



Nevada Patient Protection Commission (PPC) Meeting

State Health and Value Strategies

March 13, 2026

STATE
Health & Value
STRATEGIES

*Driving Innovation
Across States*

A grantee of the Robert Wood Johnson Foundation

Agenda

- **About State Health and Value Strategies**
 - **Today's Focus: National Trends in Perinatal Healthcare**
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- **Payment Reform**
 - **Workforce: Midwives, Doulas, and Other Providers**
 - **Rural Health Transformation Program**
 - **Behavioral Health**
 - **Other Strategies to Increase Access to Care**
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- **Questions**

About State Health and Value Strategies

- State Health and Value Strategies (SHVS) **assists states** in their efforts to transform health and healthcare **by providing targeted technical assistance** to state officials and agencies.
- The program is a **grantee of the Robert Wood Johnson Foundation**, led by staff at Princeton University's School of Public and International Affairs.
- The program **connects states with experts and peers** to undertake healthcare transformation initiatives.
- By engaging state officials, the **program provides lessons learned**, highlights successful strategies, and brings together states with experts in the field.
- Learn more at www.shvs.org.
- **Questions?** Email Heather Howard at heatherh@Princeton.edu.

Support for this presentation was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Today's Presentation

Today's Focus

- Review of strategies implemented in other states to improve and increase access to perinatal care.

Methodology

- SHVS completed a scan of articles and other resources to identify strategies being implemented in other states related to areas of interest for Nevada.
- Where available, we have noted evidence base for strategies.

Additional Considerations

- Role of social drivers of health.
- Other policies outside of the purview of Commission play a significant role in perinatal health.



Payment Reform

Payment Models Overview

Payment Models Implemented by States

Maternity Payment Bundle

A comprehensive payment for all services provided during an episode of pregnancy-related care.

Episodes of Care

A payment model that creates payment incentives to manage costs and quality across a set of services.

Blended Payments

A payment model that combines cesarean and vaginal birth reimbursement rates into a combined case rate for hospitals.

Pay for Performance (P4P)

A provider incentive to meet certain quality goals.

Reduced or Non-Payment Policies

A strategy where states reduce payments or do not cover procedures

State Examples

Colorado: voluntary Maternity Bundled Payment holds participating Medicaid providers accountable for cost and quality.

Tennessee: Perinatal Episodes of Care Payment Model accountable providers subject to gainsharing and risk-sharing based on cost and quality.

Tennessee & Minnesota: single payment amount for delivery, regardless of whether it was cesarean or vaginal.

California offers several P4P programs. In total 14 states have PRP programs in place.

20 states have reduced or non-payment policies including **Nevada**.

Other Models of Interest

Pregnancy Medical Home (PMH) Model

- State example: **North Carolina**
- Model components: Paid providers **enhanced rates for coordinated, comprehensive pregnancy care** including risk screening, care management, and postpartum visits.
- Outcomes: No formal controlled evaluation, but did see increase in tobacco cessation counseling and postpartum visit rates among participants.

Accountable Care Organizations

- State example: **Oregon**
- Model components: **Provider-led organizations paid through shared savings/risk arrangements.** Regional Coordinated Care Organizations provide comprehensive, well-integrated services designed with perinatal health as a priority. **OB/GYNs and midwives included in the accountability structure and robust quality metrics tied to payment.**
- Reduced likelihood of low birth weight and abnormal conditions and increased prenatal care use, but only for certain racial/ethnic groups.

Unbundling of Maternity Codes

What is changing?

- Shift to fee for service from a bundled payment.
- Effective January 1, 2027: 16 global obstetric codes will no longer be billable.

Why the change?

- Intent of bundled payment was to decrease c-section rates.
- ACOG and ACNM advocated for change because bundled payment:
 - 1) Does not function as a value-based payment as most are not tied to quality measures.
 - 2) Does not reflect modern perinatal care which includes screenings and counseling not included in bundled payment.



