WEBVTT

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Anne Dwyer: Welcome everyone to today's webinar on State Medicaid opportunities to support mental health of mothers and babies during the 12 month postpartum period.

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Anne Dwyer: I'm Anne Dwyer, and today's Moderator, and an associate research professor at the Georgetown Center for Children and families at the Mccourt School of public policy.

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Anne Dwyer: For those of you not familiar with Ccf, we are a nonpartisan policy and research center.

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Anne Dwyer: with admission to support access to high quality, comprehensive and affordable health coverage for children and families with a particular focus on examining policy development and implementation efforts, as it relates to Medicaid and the Children's Health Insurance Program, also known as Chip.

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Anne Dwyer: and when it comes to Medicaid and Chip, we've seen some really incredible progress over the last few years when it comes to coverage during the postpartum period, with all but 4 States taking action to pick up the option, to extend postpartum coverage through the 12 month period.

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Anne Dwyer: However, we also know it's critically important to make sure this coverage is working for individuals on the ground. And this is what we will be digging into during today's webinar with a focus on our recent report on supporting the mental health of mothers and babies during the 12 month postpartum period.

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Anne Dwyer: But before we get started a few notes on logistics, this webinar is being recorded and the recording and slides will be made available on the Ccf website.

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Anne Dwyer: We also have a. QA function. So if you have questions. Please put those questions in the Q. And A, we will try and get to them today time allowing or follow up as needed. We will instead be using the chat function to provide links to different materials referenced during today's webinar. So keep an eye out on those in the the chat box, a few of which I think may already be in there.

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Anne Dwyer: Next slide, please.

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Anne Dwyer: for today's webinar. We will first be hearing some brief opening remarks from Jim fiallick from the Perigie Fund. This project was made possible by the perigee Fund support. So thank you so very much. We will then move on to an overview of the report and recommendations followed by an expert panel comprised of attendees from our meeting this fall focused on maternal and infant mental health during the 12 month postpartum period. With that, Jim. I'll pass it on to you.

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Jim Bialick: Thanks so much, and thanks everybody for being here. I've my name is Jim B. Alec, I'm the senior

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Jim Bialick: policy and advocacy officer for the parent G fund based in Seattle, Washington.

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Jim Bialick: I wanna start out just by highlighting the importance of this work, and why we were so excited to be a part of it, not only because of the timeliness and the importance of the work itself, but also the amount of attention and action that it's already driven

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Jim Bialick: with the times as they are, which are tumultuous, to say the least, and politically uncertain, to say even less.

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Jim Bialick: the mental and physical challenges of new birthing parents, and the way that that experience impacts them and their families. That's not a partisan issue.

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Jim Bialick: and with few grand bargains on the horizon, and there are still so many families that are in need right now. So the 12 month postpart of Medicaid expansion is essentially

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Jim Bialick: essential to permanently democratizing access to this kind of care in this country. And so that's why we're so excited to have a report like this where we're starting to see not only information about what's happening, but opportunities for action.

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Jim Bialick: But I say that because there's a lot of reporting around this expansion but what Georgetown's been able to produce is more than just. weather report of the way things are going. The findings of this publication include some actual recommendations that aren't only timely, but allow for States to be innovative. And the way they design and execute their programs.

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Jim Bialick: And so

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Jim Bialick: I point that out, because, with the diversity of approaches that are going to come that come from the States to best address their populations and their and their specific needs.

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It also raises a

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Jim Bialick: big challenge and a big opportunity for increases in communication and shared learning. And so, as a both a Funder and as an advocate in this space. That's something I

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Jim Bialick: really look forward to seeing more of, and look forward to seeing the work that is ahead of us and joining a good other great great partners like George found in you all in that work. So I wanna thank you so much again for being here. And we're so excited to hear the conversation today.

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Jim Bialick: Thanks, and I'll get back to you.

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Anne Dwyer: Great. Thank you so much, Jim. And for the remarks. So today's featured speakers and panelists include my Ccf. Colleagues, Tanisha Mandestin and Elizabeth Wright Barack, along with 4 health policy experts and practitioners, including Kay Matthews, founder and executive Director of the Shades of Blue Project.

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Anne Dwyer: Joya, Career, Perry and OB. Gin and founder and president of the national birth, equity, collaborative.

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Anne Dwyer: Kima Joy Taylor, a pediatrician and founder of Anka, consulting, and Gretchen Hammer, a former State Medicaid, director and founder of the Public Leadership Group. More information, including links to our Speaker speaker, Bios can again be found in the chat.

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00:05:24.450 --> 00:05:30.469
Anne Dwyer: So with that, let's dig in now I will turn it over to my colleague, Tanisha Montesin. Tanisha, take it away.

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Tanesha Mondestin: Thanks, Anne. So next slide, please.

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Tanesha Mondestin: So first we're gonna kick off with. Why, the did we even do this project? So this project is important for several reasons. Yes, most States have implemented the postpartum extension option. But that simply isn't enough. That's a first step. But we need to think about efficient implementation.

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Tanesha Mondestin: We also know through research that untreated mental health and substance use disorders are one of the top drivers of the maternal mortality crisis in the United States, and black and indigenous mothers are disproportionately affected.

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Tanesha Mondestin: Efficient implementation is also important, because individuals with medicaid coverage are less likely to have a usual source of care, so they may not have a health provider or mental health provider that they see regularly. So use of care is also less likely in the postpartum year.

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00:06:30.830 --> 00:06:39.539
Tanesha Mondestin: Individuals enrolled in Medicaid experience, higher rates of depression, anxiety, social risk, and delays in getting care.

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Tanesha Mondestin: untreated depression in parents is associated with delays in cognitive social emotional development for children as early as infancy, so the costs of leaving these conditions untreated is high, and many of these conditions are preventable

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Tanesha Mondestin: by improving quality and access to maternal and infant mental health coverage for women and their children. During the 12 month postpartum period

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Tanesha Mondestin: Medicaid can contribute to the overall wellbeing and public health of the economically and socially marginalized women, children, and families that it serves.

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Tanesha Mondestin: Next slide, please.

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Tanesha Mondestin: Why medicaid

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Tanesha Mondestin: the relatively new state option to extend postpartum coverage for 12 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. Medicaid is the largest pair of births in the United States, covering over 40% of births

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Tanesha Mondestin: in the Us. And even half of all births. In some States

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Tanesha Mondestin: there are higher rates among black and American, Indian and Alaskan native individuals. Medicaid also covers about half of all children in the majority of low income infants and toddlers

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Tanesha Mondestin: with Medicaid being the largest payer of behavioral health care, including mental health and substance use treatment services, and this is important to ensure that postpartum parents, their infants in the parent child, diotic relationship are set up to thrive in the long term

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Tanesha Mondestin: next slide, please.

