

Mathematica Policy Research, Inc. Webinar #2 Maternal Mental Health Screening,  
Treatment and Improvement Strategies-20240604 1801-1

[Derek Mitchell] Hello, everyone. My name is Derek Mitchell, an event producer with Mathematica. Thank you for attending today's Medicaid and CHIP Maternal Health Webinar Series. This is the second webinar in a series titled Maternal Mental Health Screening, Treatment, and Improvement Strategies.

Next slide.

Before we begin, I want to cover a few housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. Closed captioning is available by clicking the CC icon in the lower left corner of your screen. You can also click Ctrl Shift A on your keyboard to enable closed captioning. We welcome audience questions throughout today's webinar through the Q&A panel, which is located at the bottom right corner of your screen. If you'd like to submit a question, please select All panelists in the drop-down menu, and then click Send to submit the questions and comments. We'll be monitoring Q&A through the webinar, and we'll address as many questions as possible.

If you have any technical issues, please use the same Q&A panel to reach out to us. Select Derek Mitchell in the drop-down menu, and then click Send to let us know how we can help.

At the end of the webinar, a survey will pop up in your browser window. We're asking you to please respond and provide feedback to help improve future webinars.

We also would like to let everyone know that today's webinar is being recorded. We will send an email to all meeting registrants when the slides and recording are posted on [medicaid.gov](https://www.medicaid.gov).

Next slide.

As I mentioned, here's an illustration on how you can submit questions and comments throughout today's webinar. Use the Q&A panel to submit questions and comments. Click the All panelists in the Ask menu. Type your questions in a textbox, and click Send. Note all the presentation team will be able to see your questions and comments. Your questions will be read for all participants to hear both the question and the discussion. For webinar platform issues, as I mentioned, select host Derek Mitchell in the Ask menu.

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With those instructions out of the way, I would like to introduce Lekisha Daniel-Robinson from Mathematica. Lekisha, you now have the floor.

[Lekisha Daniel-Robinson] Hello, and welcome again to the Medicaid and CHIP Maternal Health Webinar Series. Today's session is Maternal Mental Health Screening, Treatment, and Improvement Strategies. We have a robust agenda today, which will start with a welcome and objectives from Kristen Zycherman, followed by a brief review of maternal mental health data, then an overview of the national strategy to improve maternal mental healthcare, and then state experiences from both Michigan and Pennsylvania. A discussion will follow the presentations; but you can enter your questions at any time during the

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presentations, given the instructions that Derek mentioned earlier. I'll now turn to Kristen Zycherman, quality improvement technical director with the Center for Medicaid and CHIP Services at CMS.

[Kristen Zycherman] Thank you, Lekisha. Thanks. Hello. And on behalf of CMS, we welcome you to our second webinar in our MIHI Summer Webinar Series. We are so happy all of you could join us today and that there was so much interest in this topic because we know you share our passion for improving maternal and infant health outcomes.

Next slide.

Our objectives for today are to provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP; to describe maternal mental health challenges for individuals covered by Medicaid and CHIP. Our colleagues at SAMHSA will provide an overview of the national strategy to improve maternal mental healthcare. And our colleagues from Michigan and Pennsylvania will share their strategies to address maternal mental health in Medicaid and CHIP delivery systems.

Next slide, please.

I will keep it short, as we have some great presenters I want to get to. But, as a bit of history, CMS launched the Maternal and Infant Health Initiative, or MIHI, in 2014. Now we are ten years into the initiative and still in the midst of a maternal health crisis, which you all know. So we're using this summer webinar series, which will be followed by two affinity groups this fall, to address two leading drivers of maternal mortality, mental health and substance use, which is the leading cause of maternal mortality overall; and maternal hypertension and cardiovascular health, which is the leading cause of Black maternal mortality. And, if you are interested in more about this and other demographic utilization and disparity data, I encourage you to check out our newly released Medicaid and CHIP Beneficiaries At a Glance Maternal Health Infographic available on our website. Now I will hand it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you, Kristen. So, again, just a very brief overview of maternal mental health in the country and then, specifically, the impact on Medicaid and CHIP as we set the stage for the rest of the discussion.

Next slide, please.

Mental health conditions around the time of is not uncommon. Here we show some data for common conditions associated with pregnancy mental health concerns during this time: depression, 25.4%; anxiety; post-traumatic stress disorder- or PTSD- full, or PTSD partial, where partial does not have all of the concerns that lead to a full diagnosis of PTSD. These conditions can co-occur. They are definitely concerning and are associated with some poor outcomes, some of which we'll discuss a little bit later.