State Examples

Arkansas

- **Early adopter of bundled payment** for perinatal care and most studied.
- **Ended the model in 2021** after finding it reduced costs but did not produce sufficient quality improvements.

Iowa

- The state unbundled the global maternity package as of October 1, 2025.



Workforce: Strategies to Increase Access to Midwives

Why Midwives?



Better Outcomes

- Nurse-midwifery care associated with lower rates of Cesarean birth, labor induction/augmentation, perineal tears, and regional anesthesia use
- Higher rates of breastfeeding initiation



Equity Implications

- Indigenous and Black midwives have passed on traditions and knowledge in holistic healthcare for generations
- State regulation (late 1800s–mid-1900s) caused midwives of color to increasingly lose access to licensure

[NASHP Medicaid Financing of Midwifery Services: A 50-State Analysis](#)

Licensing and Scope of Practice



Regulatory Landscape

- States determine scope of practice and licensure before allowing Medicaid reimbursement
- Some states require collaborative agreements mandating physician supervision — impacts pay, credentialing, and admitting privileges



Nevada's Position

- Does not currently license Certified Professional Midwives (CPMs) or Certified Midwives (CMs)
- One of 25 states allowing CNMs to practice independent of physicians (per NCSL)
 - **Key question:** Do hospital credentialing and MCO policies limit effective utilization of CNMs, especially in rural communities?



National Context

- All 50 states license/reimburse CNMs (requires RN license, master's+, AMCB certification)
- 9 states + DC license CMs
- 37 states + DC license CPMs

Considerations: Studies show integrating all midwife types yields significantly better outcomes

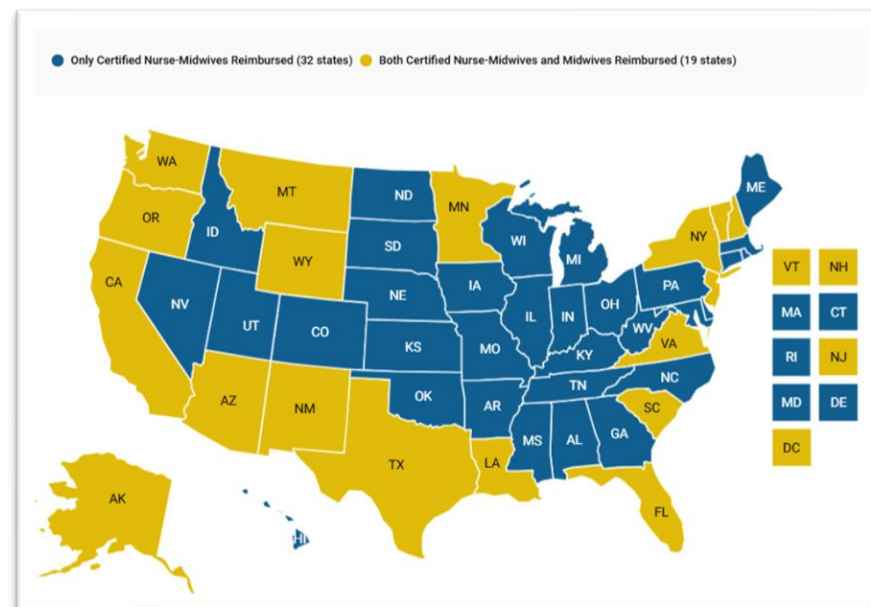
State examples: Minnesota and Washington have operationalized Medicaid reimbursement for midwives without a nursing degree.

States that have done so differ in terms of licensure requirements, maintenance of midwife registries, covered services, etc.

