action

American Rescue Plan Act, 2021[48]

- **Extend postpartum coverage to 12 months** for pregnant women in Medicaid and CHIP following the end of pregnancy. Initially limited to five years, this option was made permanent under the bipartisan 2023 Consolidated Appropriations Act. The vast majority of states (47) have taken up or are working toward implementing the 12-month postpartum coverage period as of January 2024. The full year of coverage creates a unique opportunity for states to take steps to maximize the value and utility of Medicaid coverage in the year following birth, including needed changes to ensure Medicaid and its providers have the tools to effectively promote and address maternal and infant mental health.
- A new option for states to provide **qualifying community-based mobile crisis intervention services** for individuals covered by Medicaid while receiving enhanced federal funding for three years. To date, over a dozen states have received federal approval to take up the option, which sunsets in 2027, with additional states also expressing interest.[49, 50]

Bipartisan Safer Communities Act, 2022[51]

- A phased-in national expansion of the **Medicaid Certified Community Behavioral Health Clinic** (CCBHC) Demonstration. So far, fifteen states have received planning grants under the CCBHC expansion with ten states expected to be selected to participate in the demonstration this year. As part of CCBHC certification and expansion, states have the opportunity to ensure that these clinics can meet the specific needs of moms and babies including through close partnerships with community-partners.
- New oversight and guidance related to Medicaid's **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** benefit, or Medicaid's pediatric benefit for children up to age 21. EPSDT has long required that every child covered by Medicaid have access to recommended screenings, diagnoses and treatments designed to "prevent or ameliorate" a health condition, including mental health, before it becomes more costly or complex—especially key with the glaring unmet mental health needs among children.[52] Congress called on the Centers for Medicare & Medicaid Services (CMS) to review and report on state implementation of EPSDT. This creates a critical opportunity for states to review and improve implementation of this important benefit to ensure that children, including babies, are furnished with all coverable, appropriate and medically necessary services including prevention, screening, assessment, and treatment for mental health conditions.

Consolidated Appropriations Act, 2023[53]

- Bipartisan permanent extension of 12-month Medicaid and CHIP postpartum coverage option.
- Requirements for states and managed care plans to **provide up-to-date and accurate electronic Medicaid provider directories** by July 2025.
- A new federal interagency Task Force on Maternal Mental Health, including CMS, will be releasing an initial report next year and a national strategy on maternal mental health the following year with a focus on mental health equity and trauma-informed practices.[54]

Recent CMS guidance

This guidance holds great potential for states to advance mental health among infants and perinatal women, including:

- An August 2022 informational bulletin reaffirming that Medicaid's EPSDT benefit includes prevention, screening, assessment and treatment for mental health and listing strategies states can employ to improve access to mental health services for children and youth including early intervention and treatment.[55]
- Guidance related to leveraging Medicaid to support crisis hotlines like 988 and expanding the use of Medicaid to pay for interprofessional consultation.[56, 57]
- A Medicaid and CHIP Mental Health and Substance Use Disorder Action Plan focused on CMS actions to improve treatment and support of individuals covered by Medicaid and CHIP with mental health conditions or substance use disorder needs.[58]
- A postpartum toolkit for state agencies on increasing access, quality, and equity in postpartum care in Medicaid and CHIP.[59]

CMS regulatory action

These actions offers important opportunities to connect maternal and infant mental health with state oversight on care quality and access to care. These include:

- Finalizing a rule related to reporting of health care quality measures in Medicaid and CHIP including forthcoming mandatory reporting of the Child Core Set and the behavioral health measures of the Adult Core Set;
- Proposed rules to advance access to care more broadly including mental health care in Medicaid managed care and fee-for-service programs (with the final rule expected in the first half of 2024);[60] and
- Request for comment on assessing state and managed care plan compliance with Medicaid and CHIP mental health parity requirements. Such requests for comments usually give administrations ideas on new rulemaking or guidance.[61]

In December 2023, CMS announced a forthcoming innovation grant program, the Transforming Maternal Health Model, designed to focus on improving maternal health care for individuals enrolled in Medicaid and CHIP by supporting participating state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum that addresses the physical, mental health, and social needs experience during pregnancy. A Notice of Funding Opportunity to participate in the model is expected Spring 2024.