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Tanesha Mondestin: So this project would not have been possible without the expert feedback and input from a wonderful meeting. Attendees.

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Tanesha Mondestin: 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.

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Tanesha Mondestin: Participants included our perigee funders, maternal mental health experts, state public health agency representatives, Obgi's pediatricians, health policy experts and substance use disorder policy experts

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Tanesha Mondestin: in the report. You can look at Appendix once to see a full list of meeting participants and advisors.

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Tanesha Mondestin: Recommendations reflect general group consensus on the Medicaid approaches based on meeting discussions and

recommendation prioritization. And we will see more of these recommendations later on. During the Webinar next slide, please.

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Tanesha Mondestin: guiding principles during

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Tanesha Mondestin: during the discussion of Medicaid actions at the meeting, participants adhere to a set of guiding principles. These principles sought to ensure the diverse and varied strengths and needs of postpartum people, children, and families. As the ultimate drivers of policy change.

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Tanesha Mondestin: We especially aim to ensure these principles kept the group focus on actionable steps through the lens of health equity.

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Tanesha Mondestin: Other themes from these principles were improved transparency, and the understanding that while States should take steps to expand, workforce capacity medicated alone cannot solve the workforce workforce challenges. Now I'll turn it over to my colleague, Elizabeth.

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Elisabeth W Burak: Thank you. Tanisha and Nancy will go on to the next slide.

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Elisabeth W Burak: So in the report, the first thing we did is really lay out some of the federal activities happening that may have an impact on mental health, maternal health or infant health.

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Elisabeth W Burak: Lots of Congressional and Administrative agency actions, as you can read more about in the paper.

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Elisabeth W Burak: Nick, we wanted to show the many ways that the attention on mental health can, and the needs of postpartum mothers and young children might come into play. And really, this is to say, we we know it's important that all the broad scale help mental health

and substance use disorder. Initiatives explicitly include include attention on the unique needs of pregnant and postpartum people and young children.

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Elisabeth W Burak: And similarly, when we have large-scale maternal health and early childhood health initiatives, we need to make sure that the mental health folks are at the table and thinking about the mental health needs

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00:11:11.350 --> 00:11:33.350
Elisabeth W Burak: whether it's the review of Epst and and pediatric benefits that see a messaging right now, or the new transforming maternal health model that seem am eyes Medicaids Innovation Center at the Federal level will be releasing Rfps for state money. Later this year, we wanna make sure we have this particularly this postpartum year in mind, because it's a rapid

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00:11:33.360 --> 00:11:41.899
Elisabeth W Burak: period of family growth. Postpartum changes in early developmental needs that are just going to look different than your average adult and healthcare system.

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Elisabeth W Burak: Next slide, please.

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Elisabeth W Burak: So

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Elisabeth W Burak: at first I just want to know. And you've heard from Tanisha and Ann, who are 2 of the report co-authors with all this input from these really impressive and helpful experts. And I just want to also note that Kay Johnson, from Johnson policy consulting, was a partner and also a coauthor on this report, and we really benefited from her expertise as well.

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Elisabeth W Burak: first of all, on housekeeping. I just want to note that

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Elisabeth W Burak: When we use the term maternal health, we are inclusive, and understand that there are a lot of folks, pregnant people and postpartum people that don't necessarily identify as women. I think we are trying to a lot of the terminology right now, and the Federal initiatives are around maternal health or pregnant women. So we use that. But we need to be more inclusive. And similarly, when we use the terms mental health or behavioral health, we also mean to be inclusive of substance, use disorder services, even if we don't explicitly say it

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Elisabeth W Burak: and finally, we really wanted these recommendations to be around. How can States make sure Medicaid is working the way it should in these 12 months, postpartum

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Elisabeth W Burak: rather than just extending a benefit. And and you know, what can Medicaids use its levers for? But I would be remiss if I didn't say that the for the 10 States that have an expanded Medicaid. That one of the biggest first steps you can do is making sure coverage is available for all women before, during and after a pregnancy. And the research is really increasingly there. But having said that.

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Elisabeth W Burak: we're gonna move on to what we want the system to look like for folks. So these themes, we really put a lot of specific recommendations in terms of these themes, and that

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Elisabeth W Burak: these broad buckets were really to ensure that readers don't feel limited by the examples in the report. We are all still learning and what might be an effective strategy in one state might be a different kind of solution or idea in another. So we hope that we will be able to continue this conversation with all of you moving forward, as you are able to identify ways that you can advance care during the postpartum period.

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Elisabeth W Burak: But it's also important to note that

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Elisabeth W Burak: also due to a lot of variability and flexibility in states, a lot of the examples. And I can't think of an example we

don't. That does this. All the examples we point to really don't necessarily require Federal permission through an 1115 waiver. Some cases might not even require a State plan. Amendment.

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Elisabeth W Burak: of course, depending on how changes are structured and what the landscape of the State is. So.

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Elisabeth W Burak: as we go through each of these, my colleagues from Ccf will be putting in more information if something resonates. But we hope you're not limited. By the examples we're providing next slide.

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Elisabeth W Burak: So the first is around primary care. I mean, we really organize these buckets to think about what is the full range of services and supports from from prevention all the way to treatment that that moms and babies really need during this first year.

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Elisabeth W Burak: In the first place, we started with primary care. How can we use Medicaid payment policy to make sure that primary care is doing what it should and reaching its potential

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Elisabeth W Burak: for moms and babies. This could be, however, you define a primary care, obgyn family practice doctors. The pediatrician is often a place where folks are trying to reach.

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00:15:02.180 --> 00:15:31.050
Elisabeth W Burak: Moms as well and make sure they get connected to care, and States are increasingly looking at. How can we pay more for that primary care to serve as a hub? I know in Massachusetts they're using their managed care contracts to pay more for primary care that needs certain requirements, including pediatric primary care. In California. They're paying now for preventive primary care that includes mental health, like the healthy steps, model and models that have team based care within early childhood specialists to support families.

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Elisabeth W Burak: basically, you know, it's paying for what works. And I think what we really learned from this set of actors especially.

Not only can you use payment, you can also use quality improvement

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Elisabeth W Burak: levers in Medicaid to support. Certainly these models you mentioned for pediatric or primary care, but the alliance for innovation on maternal health has come out with a number of bundles, for what maternity care should look like and post pre pregnancy and postpartum care should look like.

