National FQHC Advisory Board Brief

Improving Maternal Health Outcomes in Medicaid Through FQHCs and Managed Care

Pregnant individuals in the United States experience adverse maternal and birth outcomes at rates greater than those in nearly all other developed nations. Data from the Centers for Disease Control and Prevention indicate the U.S. maternal mortality[1] rate in 2019 was 20.1 deaths per 100,000 live births — an increase from 17.4 in the previous year. The maternal mortality rate for Black, Indigenous, and People of Color (BIPOC) in 2019 was 2.5 times the rate for non-Hispanic white women and 3.5 times the rate for Hispanic women, indicating significant racial disparities.[2] Rates of preterm births and low birth weights have also risen in recent years, with roughly one in ten infants born preterm in the U.S. in 2019.[3] BIPOC individuals have consistently experienced higher rates of preterm births and low birth weight infants than white and Hispanic women, reinforcing a theme of racial inequities in maternal health outcomes.[4]

About half of all births in the U.S. are covered by Medicaid, suggesting that state Medicaid programs and participating managed care organizations (MCOs) are uniquely positioned to address adverse outcomes present in the maternal health space. Federally Qualified Health Centers (FQHCs) must also be an essential partner in improving health outcomes for pregnant individuals and infants. As the provider of health care services to over 30 million individuals, almost 50% of whom are enrolled in Medicaid, FQHCs can impact maternal care under Medicaid to an extent few other entities can.[5] There are opportunities for MCOs and FQHCs to develop strategies to enhance care across the maternal care continuum with the primary goal of improving health outcomes.

UnitedHealthcare Community & State and its National FQHC Advisory Board (FQHC Board) authored the following brief that outlines challenges facing FQHCs and MCOs in their efforts to enhance maternal health care, as well as potential policy opportunities that could mitigate those obstacles.

In 2020, health centers:

served over
16.8 million women

provided prenatal care to more than
566,000 patients

delivered just over
170,000 infants

Roughly 1.55 million
received contraceptive management services through an FQHC during the year.

Source: National Health Center Program Uniform Data System (hrsa.gov)

United Healthcare

Critical Roles of FQHCs and MCOs

Federally Qualified Health Centers

Health centers deliver integrated, comprehensive primary and preventive care across the life span, often offering such services as behavioral health, dental, social supports, and laboratory services on site. Health centers play a particularly critical role in women's health and the delivery of maternal health services, and are especially vital sources of care for BIPOC, non-English speakers, and individuals in rural communities.[6] And yet, health centers face multiple compelling challenges that may limit their ability to fully translate critical health services into positive maternal health outcomes. Among the primary challenges facing FQHCs, the following are noteworthy:

Data Access. Meaningful data sharing among and between providers is necessary to support a person-centered experience across the health and wellness ecosystem. Depending on a state's data infrastructure or local market dynamics, FQHCs may face challenges accessing data vital in serving pregnant individuals, who will most likely be receiving care from multiple providers. This may include information on such items as lab and diagnostic test results, prior deliveries, and emergency department or urgent care visits.

Care Coordination. FQHCs employ various service models for maternal health care *(see appendix A)*. The majority of pregnant FQHC patients receive a portion of their health care services from specialists and/or hospitalists, which means that care must be effectively coordinated across all involved providers as a patient advances from preconception, through pregnancy to childbirth, and to the postnatal period to ensure that there are no gaps in care or social supports.

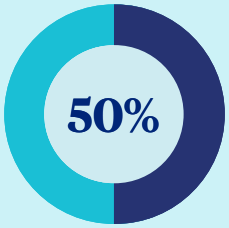
Workforce Demands. Like many providers, the pandemic has placed additional burdens on the health center workforce. Health centers already faced significant workforce shortages due to such challenges as offering competitive salary and benefit packages, geographic location, and workload demands.[7,8] FQHCs will likely continue to face these recruitment and retention challenges, reducing patient access and health center capacity.

Variations in Reimbursement. FQHCs have a unique payment methodology in Medicaid known as the Prospective Payment System (PPS), under which a health center bills Medicaid when a beneficiary has a visit with a specific provider type at the health center.[9] States can choose to structure the FQHC rate in several ways. For example, some states may pay health centers for managing a pregnant patient's delivery using the FQHC PPS, a global payment, or fee-for-service model. Depending on how state regulations structure the FQHC payment methodology, health centers' ability and capacity to provide the full range of maternal health services may be limited.