Together, these federal policy actions represent a renewed focus on both maternal and infant health and mental health, offering states new ideas or tools to advance mental health in Medicaid, both in implementing new requirements and exploring ideas or best practices highlighted in guidance. Whether leaders seek to take advantage of one or all of these federal priorities to make change, the specific and unique needs of moms and babies in the years surrounding a pregnancy should be explicitly addressed to prevent unintended consequences. For example, how are states ensuring mobile crisis intervention teams are prepared to support infants, spouses, or other family members witnessing or adjacent to a crisis? How will the family members be connected to needed care? Are states taking full advantage of support to postpartum mothers during well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures recommendations that most states use?

Guiding Principles for State Actions

Recommendations throughout seek to honor the following principles to ensure the diverse and varied strengths and needs of postpartum people, children and families are the ultimate drivers of policy change.

- ☑ **Acknowledge and respect** the varied and expressed needs of perinatal women, young children, and their families with an intentional health equity lens.
- ☑ **Seek to create shared expectations and knowledge** across families, providers, Medicaid managed care organizations (MCOs), and state systems regarding Medicaid's role and patient rights.
- ☑ **Create more transparency and accountability** for public dollars, namely in Medicaid managed care.
- ☑ **Build awareness across the health field** on the social-emotional-mental-behavioral health needs of perinatal people and young children. This includes developmentally appropriate and effective interventions that address the full continuum of care from prevention to treatment, and not limited to substance use disorder or severe mental health conditions.
- ☑ **Prioritize investments** in prevention and early intervention, driven predominantly by patient-driven needs and care quality.
- ☑ **Allow support** for both evidence-based and other best practices designed to address unique and varied family and community circumstances. This seeks to recognize that formal research studies often do not include some emerging approaches designed to better serve historically disadvantaged communities and families.
- ☑ **Support expanded workforce capacity** while acknowledging this is not a challenge Medicaid can solve in isolation, but should also not be an excuse for inaction. While Medicaid payment can do more, many other actors and funding sources are necessary for large-scale workforce development.

Recommendations for State Medicaid Agencies and Partners

All recommended steps, bulleted and bolded below, were rated by meeting participants as having both high impact and high feasibility with little variation in scores. The recommendations are categorized below based on pressing needs across the continuum of services from prevention to treatment, listed in order of potential impact, and finally feasibility by meeting participants.

1. Enhance Primary Care to Serve More Effectively as a Care Hub for Families

Advanced, team-based primary care offers opportunities to reach and more effectively serve families, including connecting them to needed follow-up care. Primary care practices (e.g., family physicians, obstetrician/gynecologists, pediatricians, nurse practitioners, or other providers) are the predominant place to conduct professionally-recommended universal screenings, including social-emotional-mental health for pregnant and postpartum women and/or their infants. CMS guidance and state payment policies have increasingly promoted and incentivized recommended screenings in primary care settings, such as maternal depression screens during pediatric well-child visits recommended by AAP,[62, 63] and by the U.S. Preventive Services Task Force (USPSTF) and Women's Preventive Services Initiative.

While a key step, the value of screening for social-emotional-mental health or substance use cannot be realized if the screening results are not used to make referrals for follow-up diagnostic assessment or needed interventions. Strong primary care should go well beyond screenings to ensure the oft-stated move to patient- and family-driven care.

> *"Screening for mental health can be inefficient if there is no system for care coordination afterwards. There is nowhere to refer people for services after screening and this is a disservice to the person and makes it difficult for the provider as well."*
>
> *– Joia Crear-Perry*

Medicaid payments for primary care lag behind private payers. While the rates can be inequitable, research indicates that across-the-board Medicaid rate increases may not in and of themselves increase access by either expanding the base of providers or propelling existing providers to serve more children and families enrolled in Medicaid.[64] Payment increases may be more effectively directed to also incentivize performance, quality, and adoption of best practices.

- **Provide enhanced payment for primary care providers seeking to integrate mental health and/or evidence-informed care models.** Much attention has been paid to integrating behavioral health into primary care practices from promotion to treatment.[65, 66] The unique developmental stages and experiences of perinatal women and young children should also be an explicit focus of such reforms. Enhanced primary care models can embed evidence-informed models designed to promote social-emotional-mental health and suitable for use in primary care (e.g., Incredible Years, Mothers and Babies, Reach Out and Reach, ROSE).[67, 68]
- **Provide enhanced payment for pediatric primary care providers that adopt a comprehensive team-based care approach to serve as a care "hub" for families and nurture the parent-child relationship.** Team-based pediatric primary care including community health workers (CHWs) and/or early childhood specialists as well as models that augment primary care (e.g., Healthy Steps, DULCE, PARENT models) offer an opportunity to more fully engage and support families during pediatric well-child visits, which are more frequent in the first year of life.[69, 70, 71]
- **Use payment and quality improvement policies to support postpartum standard of care.** In particular, states can incentivize and accelerate use of Maternal Safety Bundles from the Alliance for Maternal Health (AIM) focused on: 1) Community Care for Postpartum Safety which seeks to ensure that all women receive the care and support that they need to recover from birth, acclimate to motherhood and transition to well woman care; and 2) Community Care for Maternal Health and Wellness that seeks to ensure that all pregnant and postpartum women receive the care and support needed in responses to perinatal stress, trauma, anxiety, and depression.[72]