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Elisabeth W Burak: including specific bundles on postpartum care and mental health, and so States could tie their payment and quality initiatives to those aim bundles that have been widely endorsed by any number of organizations, including a cog Ap. And many other.

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Elisabeth W Burak: We're we're many other organizations next slide.

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Elisabeth W Burak: So our second recommendation,

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Elisabeth W Burak: is again around payment and oversight.

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Elisabeth W Burak: And this is around monitoring and rewarding successful connections to care right? The Id. We had a long discussion in our groups about. We need to make sure we're not just screening, but we need to make sure that when there's a screening that indicates there's a problem. How are we making sure that those moms, postpartum moms and babies are getting care and the treatment that they need.

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00:16:47.670 --> 00:17:14.229
Elisabeth W Burak: And one of the things that we highlighted is making sure we specify what it is that state Medicaid agencies want. What is it? What are the clear, consistent expectations of of managed care plans? I should note the majority of pregnant women and kids in this country, and most women and most kids in most States are in managed care arrangements, or the State Medicaid Agency is contracting with private plans to furnish the care for

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00:17:14.579 --> 00:17:16.609

Elisabeth W Burak: pregnant women and kids.

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Elisabeth W Burak: And when that extra layer is there for families who are just feeling this like a plan, then the State needs to be very clear about what their expectations are to find what it is, and then measure it.

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Elisabeth W Burak: And this is consistent across all of our our recommendations, but the idea that we need a lot more transparency and accountability in our managed care systems. I know at least one state that quarterly the Medicaid staff meet with all of the heads of the plans and look at, for example, developmental screening rates for kids, or look at maternal depression screening and say, how many of those

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Elisabeth W Burak: folks that had positive screens got something as a result of that. And that's one way of doing it. Another way of doing it is we've talked about in other reports is some transparency around data.

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Elisabeth W Burak: And and we we keep coming back to this theme because we have my colleagues did another report around maternal health and managed care. After reviewing 12 States, and only in 3 of those States could we even find out how many pregnant women in Medicaid were enrolled by plan. Only 2 of those 12 States actually disaggregated that by race and ethnicity. And that's not to say anything more about the outcomes and what that kind of healthcare those women were getting.

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Elisabeth W Burak: So I think there's a lot to do here to to really provide some oversight or plans.

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Elisabeth W Burak: But

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Elisabeth W Burak: we put under this bucket because I think we also overall. We need that oversight and transparency. But specifically,

what does this handoff look like? How do we make sure these connections are happening

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Elisabeth W Burak: the next slide.

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Elisabeth W Burak: So the third recommendation is around Services number one funding the right services during this time. Period. For moms and babies, and number 2 removing any barriers to those services. So my colleagues again will put in the chat. We've done some surveys of State medica agencies and infant early childhood mental health services.

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Elisabeth W Burak: That you can look to in terms of certain mental health services that particularly services that serve the mom, the parent child diad for example, with dyadic therapy, at least 8 States don't reimburse for that, or it said they don't reimburse for that, and there might be others.

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Elisabeth W Burak: But it's also not just making sure that there aren't barriers to these services. So one example we often use is prior authorization. A lot of States use prior authorization as sort of a gatekeeper for utilization and and managed care.

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Elisabeth W Burak: I know new Federal rules have put some very clear timelines that States will need to adhere to, to make sure those prior authorization decisions are made and a timely matter for families. But States can go further than that. And for for when it comes to kids, and when it comes to pregnant women, we would argue, especially this time sensitive period. Do we need to have prior authorization when it already could be an additional time barrier for moms and kids getting the care they need in that 12 month period

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Elisabeth W Burak: next slide.

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Elisabeth W Burak: So, as you can imagine, workforce was a hot topic of conversation. And and as Tanisha noted and we we had a lot of we we

noted in our discussions.

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Elisabeth W Burak: you know Medicaid cannot do everything there is to do for work for us. It's it's one. It's an important player, but not the only player.

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Elisabeth W Burak: But we do need to recognize that there are things it should be doing.

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Elisabeth W Burak: So I think one of the most popular and and one of the pieces, particularly from health equity, perspective that we wanted to lift up was this idea of Medicaid doing more to spur a community-based workforce

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Elisabeth W Burak: that when we think about Doulas, when we think about community health workers or peer supports, more and more states are looking for those for to fund and allow those different. So community-based workers to do preventive services.

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00:21:01.920 --> 00:21:07.829
Elisabeth W Burak: And so there's a lot of excitement for that momentum that's been growing. But we also want to make sure

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Elisabeth W Burak: in doing that, that we've got that they have these different kinds of workforce have the ability to help meet the needs of postpartum women and children and their mental health. How do we use these community based workers as trusted members of the community to help bring in frankly the communities that the health system has marginalized or often left out?

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Elisabeth W Burak: Over the years. How do we help use these community health workers or others to build trust back in with those systems.

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00:21:34.770 --> 00:21:41.389
Elisabeth W Burak: And so I think, you know, there's a lot to say with there in terms of implementing these kind of benefits. But I think

there's real promise.

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Elisabeth W Burak: And then, you know, in addition to just recognizing the different types of providers that Medicaid could fund that are more traditional health providers. There has been some clarification recently from Cms in terms of State health official letters about

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Elisabeth W Burak: Wh. Who can bill for interprofessional com consultation. So, for example, when a pediatrician needs to consult with the psychiatrist over a case now, Cms has clarified both the psychiatrist and the primary care, Doc, for example, can both bill for that service.

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00:22:12.300 --> 00:22:25.780
Elisabeth W Burak: And then there was recently some clarification just last month about who could qualify for a higher administrative match for skilled professional medical personnel in behavioral health. And now Cms has clarified that

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Elisabeth W Burak: social workers can qualify for that. So those are the kind of things they sound really small, they could really make a difference in terms of training or or administrative activities or supervision.

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Elisabeth W Burak: Next slide.

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Elisabeth W Burak: And this is our sort of final slide, which is I alluded to on our Federal activities work.

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Elisabeth W Burak: There's always places where State agency leaders and state leaders overall across agencies can do more to prioritize the mental health needs of postpartum limited infants. During this time of change, both separately and also together.

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Elisabeth W Burak: again, we always talk about sort of managed care contracts and states of managed care.

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Elisabeth W Burak: I didn't mention it earlier, but we had a webinar last year featuring some work that the George Washington University did for the Commonwealth Fund, where they analyzed 40 Medicaid managed care contracts for maternal maternal health, provisions in 2,021.

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Elisabeth W Burak: All States included postpartum care in the contract, which was great, but only 16 of those States had a detailed description about what that meant.