Managed Care Organizations

Managed care plays a critical role in enabling states to deliver higher quality care, improve health outcomes of Medicaid recipients, and manage health care costs. MCOs also build community capacity to serve Medicaid patients, with emphasis on health system performance and care coordination.

MCOs have broad capabilities to identify and assist pregnant individuals enrolled in Medicaid plans and tailor care management for high-risk pregnant members, many of whom require additional supports and services, to reduce complications. Additionally, MCOs drive innovation and equity through the development of alternative payment models that can incentivize and optimize maternal health care.



In 2019, more than half of managed care states have quality initiatives for MCOs that are linked to perinatal/ birth outcome measures.

Source: Kaiser Family Foundation

Although MCOs are capable of managing care across a spectrum of maternal health providers, plans must also navigate obstacles that may impede the complete coordination of care. The ability of an MCO to effectively link maternal care services is jeopardized by:

Individual health BEFORE pregnancy. Diabetes, obesity, substance use, heart disease and untreated mental health are some of the more common challenges that can complicate pregnancy. Ensuring that individuals are as healthy as possible BEFORE pregnancy supports improved birth outcomes. Additionally, the consistent focus on birth control and intentional pregnancies can support improved birth spacing and preparedness for pregnancy — both critical factors in improving health outcomes for mom and baby. Unfortunately, MCOs — particularly those managing Medicaid in non-expansion states — often do not have established relationships with individuals before they become pregnant due to the eligibility and enrollment dynamics in Medicaid.

Early identification of pregnancy. MCOs are interested in identifying pregnant members and connecting them with prenatal care as early as possible. HEDIS measures and key health plan performance metrics are often tied to prenatal care being initiated during the first trimester. While MCOs use a variety of analytic tools and provider tools to support early identification of pregnancy, gaps in coverage, limited engagement with providers or other factors often delay an MCO's awareness of a member's pregnancy and therefore the MCO's ability to support the member.

Limited transparency on prenatal care. Due to global billing practices and the time-lag for claims being submitted, MCOs often have limited information about whether an individual is receiving timely and consistent prenatal care. MCOs often have extensive care management teams supporting their pregnant members and significant contractual requirements to support these individuals; however, targeting engagement particularly to the individuals who have fallen out of care or have not yet connected with prenatal care could have the greatest opportunity to improve the provider/patient relationship and maternal health outcomes.

Gaps in data sharing. As care becomes increasingly integrated, MCOs must contend with varying levels of communication between providers. In addition, actions by MCOs to address social determinants of health may involve interactions with providers of social services, such as additional state agencies and community-based organizations. Efforts to improve service coordination among these entities may be constrained when data and information cannot be readily shared.

Lack of knowledge about FQHC models and services. Health centers operate under several clinical models and offer patients a variety of additional services and social supports *(see Appendix A).* In the maternal health space, for example, some FQHCs manage the services at every stage of the pregnancy and childbirth, whereas others may deliver only the prenatal care and coordinate with a health system or independent provider partner to provide and manage the delivery services and postnatal care. MCOs often may not have full information about the services and models in place at each health center, limiting the ability of the MCO to effectively coordinate services with individual FQHCs.

Workforce and system preparedness for innovative models. While birth centers, midwives, and doulas have all been shown to improve birth outcomes, access to these providers are not uniform and are often significantly limited, compounded by State Medicaid policy decisions on coverage, state licensure, and FQHC reimbursement policies that impact accessibility.

Opportunities to Improve Maternal Health Outcomes

In the Medicaid maternal health space, FQHCs and MCOs strive to coordinate care in ways that will optimize health services for pregnant individuals and their infants. Both have developed innovative strategies for serving diverse populations with increasingly complex needs. To advance meaningful improvements in maternal and infant health, health centers and managed care plans must further align their approaches toward achieving shared goals. Those goals include:

Access to care. FQHCs and MCOs both have capabilities to reach into the communities they serve to expand access to maternal health services and related social supports.