2. Monitor and Reward Successful Connections to Timely Care

Clear and effective direction to Medicaid managed care plans and providers, especially through contracts, is an important step to ensure coverage achieves the triple aim of improving population health, improving individual outcomes, and reducing costs. Equally important is greater transparency and accountability, including collection and reporting of data on maternal and infant health outcomes, disaggregated by race and ethnicity.[73]

- **Define and require clear, consistent expectations and processes across MCOs and providers to remove unnecessary barriers to care. Parents of infants, in particular, don't have time to waste waiting to receive needed care.** States can define and require consistency across managed care plans and providers on prior authorization and medical necessity policies and procedures so that all families and providers are equally informed and equitably treated. For example, many states are removing a child's mental health diagnosis as the sole prerequisite to access certain mental health treatment services, such as dyadic treatment. Instead, a state may use a broader set of risk factors to meet medical necessity criteria. Positive screenings indicating parent or child risks for mental health or substance use disorders, rather than a formal diagnosis, may also be used to authorize access postpartum mental health treatment and/or dyadic interventions for moms and babies together.
- **Implement cross-system communication mechanisms.** Numerous studies have documented both the importance of and the gaps in communication and linkages between primary care and other services such as mental health providers, home visiting, Part C Early Intervention, nutrition services, income support, housing assistance, and other services.[74] With most individuals covered by Medicaid receiving care through MCOs, Medicaid can and should include provisions in MCO contracts that clearly set expectations for cross-system communication and referrals to services through a human-centered experience. Encouraging closed-loop referrals is a widely recommended best practice.[75]
- **Measure Medicaid, MCO, and sub-group performance on referrals and follow-up care based on positive screens.** MCO performance related to access, including referrals and follow-up mental health care during pregnancy, postpartum and the child's first year, should be publicly available and disaggregated by region, race and other sub-groups that can help to identify areas for quality improvement (e.g., recommended screening for social-emotional-mental health in Bright Futures and USPSTF, prenatal depression screening/follow up and postpartum depression screening/follow up, measures released through the Healthcare Effectiveness Data and Information Set (HEDIS) in 2019).[76, 77, 78]
- **Monitor and report rates of recommended social-emotional-mental health screenings during pregnancy, postpartum and the child's first year.** Starting in 2024, state Medicaid agencies will be required to report on specific child and adult health care quality measures (specifically the full Child Core Set as well as the behavioral health measures of the Adult Core Set).[79, 80, 81, 82] While an important first step, measures on screenings for general development among children do not provide information to monitor use of recommended social-emotional-mental health screenings (e.g., for maternal depression or young child social-emotional development), completed referrals, or any follow-up care. States should monitor social-emotional-mental health screening rates during the pregnancy and postpartum periods (including those conducted during child's well-child visits) and publicly report performance at state, plan, and provider-levels to assess opportunities for improvement (e.g., HEDIS Measures available on prenatal depression screening and follow up and postpartum depression screening and follow up).[83, 84] Medicaid should also do more to track and report anxiety screening as recommended by the USPSTF, though the measure is not currently part of Medicaid's core set of adult health care quality measures.

3. Finance and Remove Barriers to Appropriate Services

Financing and implementation of Medicaid benefits is inconsistent across states. Federal law for Medicaid's EPSDT child health benefit requires that all "optional" services for adults be covered for children but implementation varies widely. A recent 50-state survey uncovered inconsistent adoption of infant-early childhood mental health (IECMH) services despite a strong policy and evidence base.[85] For pregnancy and the postpartum period, coverage of mental health services should be consistent, but implementation also varies.