Reimbursement Parity and Expanded Services

Reimbursement Parity

- Approximately half of states reimburse CNMs at 100% of physician rate (**including NV**, per state law and SPA)
- 19 states (**excluding NV**) reimburse both CNMs and non-nurse midwives through Medicaid



NASHP Midwife Medicaid Reimbursement Policies by State



State Examples

Expanded Services Beyond Maternity

- 36 states reimburse CNMs for services beyond traditional maternity care
- **NV**: Smoking cessation and home visiting
- **IN & MI**: SUD and behavioral health screening/treatment
- **MO**: Family planning, well-woman gyn care, and some infant care

Midwife Training, Recruitment, and Retention

California



California Song-Brown Healthcare Workforce Training Programs

State-funded grants to increase education/training in underserved areas, including CNM student training and midwifery accreditation

Colorado



Colorado Rural Midwifery Workforce Expansion Program

Federal grant for a Rural Midwifery Track with scholarships, stipends, mentorship, and rural clinical experiences

Minnesota



Minnesota Rural Advanced Practice Provider Loan Forgiveness Program

State-funded loan forgiveness for CNMs and other providers practicing in designated rural areas

New Mexico



New Mexico Medicaid Birthing Options Program

Addressed barriers to malpractice coverage for non-nurse midwives, enabling Medicaid billing for home births



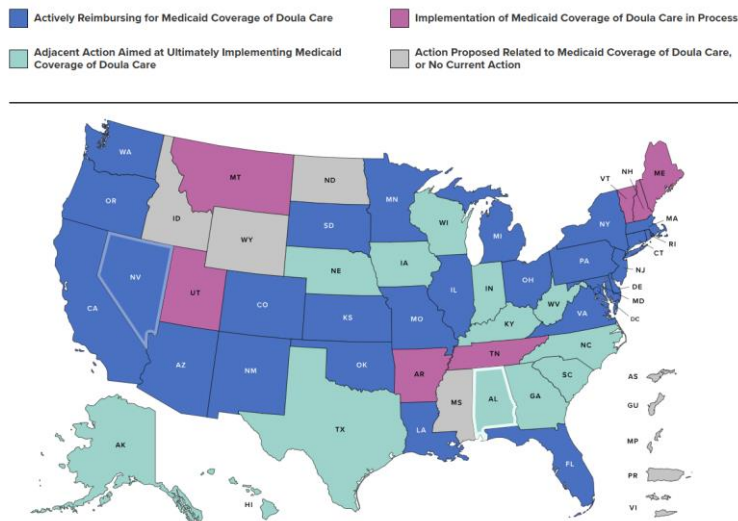
Workforce: Strategies to Increase Access to Doulas

Why Doula? And Medicaid Reimbursement



National Context

- Research has consistently shown doulas' capabilities in improving maternal health outcomes and decreasing maternal mortality rates
- 27 states and Washington D.C. actively provide doula coverage through Medicaid



Nevada's Position

- NV added doulas as approved providers in April 2022, more than [tripled reimbursement rates in 2023](#), and provides a [rural incentive](#)
- **Rural incentive:** In urban counties, base delivery rate is \$900 and \$100/visit for prenatal/postpartum (up to 6 visits; max \$1,500); 10% increase for services outside urban counties (max \$1,650)
- **Additional incentives:** NV reimburses up to two extra doula visits as incentive for connecting clients to prenatal health care and dental services

National Health Law Program, Doula Medicaid Interactive Map

Increasing Postpartum Reimbursement and Incentives

California

\$486.36/visit

Up to 2 extended 3-hour postpartum visits and up to 9 additional visits

Rhode Island

\$1,500/pregnancy

Unused prenatal visits re-allocated to postpartum; 60-min minimum per visit

New Jersey

\$100 incentive

Doula postpartum visit + ensuring client sees OB clinician

Virginia

\$100 incentive

\$50 for postpartum OB referral + \$50 for pediatric referral

D.C.