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Elisabeth W Burak: and only at least 10 States didn't specify maternal health or substance, use disorder services for maternity, maternity, specific care. So there's a lot again, a lot more that could be explicit.

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Elisabeth W Burak: And then we need to go further and make sure that that those things happen. So we felt very strongly about including in this recommendation the idea of having dedicated support within Medicaid agencies to make sure that the the program is working the way it should, and really making the most use of these public funds, and being good stewards of these public funds, because we know, as the unwinding is certainly shown us.

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00:24:07.730 --> 00:24:32.969
Elisabeth W Burak: public services is not an easy road, and these agencies really need the tools to not only monitor and make sure things are happening, but also do the kinds of exploration about what could be working better and what those barriers are, and we featured, and we were lucky to have 2 Beth Tinker and Christine Cole, from Washington's healthcare authority, who are dedicated to maternal and infant, early child and mental health, and have done an incredible amount of work.

121
00:24:32.970 --> 00:25:01.830
Elisabeth W Burak: Just in the infant and early childhood, mental health, space of educating providers, providing guides for billing, making sure that they get feedback from them on what the barriers are, as well as communities who need those services around the State, so

that dedicated attention really makes a difference, and that's not easy for a State Medicaid agency to do. But when lawmakers and the legislature or governors take notice. You know, this can really have an impact when we're trying to focus on

122
00:25:01.940 --> 00:25:07.559
Elisabeth W Burak: not just whether women and babies are getting care, but what the quality of that care might look like

123
00:25:08.480 --> 00:25:09.580
Elisabeth W Burak: next slide.

124
00:25:11.270 --> 00:25:21.310
Elisabeth W Burak: So I'm so excited to turn it over. To have a discussion with 4 of the the women who were part of these conversations in Seattle, and you can see

125
00:25:21.420 --> 00:25:43.030
Elisabeth W Burak: They happen to all be quoted in in the paper directly, because we had. We were so excited about the things they had to say, and if we could have featured everybody from the meeting, Jim was also at the meeting, we would have had everyone on this webinar, but we are thrilled to have Kima Gretch and Joya and Kay to discuss the report. So thank you so much, and I'll turn it back to Anne.

126
00:25:46.150 --> 00:26:11.569
Anne Dwyer: Thank you, Elizabeth and Tanisha, for the helpful overview and insights so now we will be turning to the discussion portion of the webinar, so we can hear from our expert panelists. And I would just remind folks, if you do have questions, please feel free to put those in the QA. And we'll try to incorporate those into the discussion. With that I would love to open it up to the panel if you wouldn't mind turning your cameras on great to see everyone's faces. And ask, really.

127
00:26:11.760 --> 00:26:26.790
Anne Dwyer: you know, there's a lot. There's a lot in the report a lot of really great information, some great recommendations. But for each of you what resonated most for you in the report, or even as part of our discussion this fall, and, Kay, perhaps I'll start with you if that's alright.

128
00:26:27.850 --> 00:26:33.810

Kay Matthews: Now that's fine. Hi! Everyone definitely nice to be here and join this conversation.

129
00:26:33.940 --> 00:27:01.770
Kay Matthews: I just can reflect on. I convening together as we put this report together, I think that it's always imperative to understand where we all have a role in these discussions and working on this project. Just let us know, like, really like what's happening out there, what's not at the forefront? What should we actually be uplifted more and like, really, truly, what's next? Because we can't continue to wait for what's next? We gotta do that right now.

130
00:27:01.770 --> 00:27:11.370
Kay Matthews: And I think that this report is a great starting point, because at this point we are all asking, What's next? We have the 12 month extension.

131
00:27:11.650 --> 00:27:21.830
Kay Matthews: What's next? And as someone who is a community advocate? Who knows that? Yay? 12 months. And now, what like? What is it

132
00:27:21.830 --> 00:27:41.840
Kay Matthews: that my community needs to know? Or what is it that we need to share to get this information out here, because what we have to do, and you'll hear me say, widen the lens quite a bit when we do widen the lens, we have to understand that both one always taking advantage of the 6 months that they had before. They now have the additional

133
00:27:42.250 --> 00:27:43.390
Kay Matthews: 6 months.

134
00:27:43.400 --> 00:27:52.860
Kay Matthews: So there was a disconnect there already. And so this is an opportunity. And what the report reflects is an opportunity to change, that

135
00:27:53.110 --> 00:27:56.049
Kay Matthews: you don't know what you don't know, and that's the truth.

136
00:27:56.200 --> 00:28:07.020

Kay Matthews: And so, as we look at the bigger picture here, we have an opportunity to really change their trajectory and stop blaming each other because it's all of us at the end of the day.

137
00:28:12.950 --> 00:28:18.760
Gretchen Hammer: Yeah. And and I can jump in One of the things that I

138
00:28:19.010 --> 00:28:37.050
Gretchen Hammer: feel like. It's really important in this report. So I went to graduate school at the University of Washington, and so this meeting felt a little bit like a full circle moment. 25 years later we were still talking about the same things I was focused on in my maternal and child health program, and in particular

139
00:28:37.080 --> 00:28:42.509
Gretchen Hammer: the chasm. I'll describe it as a chasm between primary care

140
00:28:42.540 --> 00:28:49.849
Gretchen Hammer: care when a woman is pregnant, and then in the postpartum period. Right? And so, Tanisha, you lifted up that

141
00:28:49.850 --> 00:29:14.739
Gretchen Hammer: truth that you know women who are covered by Medicaid are less likely to have a usual source of care period before they get pregnant, and then during pregnancy, which makes the journey to finding a usual source of care in the postpartum period even more complex right? The other thing I looked into the data is, Medicaid covers 63% of the births for women. Between the ages of 20 and 20

142
00:29:14.740 --> 00:29:15.780
44.

143
00:29:15.820 --> 00:29:35.479
Gretchen Hammer: I have a 20 year old he does not know how to navigate the healthcare system right it. The system is confusing. And so when a young person finds themselves pregnant, they may get connected to good obstetric care, but finding primary care after that is, is quite challenging, simply because of the way the system works.

144
00:29:35.860 --> 00:29:54.669
Gretchen Hammer: and a little bit of a lack of clarity, although I

know the professional associations are trying to improve the transition of individuals between very needed, you know good midwifery, care and upstructure care, and then into back to primary care space. So when I think about what are the mechanisms that Medicaid could use.

145
00:29:54.670 --> 00:30:01.899
Gretchen Hammer: I think that the report really lifts up a number of them, and I think there are even more for us to explore of how, if at all, can we

146
00:30:01.900 --> 00:30:25.389
Gretchen Hammer: get that connection smaller and more coherent for people? Because the other thing that's not easy to do is navigate anything complex when you have a newborn right having a newborn baby is overwhelming period, no matter what kind of resources you have, or if you're suffering from a particular postpartum challenges. It's just hard, and we make it incredibly hard with our current system.

