ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Video Transcript: Perinatal Mental Health Conditions in the Outpatient Setting Community of Learning

Session 4: Maternity Care Payment Reform and Partnering with Health Plans

Vira David-Rivera [00:00:00] Welcome everyone. My name is Vira David Rivera and I'm a TA Specialist with the AIM TA Center. Thanks for joining us for the Perinatal Mental Health Conditions Bundle in Outpatient Settings Community of Learning. This Community of Learning is jointly produced with the Policy Center for Perinatal Mental Health. As you join, please share your name, state, organization in the chat so we can know who's in the room today. Let's get started.

Vira David-Rivera [00:00:27] The Community of Learning is hosted by the Alliance for Innovation on Maternal Health Technical Assistance Center or the AIM TA Center. AIM is a quality improvement initiative to improve best practices that make birth safer, improve maternal health outcomes, and save lives. The AIM TA Center is managed by JSI Research and Training Institute, a nonprofit public health consulting organization that works both internationally and across all 50 states. We are dedicated to improving lives through better health and education outcomes for individuals and communities. The AIM TA Center is supported by a cooperative agreement with the Health and Human Resources Services Administration within the Department of Health and Human Services. The contents of this webinar today are of the authors, and they may not reflect the policies of HRSA, HHS, or the U.S. Government. Your feedback is important to us. My colleague will chat in a link for the session's evaluation. Please open the link and take a minute to complete the evaluation after the session. I'd like to introduce the AIM TA Center team who made this session possible today. Cora Kakalec, Tanisha Luthria, and Meg Sheahan. The AIM TA Center is excited to share these new posters. Thank you to the Illinois PQC for sharing their local Illinois posters that these were modeled after. We have three posters, perinatal mental health poster for emergency department providers, perinatal mental health posters for OB providers, as well as treating perinatal mental health conditions. They're all available to download and print on our website. This is our fourth session of our community of learning and we'll be focusing on maternity care payment reform and partnering with health plans.

Vira David-Rivera [00:02:34] I'd like to introduce our guest speakers today. First, we have Judy Theriot, who is the medical director of Kentucky's Department of Medicaid Services. Our patient family partner is Robin Coleman, who's a certified maternal infant health community health worker. And finally, Kylie Hibshman, the director of integrated behavioral health from the Colorado Perinatal Care Quality Collaborative. Will be joining us to speak about their experience for implementing the perinatal mental health bundle in outpatient settings. Robin Coleman is a patient family partner and maternal mental health advocate located in Michigan. Robin's passionate about amplifying patient voices, supporting families through pregnancy and postpartum challenges, and contributing to systems that ensure mothers feel heard, respected, and supported throughout their care. Robin's story

really demonstrates the role that insurers are playing in ensuring that women can access the care that they need. So I will turn it over to her.

Robin Coleman [00:03:52] Hi, my name is Robin. I'm a patient family partner with Momma's Voices and I come to you with this work as a single mother of three, a community health worker and a mental health support student. But most importantly, as someone who lived through the gaps, we are addressing here today. My pregnancy and births were not just medical events. They were moments when systems failed to listen, communicate or protect me. And those failures shaped my commitment to maternal health advocacy. My first live birth was an emergency C-section. I had employer-based insurance and went in to expecting to be a part of my own delivery. Instead, my labor was fed up with pitocin, complications began, and suddenly everything moved fast. When I was placed on the operating table, I realized a resident was performing my surgery. And not because anyone told me, but because I heard the teaching and instructions happening over the curtains as I laid there terrified, wondering if my baby was okay. I gave birth to my son, but I did not meet him for five hours. He had swallowed meconium and the cord was wrapped around his neck. No one clearly explained what was happening. I was not included, informed, or treated as a partner in my own care. That separation and lack of communication stayed with me long after surgery. My third birth was another traumatic C-section. My first incision had opened up days after surgery, so I already carry fear into this delivery. During the third birth, my son was hiding under my left muscle, which required more cutting, more bleeding, and more time. My blood pressure spiked dangerously high once again. I could not meet my son until my pressure was stabilized. Three sons, two traumatic births. In both, I experienced separation, silence, and a loss of control. After my third birth, I experienced postpartum depression. My OB-GYN recommended someone with experience in postpartum mental health, but my insurance could not cover that provider. Instead, I had to see one someone chosen by my employer's plan. That provider told me I was not experienced in postpartum depression and instructed me to return to work. I had just given birth. Was emotionally overwhelmed, carrying for three children and carrying a history of miscarriage. My employer of 14 and a half years did not take my mental health seriously, even with the full knowledge of my loss and symptoms. I ultimately walked away from my job because I had no choice. My mental health was deteriorating, and the system that was supposed to help me and support me failed me. Insurance, employment, and clinical care failed me at every level. At the patient safety level, bundles exist to prevent exactly what happened to me. Bundles create standardized informed steps that ensure mothers are listened to, risks are identified early, mental health screening is consistent, follow-up actually happens, communication is clear, and care is equitable across payer types. No one falls through the cracks. Bundles are not just checklists. They are accountability structures that are promised that no matter where a mother delivers or what insurance she carries, she will receive the care that is safe, respectful, and rooted in best practices. If bundles had been fully implemented during my births, I believe my outcomes in postpartum mental health could have been different. The transition away from bundled maternal payments and the introduction of new CPT maternal codes in 2027 creating a moment of change. Payment reform can strengthen maternal mental health screenings, ensure reimbursement for follow-up care. Support warm handoffs to mental health providers, encourage collaboration with Medicaid, managed care and commercial plans, reduce payer-based disparities, and make patient safety bundles sustainable and enforceable. My story shows that when mental health screening is optional, follow-up is inconsistent and insurance determines the quality of care instead of clinical need, families suffer. Payment reforms can change that. I am not here to blame clinicians. I am here because I believe clinicians want to provide safe, equitable, compassionate care and because systems can often make that harder than what it should be. Here is what I hope you carry with you today. Listening is a clinical intervention. When mothers say something