\$100 incentive

Postpartum visit + OB clinician connection

Doula Access and Integration



NJ: Hospital Doula Rights

Legislation ([S-4119/A-5739](#)) ensures every birthing individual has the right to a doula; hospitals must maintain accompaniment policies



NM: Doula Credentialing and Access Act

[Legislation](#) creates voluntary credentialing pathway for Medicaid enrollment; creates doula advisory council and doula fund



NYC: Citywide Doula Initiative

[Free doula support](#) for underserved neighborhoods; [recent audit](#) saw reduced C-section and pre-term birth rates for Black and Hispanic participants



Statewide Registries

Help families find providers (e.g., [Michigan](#) allows search by county and Medicaid enrollment)



Standing Recommendations

[CA](#) and [NY](#) issued standing orders to eliminate physician referral barriers for doula services



Private Insurance Coverage

Only two states ([RI and LA](#)) require private plans to include doula coverage; [NV SB 192](#) (2025) appears stalled

Doula Training, Recruitment, and Retention



\$450,000

New Jersey

Training Grant

Support doula training, including help processing Medicaid reimbursement claims



\$250,000

New York

Expansion Grant

Awarded to community-based organizations for recruitment, training, certification, support, and mentoring



\$200,000

Washington

Doula Hub

Appropriated funds to design and plan a doula hub for training on enrollment, reimbursement, and a referral system



Workforce: Other Providers

Workforce Development and Training



Oregon HOWTO

Apprenticeships, stipends, and mentoring for community health workers, medical assistants, and peer specialists



NJ Maternal and Infant Health Innovation Center

Culturally centered, equity-driven training for clinicians, doulas, and perinatal providers



OR Provider Incentives

Loan repayment, medical practitioner insurance subsidies, and scholarships for underserved area providers



PA Scope Expansions

Increasing physician assistant scope of practice to expand care delivery capacity
(slides 21, 22)



Telehealth Extension

Telehealth as workforce extender;
see KFF, CMS, and
Commonwealth Fund resources
(slide 23)

Expanding PA Practice: Scope



State Examples

Indiana - enacted **HB 1248** (2019), which replaced the PA supervision model with a collaborative model.

- Reduced administrative requirements around prescriptive authority.
- Reduced mandatory chart review requirements.
- Eliminated some restrictions on prescribing controlled substances.
- The reform did **not allow independent practice**, which kept Indiana in the **moderate category** rather than advanced.

Collaboration requirements:

- Physician must be **physically present OR available electronically** for consultation and able to **see the patient within a medically appropriate time frame** if needed.

Oregon - enacted **HB 3036** (2021), replacing the physician supervision model with a **collaborative practice model** for PAs.

- Eliminated the formal physician supervision requirement
- Removed several administrative requirements, including physician-PA ratios, physician names on PA prescriptions, etc.
- Allowed practice details and scope to be determined through practice-level collaboration agreements.
- These reforms moved Oregon into the **advanced category** but didn't grant PAs full autonomy

Collaboration requirements:

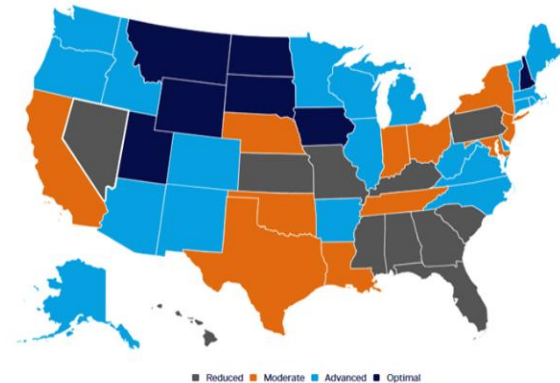
- PAs must maintain a **written collaboration agreement** with a physician or employer describing how collaboration occurs; agreements are kept at the practice site and not filed with the medical board.

PA State Practice Environment Map

Current as of July 2025

This map provides a snapshot of the current practice environment for PAs across the country. States are assigned a category as determined by their enactment of laws and/or adoption of regulations that support PA Practice Modernization.