Next slide, please.

In this slide, we show the prevalence of pregnancy related deaths with a mental health condition as the underlying cause by race and ethnicity. You can see the overall rate at the

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far left is approximately 22.5% for all groups. But for the White and American Indian or Alaska Native groups, these are almost double, if not more, the rates for other groups at 36.4% for Whites and 27.3% for the American Indian/Alaskan Native group, respectively. In fact, we have data showing that mental health conditions are the leading cause of maternal death for both Hispanic and White groups. So, while these are the rates associated with mental health, the leading causes of death among all conditions are mental health for those two groups. Next slide, please.

In this slide, we show the prevalence of self-reported postpartum depressive symptoms among women with a recent live birth by race/ethnicity, associated with the previous slide except we're talking about the incidence or the prevalence of the condition whereas the previous slide shows some poorer outcomes associated with mental health conditions and, in particular, postpartum depressive symptoms. Next slide, please.

While there are challenges in all groups, depression is more striking for postpartum individuals covered by Medicaid. You'll see here the Medicaid rate is at 17.2%, self-pay is at 13.2%, and private, lower at 10.1%. Next slide, please.

On this slide, we talk about the mental health treatment among female beneficiaries in Medicaid and CHIP. The graphic on the left shows the patients who received inpatient or outpatient prescription or virtual mental health treatment, whereas the second column shows the patients who needed mental health treatment but didn't receive. So, we're talking about some unmet need here within the population. Next slide.

Screening guidelines by the American College of Obstetricians and Gynecologists outlined recommendations for screening using validated instruments throughout various points within the prenatal and postpartum periods. Patient outcomes can improve with timely access to assessment, diagnosis, treatment, and appropriate monitoring and follow up for any positive screenings. Positive screens for self-harm or suicide should be assessed for likely good acuity and severity of risk of suicide attempt, and then arrange for a risk-tailored management approach for that condition. For postpartum psychosis, immediate medical attention is required as this is the severest form of mental illness characterized by extreme confusion and loss of touch with reality, paranoia, and disorganization in thought processes. Next slide.

Patient outcomes, as we just talked about, can improve when there is collaboration between maternal health or primary care provider, case manager, and a mental health specialist to screen for depression, monitor symptoms, treatments, and referral to any specialty care that may be needed. As we think about the maternal health continuum and the ACOG guidelines for screening, there are several points during the maternal health period to screen and treat mental health concerns to impact overall health status and reduce associated risk for severe maternal morbidity and mortality. The graphic shows that continuum and the potential places where we can impact maternal mental health and help to achieve an overall positive health status. If there are any subsequent pregnancies, that interpregnancy period is a really good time to address some of the concerns. So, we'll now hear from Dr. Nima Sheth, the senior medical advisor and associate administrator for Women's Health Services at the Substance Abuse and Mental Health Services

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Administration who'll talk about a national strategy to improve maternal mental healthcare and to identify some ways that we can turn the tide in terms of the poor outcomes experienced by some groups. Dr. Sheth.

[Nima Sheth] Hi. Thank you so much. It's so lovely to be here. We can go to the next slide.

I want to talk a little bit about the national strategy that just launched a couple of weeks ago here. It came out of a task force that was outlined in the last omnibus language outlined by Congress. It's co-chaired by SAMHSA and the Office of the Assistant Secretary for Health, so Dr. Delphin-Rittmon and Admiral Levine. There are several do outs from the task force. One is a report to Congress that was launched at the same time. The second is a national strategy on improving maternal mental healthcare. Next slide.

Today we'll talk through some of what's in the five pillars. There are essentially five pillars to the strategy and then some cross-cutting principles, that you see on the outside there: equity and access, federal collaboration, trauma-informed practices, and culturally relevant support. I'll go through the five pillars in much more detail, but these are the five pillars the task force came up with as leading to whole person dyadic perinatal mental health and SUD care. Next slide.

I'll just say, before we dive into the vision, the task force is organized under a FACO, which is a federal advisory committee. So, this is not a US government document, this is a federal advisory committee document. About half the members are US government members, and slightly under half are non-government members. We have a variety of stakeholders and experts on the task force from providers to medical professional societies, folks with lived experience, industry, and advocates in nongovernmental organizations. So it's an amazing, amazing group of people. It's about 120 people that have come together to write this document, collectively with lots and lots of expertise. This is the vision from the National Strategy, which is really talking about a system where we have true integration, and there's no longer a distinction between physical and mental healthcare, where models are integrative, innovative, and person-centered. Next slide.