feels like it's wrong, believe them. Communication is care. Explain procedures, explain decisions, and include us. Mental health is not separate from maternal health. Screenings, referrals, and follow ups must be routine, not optional. Insurance status should never determine the quality of care. Payment reform is your chance to help change that. Bundles save lives. They create consistency, accountability, and equity. My story is not rare. It is not common. And this is exactly why I'm here today. Thank you for listening to me.

Vira David-Rivera [00:10:47] Thank you so much for sharing your story, Robin, and I would like to charge all of us to improve care so that every woman receives the care that she needs regardless of her insurance type. Now I'd like to hand things over to Joy Burkhard, the executive director of the Policy Center for Maternal Mental Health.

Joy Burkhard [00:11:11] Thank you so much, Vera and Robin. I just want to echo Vira's words. We see that you're here with us and want to say thank you. What a perfect tee up to today's session. And I know others on the line, just like I heard various themes in your story, including disparities in insurance types, which is sort of backwards from the way we think about it, that there can be disparities with commercial insurance as well. We also heard about the importance of listening to women during labor and delivery, and I'm sure many other themes. So we welcome all of you to share and chat what stood out for you about Robin's story. And I have the pleasure now, it was a great introduction for me, Robin, to get to move into maternity care unbundling and talk about several key issues that are important for all of to think about as we head into 2027. And you'll see our objectives today are to talk about that bundled maternity care payment and the sunsetting of the CPT codes and what this all means for quality improvement, not just related to maternal mental health, but certainly will impact maternal mental health. And we'll also get to hear, as we heard earlier, from Judy Theriot from the Medicaid agency in Kentucky to talk the role of state Medicaid agencies in effectuating change with maternal mental-health. And then we'll get to here. About strategies from our partner at the Colorado PQC and how they are working to implement the perinatal mental health bundle in outpatient settings in rural Colorado. So very excited to hear about those strategies as well.

Joy Burkhard [00:12:59] Now I'm gonna talk a little bit about what I will cover just briefly, because there's quite a bit. We'll talk about the powerful role of payers in effectuating change in maternal mental health, particularly with regard to outpatient quality improvement. We know that hospitals control a lot of the work that we lead at PQCs and AIM entities with regard inpatient settings. And insurers play the same role for outpatient quality improvement. We'll talk about case management. We'll talked about bundled payment. This will be the core of my presentation and how unbundling of payment will change things for all of us. And then we'll also review the American College of Obstetricians and Gynecologists, prenatal and postpartum care guidelines. And again, talk about unbundling specifically. So just a reminder about the role of payers and who do we mean when we talk about payers? We mean health insurers, health plans. They're really one in the same, although the term health plan tends to be used all the time when we're talking about Medicaid and sometimes health insures are used when we talked about commercial, but generally that term health plans is interchangeable. Medicaid agencies are also considered payers and employers who are what are called self-insured are also considered payers. We'll really be talking about the role of health plans and health insurers. Also wanted to distinguish between the difference between two core concepts, coverage and payment or reimbursement. So provider contracts can include important things relative to payment. Of course, what we will pay providers for various services and also reporting. Can be requirements in provider contracts. When we talk about coverage, we really mean coverage on a member or patient contract. So for example, is there