More information is available to AAPA members. [Log in here.](#)



Expanding PA Practice: Mobility

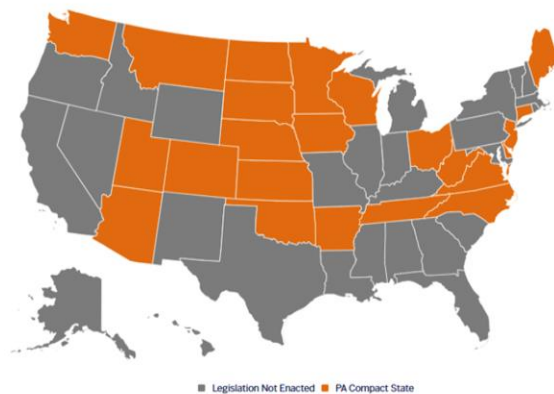


State Examples

South Dakota – enacted **HB 1146** (2026), entering the **PA Licensure Compact** as part of its application for RHTP funds.

- Allows eligible PAs to obtain a compact privilege to practice in other participating states without applying for and maintaining multiple licenses.
- Designed to reduce administrative burden, accelerate workforce mobility, and improve access to care.
- In SD, was driven by RHTP's recognition of the compact as a rural workforce-strengthening strategy.

States in the PA Licensure Compact



States in the PA Licensure Compact: Arizona, Arkansas, Colorado, Connecticut, Delaware, Iowa, Kansas, Maine, Minnesota, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin

Telehealth as Workforce Extender

Table 4: Examples of State Medicaid Programs that Require Coverage of Some Telemedicine Services in Pregnancy

State	Required to cover	Eligible conditions include:
AZ	Live video	Services within obstetrics/gynecology and behavioral health
IL	At-home uterine monitoring	Pregnancies after 24 weeks complicated by multiple gestations or preterm labor
	At-home blood pressure monitoring	For pregnancies complicated by pregnancy-induced hypertension (does not cover patients with chronic hypertension)
MA	Live video	Behavioral health services for pregnant/postpartum patients
MO	At-home monitoring	Pregnancy but only if other risk factors present like documented history of care access challenges, documented history of missed appointments, etc.
TX	At-home monitoring	Pregnancy, diabetes, hypertension
VA	Live video	Specialty procedures like obstetric ultrasound
	At-home monitoring	Pregnant women who are injecting insulin

NOTES: This is not an exhaustive list of telemedicine services covered during pregnancy under Medicaid. Rather, this list highlights only those states that *specifically* mention pregnancy-related conditions in their telemedicine laws. SOURCE: Center for Connected Health Policy. [State Telehealth Laws & Reimbursement Policies](#). Fall 2019.

KFF [Telemedicine and Pregnancy Care](#)

Table 19 – State Best Practices for Maternal Health Services Delivered via Telehealth

State	State Best Practice Example
Hawaii	AlohaCare, a Medicaid managed care plan, partnered with Healthy Mothers Healthy Babies Coalition of Hawaii (HMHB) to implement the Mana Mama Mobile Clinic, a holistic, community-based midwifery model of care serving birthing families on Oahu Island. Mana Mama uses telehealth to deliver a range of services to pregnant and postpartum people, as well as referrals to resources and information. Services are provided by licensed midwives, lactation consultants, and a nurse practitioner and can be delivered via phone and telehealth support. The program launched during the COVID-19 PHE, which further exacerbated inequities for high-risk pregnant people and infants, especially Black, Native Hawaiian and Pacific Islander individuals, including Compacts of Free Association migrants, and other people of color. ²¹²
North Carolina	During the COVID-19 PHE, Medicaid providers were temporarily permitted to provide perinatal care, maternal support services, and postpartum depression screening via telehealth and, in 2023, they were permanently permitted to use telehealth for prenatal and postpartum visits. ^{213,214,215,216}
Alaska	Until November of 2021, to expand access to care during the COVID-19 PHE midwives were authorized to deliver a subset of services via telehealth. ²¹⁷

CMS [State Medicaid & CHIP Telehealth Toolkit](#) (see tables of state examples / best practices on pages 44-45)



More State Examples

Also see Commonwealth Fund [State Policies to Improve Perinatal Health Outcomes](#) (see map on Pregnancy Care Telemedicine or access [full dataset here](#))