"One can't pigeonhole people on options to care. You can't just say there is only one treatment resource—without having options to refer patients it can be an unethical situation for a provider to deal with." – Aasta Mehta

- **Reimburse evidence-based and practice-informed models of care to promote and improve social-emotional-mental health.** Medicaid does not pay for specific model programs, but can reimburse for eligible services within specific models that are provided for individuals enrolled in Medicaid. Some evidence-informed models can be embedded in primary care (e.g., Reach Out and Reach, ROSE). Other models are designed to be delivered in home settings and/or to be used in tandem with home visiting models (e.g., Moving Beyond Depression, Mothers and Babies). Federal rules generally offer a fair amount of flexibility in location of service delivery, whether that be in a primary care setting or at home. Specific services (e.g. screening) within many evidence-informed models could be financed by Medicaid.
- **Support use of age-appropriate diagnostic processes.** Medicaid agencies in 15 states require or recommend use of the DC: 0-5 (or DC:0-3R), a developmentally-based diagnostic system for infants and young children.[86] This is an approach to making codes available that more specifically relate to young children's needs and conditions. In addition, most states cover multiple visits for diagnostic assessment, with 20 states allowing payment for as many as needed for young children. Importantly, even as states are removing a child diagnosis in some circumstances, the DC:0-5 system ensures mental health practitioners, providers and their partners have the appropriate tools to assess and target appropriate services to young children based on observations of a child's family and community, even if mental health challenges do not rise to the level of a child diagnosis. Using a research- and practice-based tool also helps to deepen the knowledge of the mental health and early childhood workforce on the ways mental health challenges present in young children, which includes attention and support to the parent-child relationship.
- **Reimburse for parent-child "dyadic" family therapy.** Research has demonstrated the effectiveness of providing treatment and interventions for parents together with their infants/young children in reducing mental health and behavioral difficulties. Evidence-based models of parent-child dyadic treatment include Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and Attachment Biobehavioral Catch-Up (ABC).[87, 88, 89] Medicaid agencies in at least eight states report that Medicaid does not pay for dyadic treatment/family therapy for children under age six.[90]
- **Reinforce Medicaid responsibilities to reimburse for mother's individual mental health treatment.** In every state, Medicaid financing should be available for eligible services and treatment, including prescription drug coverage, of perinatal mental health conditions (e.g., depression, anxiety) and substance use disorders. However, to be effective in increasing access to treatment of maternal mental health conditions, such as mood disorders in the postpartum period, states may need to redesign payment and managed care contract approaches to incent or explicitly clarify coverage for treatment. For example, in states where Medicaid uses a separate mental health or substance use disorder managed care entity, contract provisions should specify coverage of and access to treatment. Medicaid should actively review, develop, or enhance payment approaches for such services.

- **Enhance use of case management.** To be effective in meeting the needs of families during the postpartum year, states may need to develop new case management approaches. Federal Medicaid statue and regulations uses the term "case management."[91] At the same time, states can clarify how case management should be defined, delivered, and structured for this population to address families' expressed needs and to strengthen connections to needed services. Notably, case management is a required and covered service under Medicaid's child health benefit (EPSDT) for children yet states vary in the processes and parameters used to guide the benefit.[92] In addition, many states have perinatal case management programs specifically designed for Medicaid-enrolled pregnant and postpartum people. Although some sources distinguish between the two terms, in practice case management and care coordination are often used interchangeably and vary depending on the provider, program or payor. Both terms generally describe an array of activities that help to link families to services, avoid duplication of effort, and improve communications between families and providers.
- **Remove administrative barriers that can inhibit access.** Some states have removed barriers such as prior authorization or diagnosis requirements, which impede maternal, infant, and early childhood mental health services at a sensitive period of family life. Similarly, to make dyadic, family therapy or integrated behavioral health accessible, Medicaid may need to remove certain barriers such as limits on same-day billing, create standing preventive services recommendations (e.g. as for doula services in Michigan and California), and/or modify contracts with managed care and similar organizations to exempt certain types of services from additional layers of approval.[93, 94] For example, Georgetown CCF comments on proposed prior authorization rules recommend federal Medicaid officials add exemptions related to maternity care and EPSDT services from this additional barrier to care.[95] Regardless of the final federal rule, states already have the ability to remove prior authorization requirements for certain services or populations and should prioritize mothers and infants as part of efforts to remove red tape barriers to care.
- **Allow certain mental health treatment services without a diagnosis based on a broader set of risk factors.** Requiring a diagnosis to access treatment can limit access to interventions that may prevent a diagnosis in the first place. For example, Medicaid agencies in fourteen states report that a mental health diagnosis is not required for coverage of parent-child dyadic treatment, with some states using family or child risk factors such as being in foster care or having a parent with depression in lieu of a child mental health diagnosis (e.g. California).