coverage for care through 12 months postpartum on Medicaid plans? That's what we will cover for the patient. And again, reimbursement or payment is the concept for provider contracts, so just wanted to distinguish between those two things, coverage versus payment. Also, quality management committees are required by the National Committee for Quality Assurance, NCQA, at all health plans who are accredited, and most health insurers' health plans are accredited by NCQAs in the United States. So an important lever for all of you to think about when you think about QI work and partnering with health plans. We also wanted to share that all, I think it's safe to say all health plans and health insurers have what are referred to as high-risk pregnancy case management programs. We put here, and postpartum, because there's a push to expand those case management or care coordination programs to include the postpartum period. What we like about these case management programs, it puts the onus directly on health plans to assist patients in navigating maternal health care, but of course, maternal mental health care which can be particularly challenging for patients when they're in a bad state, with suffering from depression or anxiety, for example, and the bifurcated system. We often have two contracts and two policies for mental health, a separate phone number to call, separate staff to work with for mental help, and so placing the onus on the medical high-risk pregnancy case management program to navigate these things can be very helpful for patients. And of course, for OB providers who are now home base for screening and detection. We also just thought it'd be interesting to share that California recently passed a law that's first in the nation to require health insurers to provide maternal mental health case management programs. So anchoring this care coordination into their current high-risk pregnancy case management of programs and doing this for not just the prenatal period, but for the postpartum period as well.

Joy Burkhard [00:17:15] So now we get to talk a little bit about what is the maternity care bundled payment. Since the early 1990s and first developed by the American Medical Association in partnership with the Centers for Medicaid and Medicare Services in 1988, there were codes that were created to pay midwives. We didn't have very many then here in the U.S., but OB-GYNs and family practice providers who provide obstetric services. Through a flat bundled payment, also referred to as a global payment or an episodic payment. The first bullet here says it's one flat fee, a bundle payment, covering roughly 13 prenatal visits, labor and delivery for the obstetric provider, and one postpartum visit. There would be an additional visit for a wound healing if the patient had a C-section. Billed at six weeks postpartum by the last obstetric provider who saw the patient. So one claim is submitted and it covers all of the care provided since pregnancy was confirmed through that six week postpartum timeframe. And then the next bullet says, payment is made to the last provider, even if multiple providers were involved in care. So if a patient changed her OB provider, maybe found a midwife to go to or moved. Any providers that saw the patient previously would not be reimbursed for the care that they were provided, or at least they wouldn't have a chance to submit a claim. Those OB providers could try to divvy up payment, but we mostly heard that has largely not happened because it was just too difficult for providers to do that. The same rate would be paid regardless of complexity or the patient needs, so just a flat rate. For all patients, no reporting is required on the bundled payment or uniformly required on the bundle payment. There could be really rare exceptions to that based off of a particular contract with a payer and a large health system, for example. So these are not considered value-based bundled payments as most of the bundle payments that we hear about now from CMS and Medicaid agencies really are considered value-based. These sort of old 1990s codes had no value reporting requirements. And so what we wanted to share now is that these bundled payment codes are being sunset, effective 1-1-2026 for pregnancies, confirmed 1-20-26 or later. And I'm gonna share a little bit more about why these codes are being sunset. So I'm gonna start

by reminding you all what the ACOG guidelines say. First about postpartum care, optimizing postpartum care. So committee opinion was number 736 was issued in May 2018. So really almost 10 years ago and recently reaffirmed last year by that same committee. And it says that postpartum care should become an ongoing process. Rather than a single encounter, with services and supports tailored to each woman or patient's individual needs. Contact should be provided by the OB within three weeks postpartum, followed up with ongoing care as needed. And there should be one comprehensive postpartum visit no later than 12 weeks after birth. And this position, of course, in 2018, and really reaffirmed last year says that implementation of this recommendation will require reimbursement policies that support care as an ongoing process rather than an isolated visit, one-time visit, as we heard about in the current bundle payment codes.