Continuity and coordination of care. FQHCs and MCOs endeavor to provide care management that will link pregnant individuals to appropriate supports and services. However, the range of service models in use by both entities are not always in alignment. MCOs, which are often contractually required to coordinate care, and FQHCs should partner to further integrate care and effectively coordinate care across multiple providers to meet members' health and social needs and effectively facilitate family-centered care.

Improved maternal health outcomes. FQHCs and MCOs play outsized roles in facilitating prenatal, postnatal, and infant health services under Medicaid. Accordingly, both entities strive to reduce the occurrence of maternal mortality, preterm births, low birth weight infants, and other adverse maternal and infant health outcomes.

Health equity. Health equity is an overarching principle for FQHCs and MCOs as they work to improve quality and population health. Both entities can facilitate the use of comprehensive assessments that identify barriers to care related to or exacerbated by disparities. Through data collection and analysis, FQHCs and MCOs can recognize additional opportunities for reducing disparities in maternal health care.

Policy Opportunities to Advance Shared Goals

FQHCs and MCOs can build momentum toward achieving these shared goals by engaging with state Medicaid programs in support of targeted policy initiatives. In recognition of the themes presented here, UnitedHealthcare's National FQHC Advisory Board recommends that states support the work of health centers and managed care plans by adopting policies that will foster holistic maternal and infant care and improved health outcomes.

Comprehensive Benefit Design Features

Comprehensive maternity programs should include a full suite of benefits to support a healthy pregnancy, full-term delivery, and access to critical physical, behavioral, and social services and supports needed postpartum. Several states have requested authority to extend postpartum Medicaid coverage[10] to ensure that women continue to receive appropriate care in the weeks and months following childbirth. Coordination of care for mother and child can also be improved by allowing for automatic enrollment of a newborn into the MCO providing Medicaid coverage for the mother.

In addition, access to services and supports such as midwives,[11] doulas,[12] and birth centers[13] have been linked to improved maternal and infant health outcomes. The flexible and personalized nature of doula supports, midwifery-led care, and freestanding birth centers makes them particularly impactful at effectively meeting the specific needs of BIPOC and low-income pregnant individuals.

To improve access to and continuation of quality maternal health care, states should:

- Extend postpartum coverage under Medicaid to one year following childbirth.
- Allow FQHCs to be reimbursed for services delivered outside the health center to support home visits for pregnant and postpartum women.
- Cover and reimburse FQHCs for services delivered by doulas, marriage and family therapists, licensed professional counselors, and community health workers.
- Allow FQHCs to bill for multiple encounters on a single day to allow for medical, dental and/or behavioral health services to be provided in a streamlined fashion.

In addition, states and MCOs should continue to promote the adoption of digital platforms and mobile-friendly strategies to encourage patient engagement and allow for remote monitoring of women throughout pregnancy and into the postnatal period. States should adopt policies to include coverage of remote patient monitoring and provide for the reimbursement of services delivered via telehealth in a patient's home. Lastly, state Medicaid programs should support digital risk assessments for pregnant women, which could be updated as needed during a pregnancy.

Data Improvements

The sharing of data between providers and MCOs is critical to supporting a person-centered experience for pregnant individuals in Medicaid. The consequences of inadequate data sharing are felt acutely by patients themselves, but also create administrative and clinical burdens for providers and MCOs.

States should consider policy changes that:

- Support the development of and incentivize participation in statewide data sharing platforms, including health information exchanges, that could facilitate health and social determinants of health (SDOH) related data sharing between providers.
- Explicitly encourage the incorporation of race and ethnicity data along with other related metrics in Medicaid enrollment processes. This information can help MCOs, FQHCs, and other providers in identifying and addressing the specific needs of patients, while potentially shedding light on any institutional or unconscious bias in the system of care.

Social Determinants of Health

Social, economic, and environmental factors, often referred to as SDOH, are particularly critical to maternal health and family well-being. Better understanding of the impact of SDOH is essential for providing quality care to patients, while improving provider efficiency. State Medicaid programs are increasingly focusing on SDOH and supporting actions that may improve health outcomes.

To support these efforts, providers should be encouraged to conduct thorough, periodic health and social risk assessments and those assessment results should be shared with the pregnant individual's MCO. Screenings should include at least one maternal depression screening during pregnancy along with inclusion of a depression screening as part of the comprehensive postpartum visit.