4. Support Expanded Workforce Capacity

All types of providers—physicians, psychiatrists, psychologists, nurses, social workers, CHWs, doulas, peer support workers and other practitioners who serve young children need the right tools to promote and support mental health in various settings and circumstances. While Medicaid payment can do more to recognize and support the full range of possible providers, additional actors and funding sources are necessary for large-scale workforce development.

- **Finance services provided by the community-based workforce.** A small but growing number of states are allowing Medicaid to reimburse new community-based providers types such as CHWs (29) and doulas (10 states) to provide prevention, navigation and support services to parents with new babies. Research shows that their work can reduce family stress and support maternal and infant mental health and well-being.[96, 97, 98, 99,100] Notably, while CHWs could play this role in any state, many have been deployed primarily to work with adults with disabilities and seniors in need of community-based services. A reported 40 states also use Medicaid to fund peer support for adults related to behavioral health, and maternal mental health leaders are promoting expansion of certified peer support programs to provide additional training on maternal mental health and substance use disorders.[101] Appropriate Medicaid financing support, alongside direct workforce engagement, can grow the number of community-based providers available and deployed to serve families during the time-sensitive period surrounding a pregnancy and the postpartum year.[102,103]

"Community-based models can help to provide comprehensive services, including wrap-around services such as group-parenting and peer support."
– Kimá Joy Taylor

"The current workforce needs to be flipped (top-down to bottom-up) because doulas and community health workers are the ones that will communicate and connect with the folks that need services." - Kay Matthews

- **Expand the range of mental health providers who can bill Medicaid.** In many states, Medicaid and its contractors have traditionally included a fairly narrow range of mental health providers as eligible for reimbursement. A wider array of providers might be approved to deliver family (dyadic) therapy for parent and infant together or mental health services for parents individually. This includes but is not limited to: clinical social workers, psychologists, psychiatric nurse practitioners, and psychiatrists. These practitioners might be independently licensed or credentialed mental health service providers or working under the supervision of a licensed mental health service provider. They may work in an independent practice, a publicly funded mental health clinic, in-home, or as part of an integrated mental health approach in primary care. Medicaid can work closely with state credentialing and licensing agencies to ensure policies are aligned to recognize the breadth of possible mental health providers available for Medicaid reimbursement.
- **Reimburse for interprofessional consultation**. A consultation provided by a mental health professional to another provider (e.g., pediatric primary care) can help that provider appropriately respond to the mental health needs of an infant or young child and their parents. Recent CMS guidance highlights the benefits of child-specific interprofessional consultation to help pediatricians and other providers secure diagnostic assessment and other services for children with mental health needs.[104] Medicaid programs may now also reimburse consulting providers directly. Medicaid agencies in 10 states cover this service for IECMH using a variety of billing codes.[105]

- **Support provider training and technical assistance financed as administrative cost in Medicaid.** CMS has stated that provider training provided by the Medicaid agency or its contracted designee regarding the scope or the benefits of Medicaid covered services, or that is aimed at improving the delivery of Medicaid services, is reimbursable as a Medicaid administrative expenditure. This is often called "administrative claiming" by Medicaid. This could include, for example, training for case managers, individuals who develop and coordinate person-centered care planning, primary care practitioners, or hospital discharge planners. Notably, costs incurred by the providers to meet continuing education and advanced training requirements cannot be claimed as a Medicaid administrative expenditure. In other words, these funds could help providers learn how to bill, support eligibility processes, provide care coordination and navigation but not their professional education. This may be helpful to community-based organizations who are beginning to bill Medicaid and could benefit from educational opportunities around navigating billing and payment systems.

5. Prioritize Maternal Mental Health and Infant-Early Childhood Mental Health in Medicaid

State administration and agency leaders can do more to prioritize the unique mental health needs of postpartum women and infants during a rapid time of change.