The target audience for this document is the federal government, the Executive Branch, and a lot of the federal agencies that were helping to spearhead this task force. But it is also speaking to all of the partners of government. So, all of those entities, and stakeholders that are very involved with helping to implement this strategy as well. Throughout the strategy it's assumed that we have a whole of government approach, but at different times we do call out various entities to take particular actions as well. Next slide.

We'll dive into Pillar 1 here, building a national infrastructure that prioritizes perinatal mental health and well-being. Next slide.

So, there's five pillars. Each pillar is organized into several priorities, and each priority is then organized into several recommendations. Furthermore, each recommendation is separated into a Why section and a How section. The Why section is starting to give the rationale for why this recommendation, out of everything that we could have chosen. And the How section is starting to lay the roadmap for how to get to this particular recommendation. It's not a completely comprehensive, all-inclusive roadmap, but it starts

to talk to federal government and its partners around, what are some of the things that we can do? What are some of the ways that we could get to meeting this particular recommendation? So today I'm going to mostly review the priorities here with you on the pillars just for time's sake. I believe you'll have a link to the entire national strategy to review it. And the recommendations are here listed as reference, which I'll talk about but won't, because of time's sake, dive into too deeply. So Priority 1 is to establish and enhance federal policies that promote integrated perinatal mental health, substance use care. So, we also want to state that we include mental health, substance use care, as well as gender-based violence where possible, and try to really make sure that those things were woven in across every single recommendation. This priority entirely focuses on promoting integration across the board during the entire perinatal period, which means up until at least one year postpartum and having two-generation, or dyadic, care that addresses needs for mom, family, partner, as well as infants. And so you'll see recommendation 1.1.2 talks about six months of paid family leave and medical leave and universal childcare. So these are starting to talk about what are the things that we need to do at the infrastructure level? What do we need to change with regards to the infrastructure, to set up a system that sets up these families for success? Next slide.

The next recommendations under 1.1 continue to be these infrastructure support type recommendations. So, setting up policies that are non-stigmatizing and non-punitive, especially when it comes to substance use disorder screening, mental health conditions, and also suicide. Investing more federal funding into all of our programs to make sure that these topics are incorporated into the current programs that address maternal childcare. We do talk about embedding childcare into healthcare facilities, also just increasing the implementation of clinical guidelines and evidence-based interventions across the board, whether that is in technical assistance in the federal sphere, as well as what we're promoting in the field amongst practitioners. Next slide.

This is, again, a continuation on improving infrastructure but now focuses more on a reduction of disparities and promotion of perinatal mental health and well-being. This first recommendation talks about preventative services and making sure that, again, all of our funding is including this population into its current programming, all the way across the board from screening and prevention to treatment, referrals, linkages, recognizing that structural racism and historical trauma have an impact on the outcomes that we're seeing now and prioritizing solutions for improving racial equity. And then the last one is talking about maintaining the work of this task force by turning it into a coordinating committee past the 2027 sunset date. Next slide.

Now we get into Pillar 2, which is to make care and services accessible, affordable, and equitable. Next slide.

Priority 2.1, then, is to start talking about screening, diagnosis, and linkages, so the recommendations in this priority are really focused on that. This first one is talking about getting comprehensive pathways to improve screening education, as well as resources and linkages to care. And then the next one here is talking about looking at diagnostic criteria to be more accurate. So to look at range, timing, frequency specifiers. That includes looking at diagnostic criteria like the DSM or the ICD. Next slide.

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Priority 2.2 here is talking about creating accessible integrated evidence-based services that are affordable and reimbursable. So, this is where we start to talk a little bit more about accessibility and affordability. This first recommendation is talking about innovation of care delivery models. So here we talk about things like improving telehealth infrastructure, home-based care, home visiting programs, flexible patient scheduling outside of typical hours, things like that. This next recommendation is our primary recommendation on crisis services. It's talking about crisis intervention, training the workforce on crisis care and crisis care provision, and development of infrastructure and training for crisis care in perinatal populations in particular. Next slide.

A continuation of Priority 2.2, this one is talking about working with all states and all payers, not just Medicaid, but all payers to help establish financial incentives to increase reimbursement across the board because we know Medicaid reimbursement often is extremely limiting and limits the types of providers that are offering care. Also, to then strengthen the continuity of care in the community by encouraging federal agencies to add requirements under funding opportunities to develop partnerships in the community, so there's more of a smooth transition and strengthen linkages from treatment into the community and recovery support as well. Next slide.

