Using Managed Care Organization Contracts as a Lever to Address Health Equity in Maternity Care

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Introduction

The United States is facing a maternity care crisis. In 2020, the maternal mortality rate for non-Hispanic Black women was 55.3 deaths per 100,000, a rate 2.9 times that of non-Hispanic white women. Further, the maternal mortality rate increased from 17.4 to 23.8 deaths per 100,000 live births from 2018 to 2020.[1] These statistics highlight the staggering toll this crisis has on maternal and infant health around the country, and the grave implications for Black, Indigenous, and People of Color (BIPOC) birthing people.

The crisis has prompted action at both the federal and state levels. In February 2021, Representatives Alma Adam (NC-12) and Laura Underwood (IL-14), and Senator Cory Booker (D-NJ) reintroduced the Black Maternal Health Momnibus Act of 2021[2], which includes 12 bills that support multi-agency efforts to improve maternal health for racial and ethnic minority groups, veterans, and other vulnerable populations. In December 2021, Vice President Harris initiated the first ever federal Maternal Health Day of Action with a specific Call to Action[3] for the public and private sector. Part of this call is reflected in the American Rescue Act's inclusion of a twelve-month postpartum coverage expansion through Medicaid. Over half of all states in the U.S. have already, or are in the process of, taking advantage of this opportunity by expanding their postpartum coverage from 60 days of coverage to a full year.[4]

While federal-level Medicaid coverage expansion is one tool for addressing the crisis, states can also use value-based payment strategies to address poor maternal health outcomes. Value-based payment contracts serve to link the quality of care received to the cost, so that providers are incentivized to provide higher quality, more coordinated care to the patient. Several states – including Colorado, Tennessee, North Carolina, New Jersey, and Pennsylvania[5, 6, 7] – have implemented maternity care episode payment in their Medicaid programs; these models, however, are voluntary in terms of provider participation.

Terminology

A ***Request for Proposals (RFP)*** is released by the states **to** request detail on what services a Managed Care Organization would cover if awarded a Medicaid contract.

The ***Contracting Process*** includes the RFP process and the resulting contracts awarded to an MCO.

Birthing persons is a term used to describe pregnant persons that is inclusive of all genders and gender identities. Not all birthing people identify as ***women*** or ***mothers***.

This resource uses both gendered and non-gendered language such as birthing persons, pregnant people, mothers, and women to reflect the terminology used by various stakeholders and found in the referenced literature.

Gender neutral language is used when not directly citing an external resource to be inclusive of all birthing persons.

Another tool is available to Medicaid managed care states, namely, the Medicaid Managed Care Organization (MCO) contract procurement phase. This process is available and being used in many states to address and improve inequities in maternity care, given that MCOs are provided more flexibility in terms of the services they can offer to beneficiaries, than the traditional Medicaid fee-for-service model. This allows many states to effectively use the Request for Proposals (RFP) and the contracts themselves to outline specific requirements that relate to health equity and maternity care.[8]

The Maternal Health Hub (the Hub), run by the Health Care Transformation Task Force and supported by the Commonwealth Fund, leads a monthly Learning Community webinar series to identify and share learnings on essential components of equitable payment approaches that improve maternity care outcomes and lowers costs. As part of this series, the Hub invited representatives from several states to speak on their use of the MCO contracting process to proactively embed health equity into maternity care. The findings from these meetings, as well as from a literature search, serve as a basis for this resource.

Background on Medicaid Managed Care Organization Contracts

MCOs provide care to millions of individuals covered by Medicaid across the country. The participating entities are provided with a capitated monthly per beneficiary payment by the state to manage care for the individuals served.

Most states partake in a contracting process – known as procurement – to select the MCOs that will deliver care to the state's Medicaid population. The states release an RFP for MCOs, requesting detail on what services the MCO plans to cover if awarded a Medicaid contract. The RFP process also sets and clarifies expectations on certain technical and quality measurements or specific programs that must be in place to better address population needs if the MCO receives a contract.[i] Once the contracts are awarded, the contract period lasts several years.

The ability to require MCOs to meet certain requirements means the procurement phase and resulting contracts – which can be amended throughout the year - can drive major policy change. In recent years, as COVID-19 has shone a light on existing disparities in the United States' health care system, several MCO contracts evolved to focus on addressing social drivers of health and health equity. Some states have gone further, to focus specifically on ways that MCOs can contract with providers to address maternal and infant population.

Establishing Health Equity Maternity Care Requirements in MCO Contracts

Several states have used the MCO contract process to tackle both maternity care specifically, and health equity more broadly.

- In **Minnesota**'s 2021 procurement cycle, the state included an RFP requirement that MCOs describe steps they will take to reduce the bias experienced by Black and Indigenous individuals during pregnancy and birth, as well as how these actions will be

monitored once implemented. The RFP also required MCOs to describe how they intend to address disparities in health outcomes for Black and Indigenous people during and after pregnancy. At a broader level, Minnesota's most recent procurement process was designed to address the structural issues that have been found to drive inequities in health care in the state. The state asked MCOs about their plan to address structural racism, and how they will seek to improve systems and processes to be more antiracist. The RFP also sought information on how the MCO will collect and use community feedback to assess how structural racism impacts enrollees' experiences.