Joy Burkhard [00:21:28] So what about prenatal care? What does ACOG have to say about prenatal care, the clinical consensus position number eight that was issued in May of 2025 for the very first time. So last year notes that OB providers should conduct a comprehensive prenatal needs assessment and visit ideally before 10 weeks of pregnancy. Or when a pregnant individual first presents for care, so a comprehensive visit, and provide six to 10 prenatal visits based on average or higher risk. So you might notice that that 13, that number of 13 prenatal visits had changed last year. It could be 13, but as a routine matter, it'd be based on risk. So those with lower risk might receive six visits, for example. And those with higher risk 10 to 13 or even more, depending on the patient's needs. The bullet points below say that care should be tailored to the visit frequency and monitoring schedule as determined by the medical and social needs of the patient and of course the provider's judgment and that the provider, the OB provider can offer telemedicine, remote patient monitoring, text messaging, all of the various modalities that we've all come to learn about. And really enabled through this position and now through unbundling, and then individualized monitoring for routine care throughout the pregnancy based off of the patient's needs. And the journal links for both of those guidelines are listed in the slides, and we'll share them retrospectively with you as well. So I'd love to hear in chat from any of you about what you were surprised about. I imagine many of you haven't heard about this guideline in particular, but also may have forgotten about the postpartum care guideline that was issued almost 10 years ago. So now I want to get into why, and you can imagine why based off of what I've just presented, why the American College of Obstetricians and Gynecologists promoted the sunsetting of the bundled payment. These are the resources that we'll be going over today, and they'll be available to retrospectively with materials from today's session with hyperlinks.

Joy Burkhard [00:24:03] So I wanted to share that just to reiterate that the bundled payment previously was not considered value-based. So there have been confusion about that term bundle because generally now in this century and this decade, rather, we hear the word bundle and we think about quality. So a bundled-payment equaling quality. So the current bundled payment sits under this Category 1, which comes from the HCP-LAN framework on value-based payment and alternative payment methods and categories. So category one is just fee-for-service with no reporting on outcomes. And just again, to reiterate that the current bundle payment code is a pure fee-for-service code. It's one claim that's submitted without any quality reporting or pay-for- performance metrics. Category two is where we want to see all future payment methodologies in US healthcare and including in maternal health. And that would be reporting with fee-for-service claims are fine with reporting of metrics and pay-for-performance bonuses or disincentives. You could have a reduction in payment, for example, if a provider doesn't. Hit a metric that the payer of the health plan sets. So category two is where we wanna see all payment for all

maternal healthcare in the United States move towards. And this of course is enabled through health plan contracts with obstetric providers.
Joy Burkhard [00:25:52] I do first wanna also share a little bit about unbundling and the outpatient, I'm sorry, the inpatient codes, even though we're not gonna go into them in detail today. So I did want you to hear about the labor management codes. And here's a summary of what's changing with regards to unbundling. So for inpatient care, there's a daily reporting, once per calendar, day to day, facility reporting. On the initial days reported once per facility admission. There's reporting for existing guidelines for inpatient hospital care. So you can read more about this and we'll move on to delivery. You can hear about how delivery codes are changing as well. And the next slide, oops, excuse me. The next slide is immediate postpartum care. So also inpatient services for immediate post part of care.

Joy Burkhard [00:27:15] All right, so those are the inpatient code changes. So now we're gonna talk a little bit about what does this mean having the bundled codes sunset for outpatient care and now requiring outpatient providers, so obstetric providers to submit individual claims for all of their encounters, whether it be telehealth, whether it'd be a traditional clinic visit. Whether it be text interactions or remote patient monitoring or even home visiting, which is really exciting to think about sending a nurse practitioner or midwife on an obstetric team or even an RN out to a home to provide services. So some core opportunities with unbundling include the possibility of reduction of C-section. This is not unique, of course, to outpatient care, can be reflective of inpatient care. And that health plans and health insurers can consider paying a reduced payment for C-section. Health plans are starting to think about this. It was a recommendation 20 years ago or so by organizations like the Purchaser Business Group on Health that recommended a single case rate, the same rate for vaginal versus C-sections to disincentivize C-Sections for hospitals and OB providers, claims, claims based of submissions, provide us with an opportunity for the first time in 30 years to monitor what kind of outpatient care our obstetric providers are actually providing because we'll get to see claims and also of course be able to tack on pay for performance incentives based off of whether obstetric providers are delivering recommended care. We already talked about the expanded use of telehealth and remote payment monitoring, and that this is allowed and recognized in our new payment structure. And then Fair E&M payment rates. So E&Ms stands for evaluation and management codes. That's a typical way that providers will now submit for reimbursement, allow all the providers that have engaged in care to submit claims for their relative role and to think about paying obstetric providers more for the care that they've been providing, which have largely been underpaid relative to other specialties like orthopedic specialties, for example. And expanding postpartum care, we're quite excited about this. Though the unbundled payment proposal largely focused on prenatal care because that's what the bundle originally addressed and just that one postpartum visit. It does now provide an opportunity for payers to think about paying additional postpartum care, which we think is absolutely necessary for all the reasons we all know, but particularly for maternal mental health care and providing screening on an ongoing basis throughout 12 months postpartum. As we know, depression, anxiety and suicide and overdose are leading causes of maternal mortality and they happen in the late postpartum. And then the last bullet here is that insurers also have an opportunity now to really think about reinventing their prenatal and postpartum supports, including providing case management programs to patients that screen positive for maternal mental health disorders or have any maternal health complication, supporting OBs and ensuring that patients get into care and follow-up is provided. I also wanted to share that there are some concerns about unbundling and what these concerns are. So payers and purchasers are worried about cost containment, as you can imagine, and the unpredictability of now