Priority 2.3 is all about building capacity and really expanding and diversifying the entire perinatal health workforce. So all of these recommendations focus on ways that we can expand our workforce and improve the workforce. The first one is talking about all federally funded training and curriculum technical assistance having the appropriate content around perinatal mental health conditions, inclusive of SUD and GBV. The next recommendation is talking about educating future and current clinical providers. So, it's all the continuing education requirements, current certification requirements in the field, making sure that there's adequate and robust education around perinatal and mental health. Next slide.

So, again, a continuation here is to allocate long-term funding to sustain consultation programs that really help with expanding the capacity of both clinical and non-clinical providers in the perinatal mental health space. And then the last one here is talking about bolstering recruitment and training efforts to really expand the clinical and non-clinical workforce, particularly in under resourced areas. So expanding funding for current programs, creating new programs, working through public/private partnerships to do more as well. Next slide.

Now we're into Pillar 3, using data and research to improve outcomes and accountability. Next slide.

Priority 3.1 is looking at the use of data and research to support strategies and innovations that improve outcomes. The first recommendation here is calling for an expert panel that would oversee a national research agenda around perinatal mental health and goes on to talk more fully about what that research agenda would entail. This next recommendation is talking about building the trust of under resourced communities who have traditionally experienced abuses when participating in research and data collection efforts. So, this is a call to get more perinatal and nursing populations into research studies but with the

highest ethical regard and really keeping in mind the past abuses that populations from under resourced populations and populations from diverse ethnicities have experienced in the past. It builds on other recommendations that have called for learning more about perinatal mental health during this period. Next slide.

Recommendation 3.1.3 is talking about data linkages and integrated data systems, as 3.1.4 gets into creating a central clearinghouse of data and information that's accessible so the public can kind of quickly identify all the resources for perinatal health data. The last one here is really talking about implementation guidance and dissemination strategies that are paired with research and scientific findings so that, when new research comes out, there's guidance on the implementation of recommendations there and really talking about translating that research into practice and making it accessible. Next slide.

This priority now focuses more on accountability and prevention screening, intervention, and treatment. So, the first one is talking about quality improvement, essentially, and establishing and implementing quality improvement metrics for providers and hospital systems and insurers with longitudinal tracking of costs and outcomes. The next two are talking about expanding support for perinatal quality collaboratives in all 50 states, DC, and US territories. The last one is the same, to continue to fund the maternal mortality review committees in all of these areas, as well. We know that they are currently funded, but the task force felt strongly to call out the continuation of that funding to ensure that it's sustained. Next slide.

Now we're into Pillar 4, promoting prevention and engaging, educating, and partnering with communities. Next slide.

4.1 is really starting to talk about prevention at the primary prevention level and the community level. So, looking at elevating and funding evidence-based practices that promote community level detection and prevention, especially in under resourced communities. So, looking at programs like centering pregnancy prep, models like the year model that came out of the University of Maryland, for example, that are looking at bringing care and screening into the community in hair salons. Are there ways that we could adapt those types of interventions for this population, in particular? So, looking at those kinds of things that can be done at the community level and in the realm of primary prevention. Next slide.

4.2 is focused on education of the public about perinatal mental health and substance use and engagement with communities. Here we talk about a nationwide approach to clarifying messaging in the target audience. This is talking about creating a central repository for all of the crisis support warmlines and hotlines so that perinatal populations and families know exactly what service is for what, what hotline is for whom, and how to use these resources to best help them. The second one here is talking about some specific ways of engaging and educating the public. So, for example, they talk about -- here they talk about a national campaign, how to engage more communities in conversations, how to decrease stigma through national campaigns and things like that. Next slide.

Our last pillar is on lifting up lived experience. This is a really important and integral part of the national strategy that we've tried to highlight throughout. If you read the strategy, you'll see that there's direct quotes from folks with lived experience throughout the report to Congress and the National Strategy have them embedded throughout the recommendations, the priorities, and the pillars. We very much deliberately chose to make this an active part of the pillar. We didn't want to make it a pillar or to make it an active part of the strategy because we don't want it to get lost in any way. Some of our colleagues from the US Digital Services did a research sprint to support this piece, and they created a whole separate report from this. They interviewed several individuals with lived experience as well as providers that had a lot of experience in treating perinatal populations. A number of recommendations came out of that report that we then put into the strategy. Next slide.