147
00:30:28.050 --> 00:30:30.619
Dr. Kimá Joy Taylor: Thanks, and I jump in now, and the

148
00:30:30.820 --> 00:31:00.149
Dr. Kimá Joy Taylor: piece for me. Around the conversation, and the report is a reminder. It's about the implementation. And both Kay and Gretchen alluded to this, you can pass all the policies you want, but unless the implementation really is grounded, it's not gonna be as effective. And so with that, you actually do have to collect data to see if it's achieving what it said, it's gonna achieve. And particularly if you wanna assess global outcomes, right? It's not just doing it. It's like we want this to be positive for all communities, all people.

149
00:31:00.150 --> 00:31:30.070
Dr. Kimá Joy Taylor: And so that that implementation piece is incredibly important. And the nice thing about the conversation is that people were really honest about where there's quality, where there's not quality, where there's past policies that have really reinforced in equity and where there aren't, and trying to get at what States can do to root that out, and those of you know me know I'm coming up with substance use right here. But it is that idea that and and love. So, mentioning it, we talk about mental health, we often ignore substance, use, and the real requirement to talk about that

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00:31:30.070 --> 00:31:33.970
Dr. Kimá Joy Taylor: and the requirement. If you're going to talk about equitable outcomes, ensuring

151
00:31:34.180 --> 00:31:47.019
Dr. Kimá Joy Taylor: culturally effective, linguistically effective, developmentally appropriate non-punitive services which they're not enough of. And I felt like in the meeting we were really honest about, where do we need to build capacity

152
00:31:47.070 --> 00:31:58.500
Dr. Kimá Joy Taylor: where there doesn't exist capacity and where it doesn't have to be the capacity of our current medicalized system, like where we work with community to really build a system that leads to credible outcomes. For all in a way that they are not

153
00:31:58.550 --> 00:32:02.099
Dr. Kimá Joy Taylor: Manush had their children taken away in those sorts of things.

154
00:32:04.500 --> 00:32:11.220
Anne Dwyer: Thank you. I'm so glad you brought up implementation, because really this is the bread and butter of this report of we have, I mean

155
00:32:11.270 --> 00:32:27.419
Anne Dwyer: the the the amount of progress we've seen in expanding 12 month postpartum coverage over the last, you know. Few years has been really incredible. Yeah, making it work on the ground is is really the hard part, too. If you I mean again, for our panelists and and community starting with you.

156
00:32:27.500 --> 00:32:47.450
Anne Dwyer: If you were, you know, got to be in charge of this. You know the State Medicaid program and you were kind of looking at these menu of options, recognizing that each state is different. But like, what? What would you want to see implemented first? Or what do you think would be the most beneficial? And then where are the challenges that you would see kind of arising in some of these implementation?

157
00:32:47.520 --> 00:32:49.030
Dr. Kimá Joy Taylor: I think

158
00:32:49.310 --> 00:32:58.459
Dr. Kimá Joy Taylor: my dream world. One thing I'd love to see is really that is, save that focus on primary care. I mean, I'm a primary care pediatrician. So obviously a little bias, but

159
00:32:58.810 --> 00:33:04.020
Dr. Kimá Joy Taylor: but not just. There's so much talk about just payment and reimbursement, which is important.

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00:33:04.080 --> 00:33:28.810
Dr. Kimá Joy Taylor: But it's also people need time with their patients right? And so allowing for primary care providers and their team based care. See? I just slipped that in and my vision. But their team based care can actually spend time with the clients, get to know them, build that trust. And so, really focusing on what that looks like. And as Gretchen said, folks need you. You're not gonna all of a sudden have postponed connection. If there was no connection ahead of time.

161
00:33:28.810 --> 00:33:34.830
Dr. Kimá Joy Taylor: right? And so really centering on well being throughout the journey, even before people are pregnant.

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00:33:34.850 --> 00:33:48.610
Dr. Kimá Joy Taylor: The challenges I see in that with primary care, and and all of the behavioral health is, we have a workforce shortage. We don't have enough folks, and it's not diverse enough. And we're not providing culturally, linguistically effective, often not and providing evidence informed services.

163
00:33:48.610 --> 00:34:10.799
Dr. Kimá Joy Taylor: And so really building that workforce and not just docs. Right? There is a whole workforce that we need to focus on expanding and diversify for members that haven't been community health workers, Doulas, midwives of myriad types, pediatricians, pediatric nurse spectators? What is the workforce community based organizations? And how do we reimburse those folks

164
00:34:10.860 --> 00:34:25.019
Dr. Kimá Joy Taylor: appropriately and particularly like peers and community health workers reimburse appropriately with benefits something that's often left off. This is not a volunteer job and really build into the team-based care that's going to take a

rethinking of how we think of

165
00:34:25.340 --> 00:34:32.599
Dr. Kimá Joy Taylor: how we think of reimbursement. But actually, it's going to take a rethinking, and how we think of bringing people into the workforce so that it's diverse and strong.

166
00:34:35.659 --> 00:34:38.889
Anne Dwyer: And, Elizabeth, I see you popped on. Did you wanna add something?

167
00:34:40.150 --> 00:34:43.119
Elisabeth W Burak: Well, Kima you in a different way with it. But I think

168
00:34:43.560 --> 00:34:55.280
Elisabeth W Burak: this idea about the workforce not just paying the workforce and extending it, which, of course, we need, and Medicaid needs to do more and can. But Lynn Kurzie from California, I think, had a comment that that

169
00:34:55.420 --> 00:35:09.310
Elisabeth W Burak: resonated from our conversation, and it was the providers need to be assured that they can, they should continue seeing pregnant people and infants to age. One. Both have continuity of care, protections, plans, and States should pay regardless. And we have. We don't have this culture of care.