To assist health centers in addressing SDOH, states and/or MCOs should:

- Support facilitation of assessments and ensure coverage of enabling services such as transportation or interpretation services.
- Support and incentivize partnerships with providers that serve predominantly BIPOC and rural populations, including FQHCs.
- Maximize available state plan amendment and waiver authorities permitted by CMS to cover SDOH services and supports including linkages to non-covered social services (e.g., nutrition programs, childcare), housing support, job training, and career planning.
- Leverage integrated eligibility systems to reduce administrative burden, improve efficiency in determining eligibility for multiple programs, and help ensure that beneficiaries receive all benefits, both health and social services, for which they are eligible.

Payment Models

Design and implementation of alternative payment models (APMs) and value-based purchasing (VBP) arrangements should be used to facilitate clinical transformations that improve maternal health outcomes and address health inequities. Use of the Alliance for Innovation on Maternal Health Program (AIM) patient safety bundles should serve as the anchors of a maternal health program.

States should consider alternative payment strategies that:

- Encourage providers to offer treatment for substance use and opioid use disorders for pregnant individuals.
- Support obstetric services provided by rural hospitals.
- Incentivize maternal health providers and behavioral health providers to coordinate care for pregnant individuals with behavioral health needs.
- Promote counseling and education on the importance of birth spacing, and the range of contraceptive options.
- Take care not to discourage valuable services. For example, reimbursement methodologies that bundle pregnancy services with Long Acting Reversable Contraceptives (LARC) create barriers to the provision of postpartum LARC. When LARC is included as a part of a bundled payment arrangement, providers have limited incentive to provide LARC devices to newly postpartum mothers because of the often-high cost of such devices. Reimbursing for LARC separately removes this barrier. For FQHCs, states should carve LARC out of the FQHC Medicaid encounter rate and work with MCOs to help FQHCs build same-day LARC capabilities.

Conclusion

State Medicaid programs, Medicaid MCOs, and FQHCs are strategically positioned to enhance women's access to health care and support services, ensure care continuity, improve maternal health outcomes, and advance equity. These outlined policy considerations can help to support those goals and ultimately ensure the delivery of high-quality health care to the individuals and communities they collectively serve.

Sources:

[1] Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not including accidental causes.
[2] Maternal Mortality Rates in the United States, 2019 (cdc.gov)
[3] Preterm Birth | Maternal and Infant Health | Reproductive Health | CDC
[4] ACE: Health - Adverse Birth Outcomes | US EPA
[5] National Health Center Program Uniform Data System (hrsa.gov)
[6] Exploring Health Center Capacity in Rural Maternity Care Deserts (hrsa.gov)
[7] National Association of Community Health Centers. 2016. Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers.
[8] Association of Clinicians for the Underserved, National Nurse-Led Care Consortium. June 2021. The Evolving Role of Nurse Practitioners in Health Centers and Considerations for Provider Satisfaction.
[9] Federal law mandates that FQHCs can bill Medicaid for face-to-face encounters beneficiaries have with the following providers: physicians, physician assistants, nurse practitioners, clinical psychologists, certified nurse midwives and clinical social workers. Additional providers may be considered billable depending on state rules.
[10] Medicaid Postpartum Coverage Extension Tracker | KFF
[11] 2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report.pdf (medicaidinnovation.org)
[12] Hodnett, Gates, Hofmeyr & Sakala, 2013; Health Connect One, 2014
[13] Strong Start for Mothers and Newborns Evaluation: Year 5 Project Synthesis Volume 1: Cross-Cutting Findings (cms.gov)