Priority 5.1 is to listen to the perspectives and voices of people with lived experience. And, again, this all is out of that USDS Lived Experience Report. These are some of the themes that came out of that report, to really focus on the care for mothers. Often there's a sense of the care immediately going to the infant, and the mom can feel left out and forgotten. Building trust, understanding mothers as people and what's happening in their lives; and then responding to the needs of mothers and their families. Next slide.

And then Priority 5.2 is prioritizing the recommendations from people's lived experience. I won't read all these, but these are the specific recommendations that really came out of the Lived Experience Report. Each of these are mapped onto the recommendations that we have in the national strategy. If we go to the next slide, we'll see that.

You can see that each recommendation maps onto a previous recommendation that was noted in earlier pillars and priorities. Next slide.

So, I just briefly want to talk through some next steps. Now that the strategy is out, we are very actively working on implementation planning, which is really going to be recommendation by recommendation, who are all the entities that would help lead the implementation of those recommendations. So, we have started on that, and we'll be continuing with that. There's also a report to governors that's been outlined in the Congressional language. We're thinking that sometime in the spring of 2025 we want to do a lot with the states. We want to talk a lot with local government and talk about what the strategy means for states and hear from them on things that might be missing, on what implementation for states looks like with regards to the national strategy and opportunities for partnership and collaboration with states to see what we can do together. There will also be updates to the national strategy and the Report to Congress. I believe that might have been the last slide. Next slide.

This is just some of our contact information. I will then pass it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you, Dr. Sheth. And, as a reminder, the slides will be available within a couple of weeks on [medicaid.gov](https://www.medicaid.gov) is up. If you registered, we'll provide information on when it is posted. So thank you so much for your presentation. There was a lot to discuss.



As you talked about the strategies that states might be able to support, I think it's a perfect segue to our state presenters.

I'd like to now turn to Dr. Meagan Chuey, who's the nurse consultant with the Division of Maternal and Infant Health, where she supports projects that aim to improve health outcomes for families that are eligible for Medicaid. Prior to her working in public health, she enjoyed working clinically as a nurse and midwife and pulls from these experiences regularly to inform her public health efforts. Dr. Chuey.

[Meagan Chuey] Thank you so much for that introduction, Lekisha.

I really appreciate the opportunity to speak with all of y'all this afternoon about a Michigan initiative that we have to utilize a smart phone app to connect families with state-specific resources, including mental health and substance use resources. Next slide.

So earlier, Lekisha reviewed some national statistics related to mental and behavioral health challenges in pregnant people, and Michigan has certainly not been immune to these trends. Michigan PRAMS survey data shows us that depression is very prominent in the peripartum period, affecting 1 in 5 people prior to and during pregnancy, with approximately 1 in 6 people experiencing depression in the postpartum period. Additionally, about a third of postpartum people report anxiety in the three months prior to pregnancy. We also know that the rate of people who have an opioid use disorder noted at their delivery has more than quadrupled from 1999 to 2014. And we know that these mental and behavioral health challenges have wide-reaching impacts on the pregnant person, their developing fetus and infant, and the family as a unit. But perhaps most permanently, these things contribute to significant mortality in Michigan. Suicide accounts for 5% of pregnant associated mortality in Michigan, and substance use disorder accounts for 29% of pregnancy associated mortality, that pregnancy associated mortality being the death of someone who is pregnant that occurs during birth or within one year postpartum. And I just want to pause to let that sink in for a moment, that over a third of pregnancy associated mortality in Michigan is due to suicide and overdose. So, when we're thinking about improving maternal outcomes and addressing preventable causes of death, connecting people to resources and services to address depression and substance use has immense potential and is incredibly important. Next slide.

Michigan wanted to work with a pregnancy focused smart phone app that could be utilized to connect Michigan families with state-specific resources. And so we conducted a bidding process to identify the app we would partner with. It was important to us that the app be able to incorporate articles that would link directly to those state-specific resources and that we had the agility to add articles and resources as needed for time-sensitive issues. We wanted the ability to survey users to gain an understanding of what resources they were and were not aware of prior to the app. And we wanted to be able to look at and learn from data related to article engagement and click-through rates. So we ended up selecting an app that had a far-reaching platform that was already available in 22 languages and that 43% of first time pregnant people were already downloading. We appreciated the diversity of users that were supported with the app, including a 3D baby development model that was interactive and the user could choose the race or the color of that baby to best represent

what the parent thought that their baby would look like. Also of note, we knew that approximately 45% of the existing users of the app were eligible for Medicaid. Next slide, please.