170
00:35:09.310 --> 00:35:35.589
Elisabeth W Burak: And many providers don't even know that care in this case, for moms has been extended to 12 months for, or they have, for example, in California, coverage for undocumented people. And I think that speaks to making sure everybody knows what the rules of the road are, and what the expectations are, and I to me, part of this goes back to, and II know there are other States besides Washington. We just have the benefit of having them in a room. You know they have dedicated staff who are really spending time

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00:35:35.590 --> 00:36:00.530
Elisabeth W Burak: mit Ctl. And making sure, having websites, having trainings, having on ongoing conversations to make sure providers are fully aware of what's out there and what they can be doing, and that takes state capacity and State support. I know there are other states

that that work really well with title 5 agencies and public health agencies. That's also really important. You know, it's really figuring out how to leverage leverage all the different agencies that are working in this space

172
00:36:00.670 --> 00:36:03.940
Elisabeth W Burak: to get the word out to make this possible. So

173
00:36:05.900 --> 00:36:12.690
Anne Dwyer: thank you, Elizabeth, and I know, Kay, during our discussion this fall you had really emphasized in in our

174
00:36:12.690 --> 00:36:37.410
Anne Dwyer: healthcare system. It's this top down approach where we need to, just instead of thinking, oh, how do we change this top down approach, maybe thinking, okay, take a step back. It should be bottom up, we should be meeting people on the ground, working with the provider networks that are already there that are happening. And how can we support them? To really do what they're already doing in a way, as Kima. You mentioned that, you know it's paying and providing benefits. But I'd love to kind of hear your thoughts.

175
00:36:37.410 --> 00:36:45.629
Anne Dwyer: and if if you, if you could have your way, your dream world, as Kima put it, what would be kind of the first thing you would implement, or some of that, the key things would implement.

176
00:36:45.990 --> 00:36:51.660
Kay Matthews: The first thing is for folks to even understand Medicaid as a whole.

177
00:36:52.210 --> 00:37:13.960
Kay Matthews: we missed the mark in thinking, just because someone is on Medicaid, that they actually understand their benefits. This is why I'm like, what's next. So I got one year now of being on Medicaid. What am I supposed to do with that? I know that I have to take my child to the doctor? I have to do this, I have to do that, and then it stops. So

178
00:37:14.930 --> 00:37:19.719
Kay Matthews: when we look at this as a whole, it still comes back to the roles that we play.

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00:37:19.770 --> 00:37:39.740
Kay Matthews: It's just like what dr. Kima said, everybody has a role. It's the community health workers, the Doulas, the all of this. And when we look at this as the when we do talk about the implementation of who is going to help and who is a part of the system. We also have to value the road at one place

180
00:37:39.830 --> 00:38:06.390
Kay Matthews: because we just started like really saying, Do this and do with that. But then everything can be on the Doula. That's not the role. Remember, at 1 point we wanted to do list that thought that Doulas wanted to be the doctor. Not true, right. So as we continue and navigate this thing, we are still like dismantling a lot of the stigmas that come along with, and Medicaid has a stigma alone, because no one wants to yell from the top of their loans that they have Medicaid right?

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00:38:06.390 --> 00:38:12.309
Kay Matthews: Because in reality that's how we have put it down at the bottom. This is what I mean about like flipping

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00:38:12.310 --> 00:38:25.600
Kay Matthews: and getting folks to understand that there are benefits here. This is what's going to help you if we are going to continue to address this maternal health crisis that we say that we are in, we have to be more inclusive of what that is.

183
00:38:26.400 --> 00:38:30.510
Kay Matthews: it's bigger than what we are focusing on right now.

184
00:38:30.640 --> 00:38:48.449
Kay Matthews: And if Medicaid plays the role in which it does cause, like you said, it's not the only player, but it is the one that keeps coming up right. So then Medicaid has to be able to bring in more folks into the fold, so we can all again adjust this issue as a whole.

185
00:38:48.520 --> 00:39:12.719
Kay Matthews: Because we're missing a mark. And the only people that really, truly suffer for this is the clients or the patients, which, meeting whichever side your own for me, their clients. But at the end of the day the hospital caring system, that's your patient, and if you're working with us, then we're working together to ensure that this person is standing in front of us is getting the care that they

need. It's just like what Dr. Kim is said about needing more time.

186
00:39:13.170 --> 00:39:17.350
Kay Matthews: But even with the time that you have doesn't mean that you give stuff more care.

187
00:39:17.470 --> 00:39:24.500
Kay Matthews: There's a way it can be done. We see it done, and then those who are doing it the right way are overwhelmed.

188
00:39:24.600 --> 00:39:45.079
Kay Matthews: We need to address that. So when we think about this, this issue of not having enough providers and people to take over in the mental health field, that's because we don't widen the lens. And we don't see the role that community health workers play community based organizations play. There's tiers to mental health as a whole.

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00:39:45.100 --> 00:39:52.799
Kay Matthews: and everybody doesn't need our right, a psychiatrist. Maybe they just simply need a support system. You know how drastically think about these.

190
00:39:53.410 --> 00:40:19.030
Kay Matthews: what we miss is thinking logically, logically, I may not need a psychiatrist. I just need a better support system. Right? So what does that mean to have that when someone presents as such versus thinking, oh, this person needs to go to mental health hospital, or oh, the kids are in danger. Let's call cps. It's all of these things that we just continuously trigger automatically out of habit that are harmful.

191
00:40:19.110 --> 00:40:40.590
Kay Matthews: And so this is an opportunity to change all of this. Like all of us on this call sitting on this panel. This is an opportunity for us to collaborate and seriously work together, because that's the only way that this is going to change beyond the report. So we don't want the report to just sit. And it's not anything that people actually do anything with, because here's your blueprint.

192
00:40:40.810 --> 00:40:47.529
Kay Matthews: This is at least a starting point where you can look and get going. But we can't continue to wait for what's next.

193
00:40:47.660 --> 00:40:51.790
Kay Matthews: That's what I see, and a dream space for me in doing this work.

194
00:40:56.560 --> 00:41:13.050
Anne Dwyer: And, Gretchen, can I turn to you anything else to add? There, I mean, from a former State Medicaid director? You've really been in the weeds kind of now. But you know what what you kind of see is where the opportunities are, and some of the challenges are with this kind of menu of options of again, where states can advance.

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00:41:13.140 --> 00:41:21.340
Anne Dwyer: you know maternal mental health and the postpartum year for both mom and baby as it again, as it relates to some of the things that we've pulled out in the report.

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00:41:22.010 --> 00:41:22.940
Gretchen Hammer: Yeah.

197
00:41:23.840 --> 00:41:37.659
Gretchen Hammer: II really resonate with with Kay and Kima about. You know, we have to recognize the multiple roles that people play and the appropriate roles that people play. One of the things I've always wished is that we could.