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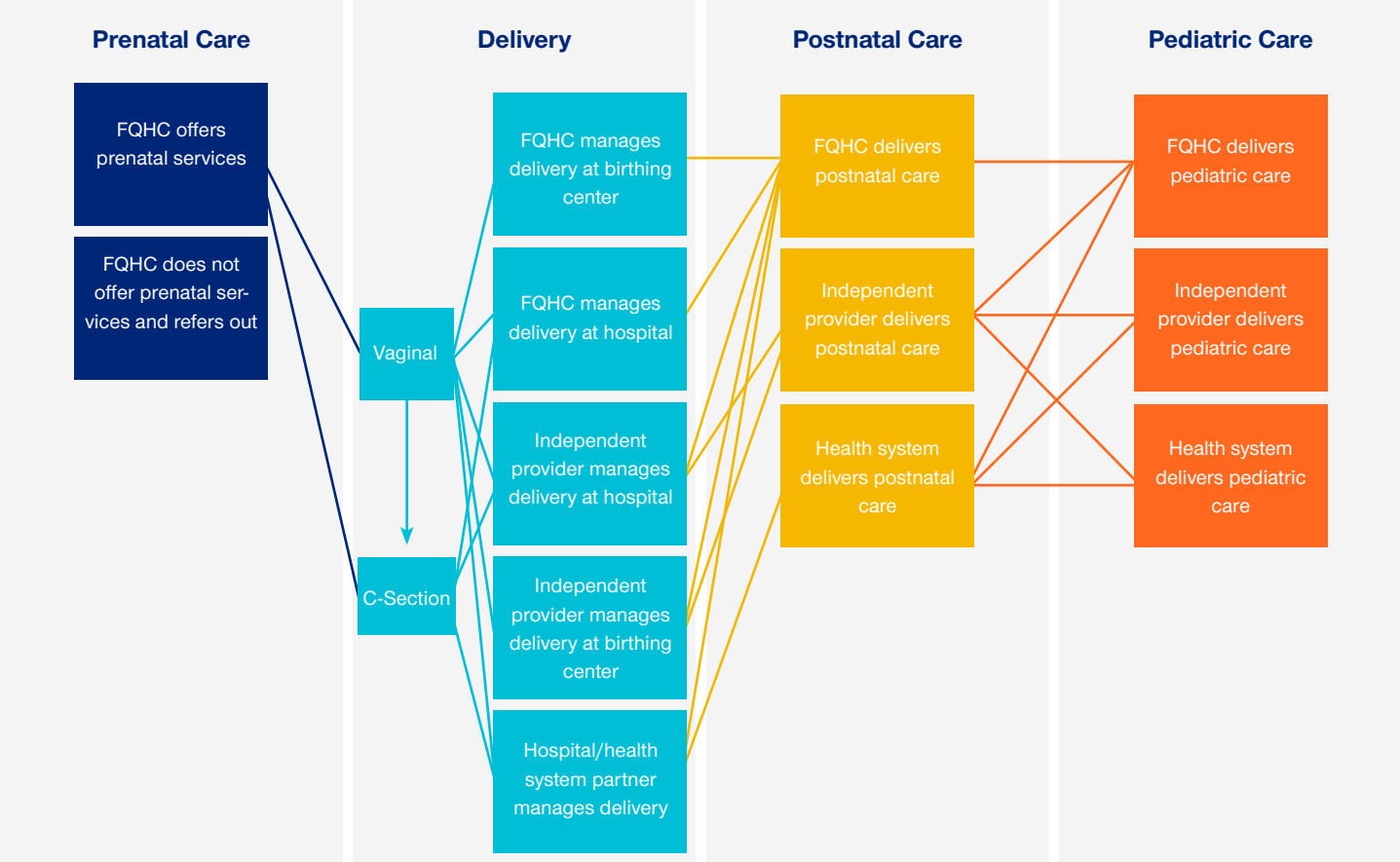
Appendix A. Maternal & Infant Health at Federally Qualified Health Centers (FQHCs)

Diagram of FQHC Maternal Heath Care Models

Preconception

Access to care preconception is crucial as health conditions and risk factors can affect a woman or her unborn baby if she becomes pregnant. Health centers provide a comprehensive set of services over the lifespan that can support a woman's health well before a pregnancy and long after, including:

- Primary Care
- Preventative
- Mental Health
- Substance/Opioid Use Disorder
- Dental
- Vision
- Pharmacy
- Lab
- Family Planning
- Transportation
- Translation
- Health Education
- Disease management
- Nutrition
- School-Based Services



Examples of Additional Services FQHCs May Offer Related to Maternal and Infant Health

Perinatal Care Coordination & Support	Breastfeeding Support & Education	Baby Items
Prenatal Group Visits	Sonography	Parenting Group Visits	Home Visiting	WIC