A lot of these statistics were demonstrated in Michigan specifically, with a third of pregnant people already downloading this app and over half being eligible for Medicaid. And of note, a little over a third of users identified as Black or African-American. I wanted to highlight this because we know that there are long-standing maternal and infant health disparities in Michigan and that these disparities are rooted in racism and systemic injustices. And so, to address not only maternal health outcomes broadly but racial inequities in these outcomes and inequities and access to services, we wanted to make sure that the systems that we're developing are available to and useful for Black families. Next slide.

So, what does this look like in practice? When a user joins the app, they're asked for their state of residence and what insurance they have. Users are shown a personalized feed of articles and videos on their main app page based on their gestational age. So users that say that they reside in Michigan will see the Michigan-specific content that we've developed in collaboration with the app creator. We've developed a couple dozen articles at this point, each with a link to a specific Michigan web page for more information or assistance. Additionally, Michigan-based users see what we call the sticky card on their main app page, which always stays in the same place; and clicking on it lists all of the resources that have been linked to in the app. So the thinking here being that someone may see a resource one day, not need it or want it at that specific time, but at a later date they might want to quickly be able to access it without scrolling through all of the articles in the app. So, the sticky card captures all of these resources in one location for users to find easily and quickly. Next slide, please.

As I mentioned, we have dozens of Michigan-specific articles, including a mental health article. And it was written in a way to normalize peripartum mental health struggles. It lists possible symptoms of anxiety and depression, and it links to a behavioral health resource finder that is searchable by county for Michigan. We also have three different articles in the app that relate to substance use, the first being a general article about substance use and pregnancy and things to know regarding potential harm or impact to the fetus. We have an article about medication safety generally, and the importance of locking up and keeping out of the reach of children all medications or substances, including methadone, marijuana, and edibles. And the last thing, an article about the plan of safe care. If you're not familiar, a plan of safe care is a personalized and comprehensive document that addresses the needs of infants that were born exposed to substances in their families. So Michigan has been working diligently to support the plan of safe care for all infants that were born exposed to substances. And we're working towards a new protocol that supports developing a plan of safe care prenatally rather than only after the baby is born. The idea here being that connecting families to resources and treatment as early as possible in the pregnancy helps support that family, strengthen the dyad, and hopefully reduces the risk of infant separation or child welfare involvement for the family postpartum. This article talks about what a plan of safe care is, why it's helpful, and where a pregnant person can get help in completing one prenatally. Next slide.

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The funding for this work came from the Governor's Healthy Moms, Healthy Babies Initiative with a specific goal of linking families to home visiting. Michigan has eight evidence-based home visiting models with hundreds of home visiting agencies across the state that serve pregnant people and their infants through toddlerhood. While each of these models has their own eligibility criteria and strengths, they all aim to link families to needed resources, including mental health and substance use support. At any time, the app has eight to ten articles, videos, and stories that highlight the ways in which home visiting can support families and the benefits of home visiting, recognizing that this connection is a further opportunity to offer pregnant and postpartum people screening for mental health and substance use challenges, and to support people in engaging and accessing needed treatment. These articles about home visiting link to our home visiting web page that is hosted on Michigan's 211 website. And we recently built the ability for families to send itself referrals to home visiting agencies electronically. So rather than families having to pick up a phone and call to be connected with home visiting, they're able to complete a screening tool that identifies which of the models they're eligible for and which agencies in those models are available in their geographic area. So, the app works to connect people to mental and substance use supports through articles on those specific topics and also by linking to home visiting for ongoing support and connection to resources in person for a family as needed. Next slide.

That is all I have. Happy to answer any questions at the end, and I will pass it back to Lekisha.

[Lekisha Daniel-Robinson] Excellent. Thank you so much. I'm sure there will be questions. But now, next slide, please.

I'd like to turn to Dr. David Kelley, who is the chief medical officer for the Pennsylvania Department of Human Services Office of Medical Assistance Program where he oversees the clinical and quality aspects of the Medicaid program and provides benefits to over 2.5 million recipients. Dr. Kelley.

[David Kelley] Good afternoon, and thanks again for the opportunity to be able to share some of the activities that Pennsylvania is doing concerning maternal mental health. Next slide.

This is a really brief outline of many of the activities that we've done over the years and listed almost historically.

Just as some context, within Pennsylvania, we have mandatory managed care for over 2.7 million recipients. And we provide over 40,000 live births, about a third of the state's births. And we have done adult and postpartum expansion. And we are a behavioral health carve-out state. So, it gives you a little bit of contextual background.