allowing and having providers submit claims for all of their services. We'll get to hear from Dr. Theriot in a minute about how Kentucky. Has considered unbundling for quite some time and what it's meant for care and cost containment. Providers are worried, OB providers are worried about administrivia is the term we like to use. Now having to submit claims for all care, even though it means that they'll get reimbursed for the care that they're providing, the sort of back office support for more claim filing, hopefully not having to deal with claim denials. Or prior authorization requests, which we're not hearing. Health plans and Medicaid agencies are going to require more prior off. It's sort of like a wait and see period is what we're hearing. But there could be prior off that comes down the road later. For example, for any obstetric provider that wants to provide maybe 17 prenatal visits or 10 postpartum care visits, for example. Maybe health insurers would say, oh, we really want to request prior authorization and see what's going on with the patient before we'll reimburse you for those extra services. Payers, of course, will have more administrative on their end. Opening provider contracts is a big deal. All OB contracts and fee schedules to update how reimbursement will happen. All of that needs to happen before January 1st, which is a lot of work and patience. We wanted to flag for you that there's a possibility that patients may get billed more now that there are multiple claims being submitted. This of course is the nature of the beast with claim submissions and they'll get more notices from their health insurers, commercial health insurers for Medicaid enrollees. Patients already are not obligated to pay anything out of pocket for maternity care. So this is really for privately insured patients and the fact that they'll likely get more paperwork and perhaps get more confused about what's happening. I want to share just a little bit more about that in particular. The U.S. Preventive Services Task Force, the USPSTF as it's referred to, and the Women's Preventative Services Initiative, WIPC, classifies the following as preventive. For commercially-insured patients and therefore should not include any cost share. Routine prenatal care, so standard visits, folic acid, anxiety and depression screenings, preventive counseling and programs for various things, including supporting mental health if it's preventive counseling, preeclampsia screening and medication to prevent preeclampsia, STI tests. Smoking cessation support, and breastfeeding and lactation counseling and supplies. Those are all preventive and there should be no cost share. But cost share, this is where things get tricky. Potentially, we worry could be applied to prenatal visits for diagnosis or treatment of symptoms such as gestational diabetes, depression and anxiety treatment, preeclampsia or chronic hypertension monitoring. So once someone's been diagnosed and you can see other types of diagnoses that could trigger cost share. We'll talk a little bit about what we're suggesting prevent this from happening in just a moment.

Joy Burkhard [00:35:00] And we wanted to share one example of how this has already started to happen under the Affordable Care Act, which you might recall, and I'm sure those of you that are covered under employer sponsored plans perhaps have had this happen to you already when you go for your annual well woman exam or even an annual visit with your primary care provider. If you have any questions, please feel free to ask them. If the services that are discussed are anything about new symptoms that you're having or current diagnoses that you are having, then cost share will apply. I mean, it's not a free zero cost appointment. Some providers offices have gone as far to say that if it's an annual exam, this is preventive and you can't talk to us about those things. Instead, you may need to make another appointment. So it's really the Affordable Care Act gone wrong, in my opinion. And so these are the things we are worried about with regard to preventive care and prenatal care being considered preventive with a bundle payment now changing to providers. We wanted to share before we introduce our next speaker or reintroduce our next figure, what did want to share that the Policy Center working on these costs. Cost concerns with members of Congress and also federal government agencies to try to avoid

these types of things from happening. We are also, I should go back to last slide, also have issued guidelines around implementation to health plans and Medicaid agencies about waiving cost share for any claim with a TH modifier included. So we are, we are working on preventing these things from happening. Stacey had already dropped into chat earlier, our blog, an article on implementation for health plans and health insurers and Medicaid agencies to make sure that this cost share or not Medicaid but health plans for commercial insurers to make sure those cost share concerns are not actually what women face.

Joy Burkhard [00:37:17] And we did also wanna flag with regard to some Medicaid agencies have actually unbundled early or never used the bundle. You can see examples here on this slide. And so take a look with your Medicaid agency, do a Google search, find a Medicaid webpage to see if your Medicaid Agency already unbundled or never implemented a bundled rate and make sure that you're following that in your states. So. With that, I am really excited to get to turn it over today to Dr. Judy Theriot to present on what Kentucky's doing with regards to maternal mental health, and she'll also be discussing a bit about a bundle and that Kentucky has not implemented the bundle for quite some time now. Judy, I'm so happy to turn over to you.