- **Create an explicit focus on maternal mental health and IECMH in major delivery system or managed care reforms.** State payment or delivery system reforms should prioritize maternal and early childhood mental health. One key step is to proactively seek guidance from perinatal mental health and infant-early childhood mental health providers and the lived experience of families and communities impacted early in the reform process, well before major systems changes are proposed or finalized. For example, state should seek such input on MCO contract expectations or state efforts to expand or certify new CCBHCs. This can help to ensure that large-scale changes designed around the acute or chronic needs of adults are in balance with the unique and time-sensitive, developmental needs of perinatal people and young children.
- **Use managed care contracts to direct payment toward desired outcomes.** In addition to clear reporting metrics, states can create additional clarity and accountability in managed care. Contracts and any authorizing state policies should clarify MCO responsibilities to ensure families are aware of their rights, responsibilities and benefits, streamline access to care, and remove unnecessary barriers to services. States may require plans to establish performance improvement plans (PIPs) or priority projects around maternal mental health and early childhood mental health. They can also set payment parameters or incentives for new services (e.g. incentivizing or requiring plans to directly contract with community-based providers, such as doulas or CHWs.
- **Dedicate Medicaid agency capacity to support maternal health and IECMH.** States with ongoing and active initiatives and investments for perinatal women and young children in Medicaid, such as Washington State, dedicate staff positions to overseeing financing and delivery system mechanisms to support and improve maternal and infant-early childhood mental health. Ideally, such dedicated staff capacity should be publicly and sustainably funded; however, some states have launched efforts with philanthropic funds to create new capacity within the agency.
- **Create state-level interagency decision-making groups that share accountability for collective impact.** The new federal Task Force on Maternal Mental Health offers a model for similar state-level collaboration and accountability. Such groups, whether ad hoc or ongoing task forces, are only effective if the right systems and actors are represented, engaged, and accountable.[106] Too often Medicaid is not an active player (e.g., Maternal Mortality Review Committees, early childhood system groups).[107] Federal grant programs, such as the HHS Early Childhood Comprehensive Systems grants, have potential to fund such state-level cross-system work.

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The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based at the McCourt School of Public Policy.

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Appendix 1: Meeting Attendees*

Name	Title	Organization
Jim Bialick	Senior Policy and Advocacy Officer	Perigee Fund
Elisabeth Wright Burak	Senior Fellow	Georgetown University Center for Children and Families
Joy Burkhard	Founder and Executive Director	Policy Center for Maternal Mental Health
Christine ColeInfant	Early Childhood Mental Health Program Manager	Washington State Health Care Authority
Joia Crear-Perry	OB/GYN, Founder and President	National Birth Equity Collaborative
Anne Dwyer	Associate Research Professor	Georgetown University Center for Children and Families
Anna Lipton Galbraith	Director, Maternal and Family Health	National Academy for State Health Policy
Gretchen Hammer	Founder, Public Leadership Group	Public Leadership Group
Kay Johnson	Founder and President	Johnson Policy Consulting, Inc.
Elizabeth Krause	Director of Programs	Perigee Fund
Kay Matthews	Founder and Executive Director	Shades of Blue Project
Aasta Mehta	OB/GYN, Medical Officer of Women's Health	Philadelphia Department of Public Health
Mariel Mendez	Program Officer	Perigee Fund
Tanesha Mondestin	Research Associate	Georgetown University Center for Children and Families
Andrea Palmer	Program Officer	Pritzker Children's Initiative
Kimá Joy Taylor	Pediatrician, Managing Principal	Anka Consulting, LLC
Beth Tinker	Clinical Nurse Consultant	Washington State Health Care Authority
David Willis	Pediatrician, Senior Fellow	Center for the Study of Social Policy

*Rhea Boyd, pediatrician and child health advocate with the California Children's Trust, also provided feedback on recommendations in a separate meeting with CCF authors.

Appendix II – Select Resources for More Information

From Georgetown University Center for Children and Families

Opportunities to Support Maternal and Child Health Through Medicaid's Postpartum Coverage Extension (July 2022)

State Trends to Leverage Medicaid Extended Postpartum Coverage Benefits and Payment Policies to Improve Maternal Health (March 2023)

Opportunities to Leverage Medicaid and CHIP to Improve Maternal Health and Eliminate Racial Inequities (April 2023)

Medicaid Policies to Help Young Children Access Infant-Early Childhood Mental Health Services: Results from a 50-State Survey (June 2023)

Where Things Stand on the Medicaid and CHIP Provisions of the Bipartisan Safer Communities Act (August 2023)

Medicaid Support for Infant and Early Childhood Mental Health: Lessons from Five States (September 2023)

Medicaid Managed Care, Maternal Mortality Review Committees, and Maternal Health: A 13-State Scan (October 2023)

Partner Resources/Tools

Optimizing Postpartum Coverage Extension (National Academy for State Health Policy, 2023)

2023 Maternal Mental Health State Report Cards (Policy Center for Maternal Mental Health)

Innovation in Perinatal and Child Health in Medicaid (Institute for Medicaid Innovation, 2023)

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