So, several of the activities that we've done over the years related to mental health. And, again, there are a lot of activities we've done around substance use disorder, but I'm going to focus primarily on mental health today.

First is really screening for moms for depression at well-child visits and paying some extra for that activity. We know that moms tend to show up quite frequently at the well-child visits, and it's an extra opportunity to screen and then get those individuals into treatment. Or the second intervention that we've done, and this has been going on for many, many years is what's called our OB Needs Assessment Form. This is a form that providers fill out electronically and submit this information to our physical health plans. So before our physical health plans ever get a claim, on this Needs Assessment Form is a whole host of information, including mental health conditions and screening activities, both prenatal and postpartum, for depression but also for other mental health conditions and SUD conditions. It's an easy way that's non-claims based for our MCOs to gather the information that they need. And then they can take that information and work with individuals and providers to get them additional services like our home visitation program that I'll talk about in a little bit. This also allows our providers to work collaboratively with our MCOs who identify individuals that have the highest need and get them into those mental health services and SUD services that they need.

We also for many years have had our managed care plans annually report both prenatal and postpartum screening, as well as treatment. And these are quality measures that are validated each year. They're done with chart review. It gives us really a good pulse on what is happening within the OB offices and our federally qualified health centers. Typically, our screening rates are around 86% for both prenatal and postpartum. And those that screened positive are somewhere between 19 and 22%. And our treatment, per the chart reviews, ranges anywhere between 85 to 90%. So it gives us an idea of what's happening within those offices. Happily, I'll say that we've seen a steady increase in those measures each year. I will say that we do see about a 4 or 5% absolute inequity in both of those measures. And that's something that we want our health plans and providers to work on.

Next, we have a Perinatal Quality Collaborative that has really focused mainly on SUD. And Michigan mentioned the plan of safe care. Likewise, there's a big effort working within our OB community in those health systems to provide screening early on and develop plans of safe care for SUD and then make sure that those moms continue in treatment and their substance-exposed infants are monitored and cared for appropriately. There also is a huge second additional effort on maternal depression called MOMD, and I've put a link in there to some of the quality improvement activities at the provider level. Within Pennsylvania, we have several large integrated health systems that have, in some instances, collaborative and integrative care models for physical health, behavioral health, and SUD, live within those practices. I wish we had more of them.

And then there's a lot of leveraging the use of telemedicine. But, within a lot of our large health systems, there has been a longtime focus, both during prenatal and postpartum visits but also during hospitalization, to really do depression screening and to also make sure that those folks get referred for treatment.

The next bullet, again, is just a mention of our home visitation program. And this is, again, where licensed and unlicensed individuals can be visiting any mom that's high risk or a first-time mom, and it goes up to 18 months postpartum. This is an opportunity for individuals working in community-based organizations to interact with mom and to

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identify issues for both mom and baby, and maternal depression screening being just one of many things that they're looking to monitor, and then provide advice as far as getting folks to clinicians, if indeed they are finding that someone may indeed be depressed. One of our value-based arrangements that we have with our maternal care providers, we have a care bundle gain share program. And I'll just mention that it does reward specifically for both prenatal and postpartum depression treatment so not screening but actual treatment. Our big focus is on screening. But really, the bottom line is getting individuals treatment as well.

And then I'll just, to be forward looking, one thing that we're still openly discussing and hoping to operationalize is a perinatal behavioral health consultation call-in line for providers that, if they have an individual that screens positive and perhaps there's not quick availability, or that OB or PCP may not feel they have the expertise to treat mom, this consultation line can be a good next step. So I'll stop there and turn it back over to Lekisha.

[Lekisha Daniel-Robinson] Great. Thank you, Dr. Kelley.

So, we have a number of questions that have entered into the chat and/or the Q&A pod. Next slide, please.

If you have additional questions, please feel free to add. We are running low on time, but we'll answer as many as we can. The first one here is, at which points during the perinatal period should mental health and substance use screening be done? For mental health, screening should occur at the first OB visit, at a midway point between 24 and 28 weeks, and then postpartum. As far as screening for opioid use and other substance use disorders, it's typically done or recommended to be done as part of that first, comprehensive OB visit. The next question is for Dr. Sheth, but I understand her colleague Madonna Green is available. What suggestions do you have for integrating behavioral health into holistic care for Priority 1, for states that have behavioral health carve-outs? And Dr. Kelley also spoke to that.