Judy Theriot [00:38:13] Thank you. Thank you so much. It's a pleasure to be here. Again, I am the medical director for Kentucky Medicaid, and we have not had a bundle for many, many years in Kentucky. But we still anticipate some growing pains when all the new codes go live in January. So just a little bit about Kentucky Medicaid real quick. We have about 1.4 million members enrolled, about 660,000 children, which is about half the number of children in the state. For our expansion population, that's just under half a million. 65,000 providers and our budget and... Fiscal year 2025 was just over 20 billion. So we have a good part of the state budget. We're responsible for about half of the births in the state, which is we get about 50 to 52,000 births a year, so about 25,000 births are supported by Medicaid. Like I said, we have not been bundled, but But honestly, I don't think the providers knew that. A lot of the providers did not know that. So they billed after the pregnancy was over, putting in all of their bills at the same time. And so it was news to a lot of people that Medicaid was not unbundled. They just treated us like any other biller. But we're anticipating problems when the changes happen. The providers are used to very few codes, and now they're gonna have a lot to choose from. Like Joy was talking about, a lot of them are hospital-based codes, but there are codes in outpatient as well, especially prenatal and postpartum codes that they will have to learn to use. So we are offering to meet with providers, to do individual trainings with them, to help them navigate these changes. Kentucky is an MCO state, so we have five MCOs, our managed care organizations, and probably 95% of our pregnant women are covered in an MCOs. The rest are fee-for-service, so the vast majority of the pregnant women are with an MCOS, and... The MCOs are what dictate and provide that care. So it can be different depending on which MCO you're in. And we'll go over that a little bit. And we're asking folks to develop kind of cheat sheets on the codes on how to do it. So you don't have to go to a book or a website or things like that. When you're the middle of a busy clinic day, you can have a little cheat sheet to look at to try and figure out what you're supposed to do to code. So we're working on these things, because we do anticipate a problem coming up. Now, even though we've been unbundled, one of the craziest things is that we would have a hard time finding out if somebody was pregnant. So we had to create a notification of pregnancy form. And the reason for that is if we wanted to do a study, look at our data on pregnancy, We would have to start at the birth. And go backwards to see what happened during the pregnancy period. It was very difficult to find out when somebody got pregnant unless you're going backwards. And a big part of that was because people weren't billing

when pregnant women came in the first time. So hopefully the new codes will change that. I hope they will. I think it's going to be a big problem trying to get people to change their habits. But, why do we care? Why do we wanna know if somebody's pregnant or not? Well, there are a lot of things that can be offered to pregnant women when you know they're pregnant. There's different services that can happen, different resources that may be needed. There are the high-risk pregnancy programs that all of the MCOs have to have by law, but they can't offer those programs to women unless they know they're pregnant. So we created this form, and I know this really sounds simplistic, so that when someone is pregnant, we have the provider send us the form, and we, us and the MCOs, so then we know. And what's on that form? It doesn't just say you're pregnant, it says pregnancy, and also if there's any high-risk conditions, diabetes, anything medical that could be, make you more high risk, anything social determinants of health related that can make you high risk if you're unhoused or underhoused. And then we can connect you to resources. So if it's a medical resource you need, we can do that. If it's social resource, if it anything, the sooner we know about it, the faster we can connect the mom to resources that are available to her. And so we've started this last year. Many states have it. They reimburse providers for completion of the form. We do not reimburse at this time, but we've seen a wonderful uptake since we rolled it out with providers completing the form and filling it out for us. And we are reaching out to a lot more moms to connect in the services. So next slide. It's me, I'm sorry, hee.