- **Louisiana** tailored its 2021 RFP to elicit information that allows the state to analyze a plan's intention to address equity in maternity care. Interested MCOs were required to submit how they plan to use data analysis and community input to address inequities in outcomes experienced by Black birthing individuals and their newborns. Further, interested MCOs had to include what outcome measures they plan to focus on for birthing individuals and newborns, including the specific actions and timelines the organization will take to improve performance on those measures.[9] Looking at health equity more broadly, Louisiana asked MCOs to describe their ability to develop, administer, and monitor completion of training for staff on health equity topics beyond Culturally and Linguistically Appropriate Services standards, as well as how they intend to incorporate community feedback into program development and improvement. In the next round of contracts, Louisiana plans to ask MCOs to describe how they will partner with community-based organizations and reimburse providers for collecting health-related social needs.
- In **Michigan**, once an MCO is selected to contract with the state, the organization must report select quality metrics by race and ethnicity; one of the available measures for selection is the rate at which postpartum care is received. Since enacting this requirement in 2012, Michigan has successfully narrowed disparities in rates of postpartum received between the Black and white birthing people by 10 percent.[10] Michigan's RFP process also requires MCOs to describe actions they will take to address health equity.

  A unique component of Michigan's MCO contracts is the requirement for MCOs to employ and use Community Health Workers (CHWs). Once the MCO contracts with the state, it is required to contract with at least one CHW per 5,000 members. If the CHW is employed by a CBO or local clinic located within the community served, instead of by the health plan, the state provides a higher reimbursement. This model can be used as a template for contracting with doulas and midwifes, two models of care that have shown great promise in reducing inequities in maternal and infant health outcomes. [11,12]
- **Pennsylvania** offers MCOs both a Pay-for-Performance (P4P) model and a maternity care bundled payment model.[13] The P4P model requires MCOs to target improvements in quality or access to care for prenatal care in the first trimester, postpartum care, well-child visits in the first 15 months of life, and several other measures relating to health equity. If improvements are made (as defined by the contract), the MCO receives additional money.

The maternity care bundled payment includes all services provided during the pregnancy episode: prenatal care, labor and delivery, care coordination services, and up to 60 days postpartum for the mother and newborn. The bundle requires providers to report eight quality measures including timeliness of prenatal care, postpartum care, prenatal and postpartum depression screening and follow up, among others. The participating MCO and state agree on a set target price at the beginning of the contract year, and then the provider is paid under a fee-for-service model for the remainder of the year. At the end of year, a reconciliation process occurs that compares the fee-for-service payments administered to the target price. The provider then receives a percentage of shared savings determined by the provider's performance in relation to the target price and quality metrics.

While the broader RFP requirements addressing health equity are not directly tied to maternity care, expanding collection of community feedback and social needs data, as well as access to community health workers, has a beneficial impact on all patients seen, many of which may need maternity care services. As mentioned above, **Michigan**'s requirement of contracting with a CHW can also serve as a template for contracting with doulas and midwives in the maternity care setting.

The Importance of Community Led Birthing Efforts

One component that is critical to supporting equitable maternity care delivery is notably missing from the State contracts: namely, incentives or requirements to include perinatal health workers or midwives as part of the care delivery team. Community-led birthing models of care rely upon doulas, midwifes, and freestanding birth centers, all of which are invaluable to reducing inequities in maternity care. Research shows that birthing people who receive care from doulas and midwifes experience lower rates of pregnancy complications and have more positive birthing experiences; this is especially true for people from historically underserved communities.[14,15]

An Institute for Medicaid Innovation (IMI) report offers policy recommendations related to how the MCO RFP process can be leveraged to support the community-based maternity model, including requiring measures of access to midwifery care, requirements that MCOs reimburse credentialed Certified Nurse Midwives (CNMs) at 100 percent of the Medicaid fee schedule, and listing CNMs as an obstetric provider in the plan's provider directory. Regarding greater access to birth centers, IMI suggests requiring MCOs to clearly define the credentialing and contracting process to add birth centers to their network; listing birth centers as viable providers; and reimbursing centers at 100 percent of the Medicaid fee schedule for professional and faculty services. These steps provide a template for how states and MCOs can incorporate community-led models of care design components to improve outcomes.

The MCO process can also be used to bring community-based doulas into existing networks. Currently, six states – Oregon, Minnesota, New Jersey, Florida, Maryland, and Virginia – reimburse for doulas services in Medicaid, with several other states planning to implement doula coverage in the coming years.[16] Florida has taken a different approach to covering doulas as the state includes doula care as an expanded benefit that MCOs can include in their services. This allows MCOs to set their own expectations instead of following state guidance. So far, all

MCOs in Florida have adopted the benefit.[17] Covering doula services in Medicaid, especially through MCO contracts, does not come without challenges, however. As many doulas come from private pay backgrounds, the contracting process can be difficult for doulas to navigate. Some state Medicaid programs and MCOs also have multiple credentialing requirements for participation, which presents another challenge.[18] State Medicaid departments can offer key guidance about credentialing and contracting to help both MCOs and doulas contract with one another.

Conclusion

The RFP contracting process is a powerful tool available to states that participate in Medicaid Managed Care to address and improve inequities in maternity care. The examples included above provide a wide range of activities – from engaging the community, to investing in antiracist practices, to specific actions an MCO must take to reduce inequity in maternity care – that can be included in the MCO contract to improve outcomes. While a promising start, there is still room for innovation in the RFP contracting process. The importance of including community-led birthing models cannot be overstated; these models not only improve outcomes but improve the care experience for patients served.

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