198
00:41:37.680 --> 00:41:51.739
Gretchen Hammer: We could organize healthcare services more like a school district or a school. And the reason why is because if you read a school strategic plan or whatever it typically speaks to something like, we want our students

199
00:41:51.780 --> 00:42:10.210
Gretchen Hammer: to have educational experiences that set them up to be good human beings right? They they'll know how to learn. They'll know how to interact with multiple different types of people like there is a vision of, like, collectively, our resources are dedicated to an outcome of this child leaving this educational space

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00:42:10.210 --> 00:42:38.879
Gretchen Hammer: ready to go. And we really don't have that. I think that's what Kay was saying. The hospital has a set of criteria. The community based organizations do. There isn't really good mechanisms

for shared accountability. So this is where I think Medicaid can play a role in establishing that vision. And I think again Oregon did this in some of their early learning hubs and some of their early work on children's, which is to say, if Medicaid is the primary source of coverage for all children 0 to 5. In the State of Oregon

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00:42:38.900 --> 00:43:07.210
Gretchen Hammer: we have a collective responsibility to make sure those kids show up ready to go to school and ready to be good people right? Like we play a role in kindergarten readiness as that example. And so II think if you go up as Kay said, widen the lens, we're not just here to hit a clinical quality metric, we're actually here to help a family get launched. And to make sure Mom is well supported so she can play. They can play the role that they need to play baby's well supported.

202
00:43:07.210 --> 00:43:25.119
Gretchen Hammer: You can begin to hold all of your contractors and providers to a slightly higher vision of what role they're playing in the system right? And that's complicated. And you gotta have a lot of stakeholder meetings and those kinds of things. But I think you actually can line up all of the mechanisms of Medicaid

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00:43:25.120 --> 00:43:44.420
Gretchen Hammer: to to see a bigger picture here. That is about helping newborns and their parents and their families get off to the right start, and that includes without question the data is abundantly clear. Families feeling well supported and having their social needs met so that they can be what they're supposed to be doing, which is engaging in that baby's life

204
00:43:46.140 --> 00:44:06.030
Anne Dwyer: so much correction. And we have gotten one or 2 comments. In the QA. Just asking about the transforming maternal health model, which I know is a new Cm. On my announcement, with more information and and I believe, application period coming this spring. But just curious. Will one your take on on the model if you have one, but also

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00:44:06.110 --> 00:44:17.110
Anne Dwyer: what you know when we, looking at some of these recommendations, what authorities are needed and what authorities are needed? Where can States take some of these recommendations and start? But perhaps making

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00:44:17.300 --> 00:44:26.999
Anne Dwyer: or really making changes today versus where would they might need some changes to their, you know, approval from the Federal Government as part of the State Medicaid program. I'd love to get your perspective on that.

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00:44:31.900 --> 00:44:49.769
Gretchen Hammer: Well, and since you went straight to sort of Medicaid policy, I'll jump in and then hand it to my colleagues, who know a lot more about engaging directly with communities and serving people directly. I actually don't think you need to be fancy to put some of these things in place. Right? This is basic Medicaid policy.

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00:44:49.870 --> 00:45:07.670
Gretchen Hammer: Who is eligible for the service? What is the service? Who can provide it? How you were gonna assure quality. What's the appropriate payment? Right? I mean, those are the levers that Medicaid works through on every single policy that comes before our Medicaid program, determining eligibility, criteria, etc. So

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00:45:07.950 --> 00:45:17.449
Gretchen Hammer: I think that you certainly can get fancy. I'm not suggesting, like, you know, if you don't need to. But this doesn't require in my mind advancing

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00:45:17.710 --> 00:45:23.409
Gretchen Hammer: the concepts in many of the concepts. In this paper, as well as pretty good general

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00:45:23.910 --> 00:45:33.059
Gretchen Hammer: care, improvements, provider supports, and other things, do not require special authorities, and if they do, you can. You know to the extent that it was, Elizabeth said.

212
00:45:33.060 --> 00:45:56.280
Gretchen Hammer: many States do leverage Medicaid manage care a fully capitated benefit. You know you can lean into some of those flexibilities. But in general, for improving, strengthening, primary care, expanding the workforce and those kinds of things. Those are pretty straightforward Medicaid policies. And I think trying. Sometimes Medicaid programs can be a little afraid when everybody's like we need a huge 1115 waiver

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00:45:56.280 --> 00:46:03.939
Gretchen Hammer: that's administratively overwhelming. So just using the regular mechanisms of the Medicaid program, I think. You have a lot of opportunity.

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00:46:05.180 --> 00:46:07.070
Anne Dwyer: Thanks so much, Gretchen. And

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00:46:07.190 --> 00:46:35.950
Anne Dwyer: on a related note, but more kind of on the ground. Kima and Kay, curious to kind of get your thoughts on what you think should be happening outside of Medicaid, so we wouldn't kind of use the Medicaid authority. But what should we happen outside of Medicaid to make Medicaid changes most effective? I know, one commenter made the note of like, should we be thinking about changing medical school curriculum to really set up the next generation of providers to kind of handle these issues in a more appropriate, you know, more equitable way. So maybe, Kima, I'll start with you.

216
00:46:39.100 --> 00:46:40.160
Dr. Kimá Joy Taylor: Yes.

217
00:46:40.170 --> 00:46:59.680
Dr. Kimá Joy Taylor: all of it. Now I think one something question said, something really important, one. We have to agree on that vision and broader the Medicaid. But you know the Public Health Department, the State Health department. What is the vision? And that will, and then influence all of these? I do a lot of on provider diversification.

218
00:46:59.740 --> 00:47:06.200
Dr. Kimá Joy Taylor: and I humbly believe, even though I went to medical school, and we have the wrong criteria for who should be admitted to medical school

219
00:47:06.260 --> 00:47:34.200
Dr. Kimá Joy Taylor: grade or an Mcat task that tells you whether you're gonna be able to interact well with patients and have culture and linguistically effective care and be culturally humble. We need to get at the things that can actually make you a better provider to help families launch. So again, having that vision, and then that helps us understand who we let into medical school, or nursing school, or in a school. And then what is a part of that curriculum? Absolutely. I think the other ple places which case talked about a lot is.

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00:47:34.900 --> 00:47:42.660
Dr. Kimá Joy Taylor: it? Is all of it. It's that support system. Some people already have it, and they don't even recognize it, and they rely on it heavily.

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00:47:42.700 --> 00:48:03.569
Dr. Kimá Joy Taylor: A lot of folks don't. It is having schools that believe in you and your children having grocery stores where you live, having easy access to jobs that pay benefits and higher. And so it's a lot of the societal determinants. I see, I word, societal, because in many instances societies determine whether or not. You have these, this access

222
00:48:03.690 --> 00:48:21.059
Dr. Kimá Joy Taylor: social determinants kind of like, we get you an Uber, and we're done. No, we really need to focus on whether you actually have access through public transportation and other places like, what is society gonna do to re change, to change where we need to be? But I think it. I humbly believe it really goes back to what Gretchen was saying. We don't have a vision

223
00:48:21.110 --> 00:48:36.460
Dr. Kimá Joy Taylor: for wellness and well, people and equitable outcomes, and having parents have time to love and be with their kids without always fearing is child welfare coming? Am I gonna have access to food? Am I gonna get a job like. So I think it.