[Lekisha Daniel-Robinson] So, can we talk about how OBs are reimbursed for completing the OB Needs Assessment Form and how many OBs actually complete and submit those forms? For Dr. Kelley.

[David Kelley] Sure. Thanks. Actually, our managed care plans provide incentives to the providers to complete those forms. Each MCO has a slightly different incentive in dollar amounts, but there are dollar amounts that are paid to the providers to complete either the series or up to three OB needs assessment forms. I think the last time we looked at our data we have at least one OB Needs Assessment Form on 85% of our live births. So it's pretty high uptake, and there's really very good information flow.

[Lekisha Daniel-Robinson] Thank you. Let me pose a question to Dr. Chuey. What state services are underutilized that you want to see utilization increase as a result of the app?

[Meagan Chuey] Thank you for that. So the main intention of starting the relationship with the app was to increase awareness of and uptake of home visiting. So that has been our main push. We've also surveyed the users to see what type of resources they need and have

developed articles accordingly. The users that we surveyed have said that they need more support in breastfeeding. There continues to be a big need of connecting folks to WIC, as well as My Bridges, which is our state application for social services. Those are the biggest, although we have found that all of the dozen-plus articles have good reading statistics, good click-through rates. So even if they're not the most popular, there is enough of a breadth of connections to resources and services that it seems like there's uptake of something.

[Lekisha Daniel-Robinson] Great. Thank you. And can you talk just briefly about how the app is financed? Are there any fees to users or anything like that, that you can share?

[Meagan Chuey] It's free for users for the basic platform. It is paid through charges by the number of users per month who are eligible for Medicaid. And so, when users join the app, they're asked what type of insurance they have. If they say that they have Medicaid or that they are currently uninsured, they qualify for our purposes as Medicaid eligible. And so that is how we are charged for these services. The folks that report receiving Medicaid or being Medicaid eligible also have access to the plus version of the app that you typically do have to pay for, but they have access to that for free, as well, which includes additional videos and support.

[Lekisha Daniel-Robinson] While you have the floor, let me pose a question to you about how the app is promoted.

[Meagan Chuey] So the app company themselves do the promoting, so they have their own promotion for the app. Then we're charged for how many of those folks are eligible for Medicaid. What we have heard from our home visiting agencies and our home visitors in this state is that they also want the ability to more easily connect the families that they're already serving to the app because there is such a wealth of information there. So we're developing QR codes on badge buddies for home visitors so that they can have something that's easily scannable from the phone to the families that they serve so that those families can then download the app and have access to all the resources on the app.

[Lekisha Daniel-Robinson] I think we have time for maybe one to two more questions. Thank you for your that response. How is Pennsylvania defining treatment for care?

[David Kelley] Quality measures?

[Lekisha Daniel-Robinson] Yeah.

[David Kelley] Sure. So, we developed this measure probably over a decade ago, actually preceded the NCQA measure. And we at the time looked at administrative claims. So even though we're a carve-out state, we have the ability to look at behavioral health claims. So you could look at follow up for various types of counseling on the behavioral health side of the fence, and then we also looked at pharmacy claims. So it's very similar to the NCQA logic. And I'll say that we preceded the NCQA, we wrote a lot of the logic around the claims-based approach, but we looked at both counseling-related services from behavioral health providers, as well as medication, looking at pharmacy claims.

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[Lekisha Daniel-Robinson] Great. Thank you. So, let's go to the next couple of slides, please.

Some upcoming events and opportunities. I want to thank everyone for joining today and for our wonderful presenters for those presentations and responses to questions. We have a few more presentations coming up on the series. The next one will be June 25, Decreasing Fragmentation and Maternal Substance Use Disorder Screening and Treatment. I know that there were a couple of questions related to that, so stay tuned. Next slide, please.

And then, as Kristen noted at the outset, there are maternal health affinity groups for which there will be an expression of interest webinar on August 6 related to maternal mental health and substance use, as well as improving maternal hypertension control. So, more information to come there. Next slide.

The link provided here is for the Medicaid and CHIP Beneficiaries At a Glance Maternal Health Infographic that Kristen also mentioned at the beginning of the webinar, as well as other information about addressing maternal mental health and substance use disorders. Next slide, please.

At the end of the webinar, there will be a survey. We ask that you complete that so that we can use that to inform future webinars, as well as technical assistance opportunities.

If you have any additional questions, please feel free to address them to [MedicaidCHIPQI@cms.hhs.gov](mailto:MedicaidCHIPQI@cms.hhs.gov).

Thank you again, everyone, for joining.