Judy Theriot [00:44:15] Another thing that is required, oops, by law, is a health risk assessment. And so all of our MCOs are required to do a health-risk assessment, and that is when somebody joins the MCO, when annually, and then when you become pregnant, you complete the health- risk assessment, and it has similar type questions and asks about behavioral and environmental risks, and so if things pop up, you can connect people to the needed resources. Now, this is, all MCOs in the country are required by law to do this health risk assessment, so every state, and if you look into it, it's hardly ever done. And the reason for that is the MCOs will say, well, I reached out and they hung up on me, or they didn't answer the phone, or they started it and it was too many questions, so they hung up. You know, so it's hard to get people to fill out forms. So I think you really need to add a little bit more teeth. Instead of just saying you have to do this health risk assessment, you know, it should be, you have do it. And if, make up a number, if 40% of the women aren't completing this form, then you're gonna be monetarily penalized. You know we will monetarily penalize MCO if they're not meeting whatever percentage that you decide. So you just have to put a little bit more teeth behind it. And then I think people will be very imaginable and come up with ways for the form to be completed. But this is a tool that you have to help identify women that may be in need of additional resources. MCOs also have that value-added benefits. So one of the things is a high-risk pregnancy program. They're all, again, like Joy mentioned, by law have to have a high risk pregnancy program, while you can't get people into that program unless you know they're pregnant, and you have to do a risk assessment to see if they meet the criteria. One thing that we also found in our MCOs, we asked a simple question, what is your definition of high risk? Who gets into your program? And we have five MCOs. All five of them had different definitions of what is high risk. And it was crazy that you could be high risk in one program and not high risk in another program. So we've developed our own definition of high-risk pregnancy that we're working on now it. That the MCOs are gonna have to follow. So at least everyone will have the same definition and the same opportunity to benefit from the programs. All MCOs also have the individual care management. Three of our MCOs have doula benefits. Kentucky does not cover doulas with basic Medicaid, but the MCOs can. And so that's a big difference with what is covered on Medicaid and what is a value added benefit. So the MCOs... Can choose to have doula benefits. They can choose who to do

different things that Medicaid has a lot of trouble getting started and getting done based on your state plan and things like that. Value-added benefits include lactation consultants, breast pumps, all of the MCOs all have these pregnancy apps. I know I've been talking to different states about rural health transformation and some states are creating their own pregnancy app and they're all excited about it. Which is good, but I bet you it already exists in their state. The problem with these value added benefits is nobody uses them. It's difficult to adhere to, it's difficult even find out what's available and it's hard for the moms to get the benefits and the providers have no idea that they exist. Home delivered meals and cell phones and things like that are all things that you can get. This is a little snapshot of one of the pages in our value added benefits book. And so we have five MCOs. There they are. One of the things that can get is monetary rewards or incentives for attending visits. So this is money that the the member can get for attending visits, they also can get, you know, $25 to $50, depending on the MCO to go bring a child to a well-child visit. So it adds up over time. Why people don't do this? Because they don't know it exists. And so part of the thing that I think we really have to do a better job at is making sure our providers know that these things exist. So we can help the patients benefit from them. And so we've made, we put this on our website, we have an electronic version, our public health and our KyPQC colleagues printed out and make nice little bulletins that they can give out to providers so people know what they can, and it also of course tells you how to sign up for the benefits. So that's something very important that we can give to our moms that exist now. But nobody uses it. Oh, this is just a copy of our high-risk pregnancy definition that we came up with, that we're instituting. And you can see it not only has medical causes of being high risk, but also behavioral and social issues that can deem you high risk. And therefore into the program of case management and getting more resources. Another thing, and Joy mentioned this too, value-added payments or pay-for-performance arrangements that the MCOs have with their providers to improve quality. And it can be anything trying to improve depression screening, like this example here, or it could be decreasing low-risk C-sections, decreasing Pitocin use. So it could anything, but the MCOs instigate it have a contract with the providers. And reward the providers for improving quality. And this is, again, a value-added benefit or value-based payment model is something that all MCOs have and they are supposed to have with providers that are under contract. Again, this is some of the things that you can do to help measure what's happening instead of just saying you have to have the value-added benefits. Get a utilization report. So you know how many moms are benefiting from that postpartum care. You know, $50 should go into that visit, you know? And if it's only 10% of the moms, then something's wrong. You know they need to pick up their game and make it better.

Judy Theriot [00:51:26] Alrighty, and so you guys can see this. This is just a snapshot because we're talking about mental health care. When I looked at the primary admission diagnosis, postpartum, this was the top 10. Now, there were hundreds of definitions on the list or diagnoses, but you can see how many – oh, this is supposed to be bipolar, but three of the top ten is a mental health reason for being admitted to the hospital. So we have a huge issue with that. So another thing you can do is to have quality measures that people know about, that you're... Tracking to improve depression screening, different things like that. So the MCOs, the providers, everybody is working in that direction. And just in closing, these are some of the things that we talked about, the different levers that you have to help improve the quality for care for moms on Medicaid in your states. So thank you very much.