224
00:48:36.670 --> 00:48:44.900
Dr. Kimá Joy Taylor: Yes, absolutely in every other space. And it starts with that vision. And it starts with leadership that can bring people together to move us in that direction.

225
00:48:47.870 --> 00:48:49.419
Anne Dwyer: Okay, anything to add there.

226
00:48:49.840 --> 00:49:00.530
Kay Matthews: I'll make it short. Alright cause, Dr. Kima said, a vision for wellness that comes with so much of the biggest thing you have to understand

227
00:49:00.640 --> 00:49:29.579

Kay Matthews: that wellness has to be the 100% focus. If we don't understand that, then we keep missing the mark. So a vision for wellness requires all the moving parts to come together. And that's exactly what we need. And how are we going to get there, we again have to see value on the role that everyone plays. I'm thinking, the biggest piece with Medicaid is the care coordination outside of their system.

228
00:49:29.910 --> 00:49:41.100
Kay Matthews: So what does it look like to work where we all know our shortcomings in some way, where the system is not working here. The system is not working here. Well, who is it working for and put them in that place

229
00:49:41.610 --> 00:49:55.070
Kay Matthews: like that? Seemingly. That's logical thinking to me. So if there's a disconnect, then who can make that connection? Who can make that happen? And one of the things I think it was you, Dr. Kim, that said earlier, we're not gonna do this for free.

230
00:49:55.190 --> 00:50:18.330
Kay Matthews: So we're going to have to come up with a pay model that incorporates community-based organizations so that we, too, can build, and what that looks like and what that amounts to. It's a service is. It's a trade off giving good service, getting good service. It's it has to be twofold. And so a vision awareness is that that's it right there. But you have to understand all of the moving parts

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00:50:18.330 --> 00:50:41.540
Kay Matthews: that their place in our roles. And how do we collectively come together? I think one of the other things that was touched on is the Meta, the the medical students. I work with medical students twice a year. That's because of the professor, though not because of the entity. But the professor sees value and hearing from a community member and what's going on in the communities that these students will one day serve.

232
00:50:41.720 --> 00:51:04.930
Kay Matthews: So you're getting like the the leg up to be able to know what's going on out there. But who else needs value in doing that and just changing the structure of what's being taught? Because by the time they get to us in the hospital systems. So a lot of unlearning that has to happen right, it's better to start while they're in school. And change some of those dynamics as well. So that's that's a big part, and I'll just stop there.

233
00:51:06.170 --> 00:51:34.290
Gretchen Hammer: and I'll just jump on that Kay, because I think the inclination for a Medicaid director, or others or other programs is to worry about credentialing and contracting and quality. And I think you would just have to look at yourself honestly and say, Let's be honest. The people we're paying now aren't getting it done. And so we have to find other people to and trust that other people can deliver on the quality that we are looking for. Because

234
00:51:34.290 --> 00:52:03.199
Gretchen Hammer: I it. It is the first thing we had a great presentation at a conference one time about barbershop sort of mental health support. And the very first question for some of the audience was a sort of How do you protect patient privacy? And how do you enroll them as a provider and Medicaid? And I was like, no, it's not the question we need to ask, we need to ask, how do we support this kind of support through a Medicaid programs? Lens. So I just want us to remind ourselves our first inclination. They have to have program integrity. I'm not at all suggesting.

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00:52:03.200 --> 00:52:09.280
Gretchen Hammer: you know, you don't have some protections in place, but we have to be honest. The people we're paying today aren't getting it done.

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00:52:11.570 --> 00:52:14.500
Elisabeth W Burak: Gretchen, you make a really good point that I wanted to send.

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00:52:15.080 --> 00:52:19.730
Elisabeth W Burak: Think about, because I think one of the reasons we came back to these themes is, we want to be.

238
00:52:20.270 --> 00:52:38.150
Elisabeth W Burak: figure out how to help Medicaid create conditions that allow communities to do their best work in ways that make sense for those communities, right? Whether it's barbershop or something else. And of course you can get through the details and roll your sleeves up and figure out how those things work. But it's having the vision, and then figuring out how to make the pieces work together. That's so important.

239

00:52:38.150 --> 00:52:52.630
Elisabeth W Burak: And I one of the things we also talked about, and Kay, you alluded to it. But I just wanna lift it up is when we talk especially about extending the workforce through like duals or community health workers or peer support. Sometimes the inclination is we can do one of those or make this. One person can do everything, and

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00:52:52.680 --> 00:53:17.640
Elisabeth W Burak: they shouldn't necessarily be seen as mutually exclusive. Just like, you know, a lot of school systems have counselors and social workers. So I think we? Really, we need both and right. This is a moment in time where it can take different people to different things and different communities are probably going to need different things, and Medicaid is in a good position to set up those conditions to be flexible, and that that's something where Medicaid flexibility can really be used to be in a helpful way.

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00:53:19.930 --> 00:53:30.440
Anne Dwyer: Well, thank you, Elizabeth, and to our panelists for an incredible discussion. With that I will wrap up the discussion portion of today's webinar.

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00:53:30.440 --> 00:53:52.930
Anne Dwyer: And again, just a huge Thank you to the panelists and to all the leaders who shared their time and expertise to make the report a reality. Also again, thank you to so much to perigee fund for supporting this work and to our Ccf. Colleagues behind the scenes who've been putting links in the chat, moving the slides just as a reminder. There's a number of materials and resources in the chat and our

243
00:53:52.940 --> 00:53:58.799
Anne Dwyer: the recording and the slides will be made available on the Ccf website, a link to that is also in the chat.

244
00:53:58.830 --> 00:54:12.070
Anne Dwyer: And finally, a big thank you to you, to all of you for taking the time out of your day to join today's webinar and the discussion around supporting mom moms and babies during this critical postpartum year. Thank you so much for your interest and for your work in this space.

245
00:54:12.300 --> 00:54:39.829
Anne Dwyer: With that we will wrap up today's webinar. And I will note

that you can find the full report along with a company blog and Ccf
website, which I think we go to the next slide. We also have links
there as well. Thank you. And also a host of additional materials and
resources, including our state data hub and our unwinding track are
all on our Ccf website. So with that, thank you again. So much for
your interest and have a great day.

246
00:54:42.460 --> 00:54:43.890
Elisabeth W Burak: Thanks. Everyone.