Kylie Hibshman [00:52:47] All right, and I think I am up next. Hi, everyone. So nice to meet you. My name is Kylie Hibshman and I am the Director of Integrated Behavioral Health at the Colorado Perinatal Care Quality Collaborative. We are Colorado's PQC and

I'm really happy to be here today to talk with you all a little bit about how we have been implementing an adapted version of the Perinatal Mental Health AIM Patient Safety Bundle in outpatient clinic settings. So with that, we've primarily been doing this through our IMPACT-BH program. IMPCT-BH stands for improved perinatal access, coordination and treatment for behavioral health. IMPACT-BH launched about five or six years ago in partnership with the Colorado Behavioral Health Administration. And it initially launched primarily actually as a grant program to support rural communities in strengthening and integrating their perinatal behavioral health systems through perinatal navigation in partnership with a clinical training. Component focused on improving perinatal mental health screening and response and outpatient clinic settings. Very long story short, over the past five years we have been partnering with communities all across rural Colorado to really understand how we can continue to improve this program. And most recently on July 1 of 2026 we actually launched an updated version of the program that is truly, a QI, a quality improvement program adapted from the IHI Institute for Healthcare Improvement Breakthrough Series approach to quality improvement. And the program now is really based on the AIM patient safety bundle focused on identifying perinatal mental health conditions. If you see this map, you can see that our program has grown significantly over years. We started in three counties. The darker green counties on that map in rural Colorado are our former grantees and participants in this program and the dark purple band you can see really in central Colorado. For those of you who are familiar with Colorado, this is still very much rural part of the state's just west of what is known as the front range here in Colorado, the greater Denver metro area. And we have actually 12 counties that are participating in our new updated model that is focused on, again, implementing QI practices to improve perinatal mental health identification and response. So a little bit about how we are operationalizing the AIM patient safety bundle. So again, like I noted, this is a learning collaborative model. It's a 12 month program that runs from July to June every single year. And there are really three main core components of the quality improvement program implementing the AIM patient safety bundles. So we do have learning sessions. We have four learning sessions scheduled throughout the year. The first and last learning session are in-person, actually bringing together our cohort of rural outpatient clinics, as well as we do also work with rural community-based organizations. We do provide quality improvement coaching in addition to clinical coaching with a team of clinical perinatal mental health experts here in Colorado. As well as we do have action periods where sites are implementing what are called PDSA cycles. So for other PQCs or other folks who implement QI, you will be familiar with these, right? Implementing plan, do, study, act cycles. To really increasingly improve their perinatal mental health screening and response practices. The crux of this style, right, is you start really small. You test small tests of change to identify what might work in your outpatient clinic and then slowly scale those practices over time.

Kylie Hibshman [00:56:49] In addition, the way that we set off in our state to really operationalize, excuse me, the patient safety bundle is we actually decided in partnership with our sites to create a clinical and QI curriculum. So you can see here on this slide, a little bit of a high level outline of our clinical and QI curriculum over the year, right? That is really interspersed with the learning sessions and the action periods. So we kick off in Q1 of each cohort cycle focusing really on core QI practices, right, setting a project charter, smart aims, and the first PDSA cycle, as well as sites kind of from the clinical side of things, they implement in community mapping. And leading into Q2, all sites take, we actually developed in partnership with our sites, our current and former ImpactBH sites, as well as our clinical experts here in Colorado, a Spanish-English bilingual course. It is four hours and it's called We All Have a Role. And it goes through the basics of perinatal mental health as well, as our program does dive into SUD, substance use disorders and

intimate partner violence. However, for the purposes of our conversation today, we're really focusing on mental health. But this course that we developed is a way to provide asynchronous clinical content to our outpatient clinic sites, as well as to our community-based organization sites. That clinical content, we do provide CE. Again, it's available in English and Spanish, and it is complemented by live clinical coaching that we incorporate into the quality improvement learning collaborative model. As well throughout the year, right? We are currently in Q2 with our sites, but next quarter we will focus on spreading and scaling of QI successes, focus on clinically complex cases, and using data for storytelling. Finally, I just wanted to share some data from our particular sites. We are seeing improvements. We do see improvements in the clinical setting as well as across communities. Communities launch what are called perinatal continuum of care working groups and those working group sites report are as extremely valuable or very valuable within their program. So with that, I see Joy here. I'm happy to answer questions about how we are doing this, especially what is working for us during the Q&A, if you have any questions.

Joy Burkhard [00:59:26] Thanks so much, Kylie, and we're inviting everyone to come back. We have about a minute left, so I just wanted to remind folks to complete the survey on today's session, and also we are dropping into chat a link to our annual forum. Invite all of you to attend while I do a breakout session with AIM Entities at our event in partnership with AIM TA Center. 50% off discount code, and that event will happen in March. I'll hope to see you all there, and we'll turn it over to you, Vira.

Vira David-Rivera [00:59:59] Great, let's have a quick thank you to all of our speakers. A recording of the session will be available in about a week. After the session, we will email it to you as well as post it to our website.