Rural Health

Rural Health Training, Recruitment, and Retention



Nevada's Position

Nevada RHTP

Addresses workforce recruitment and retention through:

- Creation/expansion of rural medical residency programs
- Financial incentives: housing, relocation, signing bonuses, CME stipends
- Pipeline strategies: rural high school-to-career pathways and local training programs



State Examples

New Mexico

Project ECHO telementorship and case-based learning to upskill clinicians

FL, ME, VT

Expanding scope for EMS providers and paramedics

Illinois

Workforce expansion initiative includes developing education and training for doulas and lactation consultants

Pennsylvania

Increased training and credentialing for midwives

RHTP Opportunities for Perinatal Population



Nevada's Position

NEVADA RHTP

Rural Health Outcome Accelerator

Expanding scope and capacity of partnerships to deliver behavioral and maternal health services in rural areas



State Examples

State	Program / Approach
Alabama	Telerobotic ultrasound devices and labor/delivery carts to rural hospitals
California	OB Nest remote self-monitoring; e-Consult and perinatal psychiatry access
Kentucky	PoWERing Rural Maternal Health — community-based teams, remote monitoring, telehealth
Connecticut	CT Family Bridge Program — universal nurse home visits across rural regions
Nebraska	Mobile clinical units, oral health teams, remote monitoring. Subrecipients include Nebraska Perinatal Quality Improvement Collaborative
Alaska	Remote fetal monitoring, coordinated case management, telehealth for high-risk pregnancies



Behavioral Health

Integration of Behavioral Health in Perinatal Care



Colorado **Integrated Care for Women & Babies**

- Statewide program integrating OB healthcare with behavioral health and SUD treatment (including MAT) at the same location



Rhode Island **Perinatal Substance Use Task Force**

- Multidisciplinary group focused on care coordination, bias-free prenatal care, and protection of the parent-child relationship



Pennsylvania **Centers of Excellence**

- Primary care, hospitals, FQHCs, and SUD providers delivering whole-person care with community-based care management teams
- 45 Centers of Excellence

Additional Considerations

- Monitoring network adequacy for perinatal mental health providers
- Creating care management programs with transportation and childcare support
- Deploying peer support specialists into clinical and community-based settings to expand the behavioral health workforce

Screening for Perinatal Depression



Nevada

- **One of 11 states that require** caregiver and maternal depression screening at well-child visits.
- Parent is screened four times from birth to age one.
- **Requires MCOs to report on prenatal and postpartum depression** screening HEDIS measures.

Additional Considerations

- Direction on screening and billing during pregnancy



State Examples

- **Massachusetts:** law requiring referral to a mental health clinician following a positive screening.
- **Alaska & Arizona:** require referrals to a mental health clinician for Medicaid enrollees.



Other Strategies to Increase Access to Care & Improve Quality

Strategies to Consider

Addressing Racism in the Healthcare Workforce



National Context

- **Birth-related mortality rates among Black, American Indian, and Alaska Native people are two to three times the rate of White people.**
- Certain subgroups of Latina birthing people also have higher rates of **maternal mortality** compared to non-Latina White people.
- **Black birthing people are at an increased risk for pregnancy-related complications.** For Black birthing people, **these risk factors are present across all age groups and education levels and have persisted for more than a century.**
- Source: [Promising Approaches to Reducing Disparities in Birth-Related Health Outcomes in Medicaid](#)



State Examples

- **California:** Requires hospitals and birth facilities to implement evidence-based implicit bias programs for all perinatal care providers.
- **Minnesota:** Dignity in Pregnancy and Childbirth Act (2021) requires hospitals providing obstetric care and birth centers to offer continuing education/training on implicit bias and antiracism.
- Source: [Promising Approaches to Reducing Disparities in Birth-Related Health Outcomes in Medicaid](#)

Perinatal Quality Collaborative



National Context

Centers for Disease Control Perinatal Quality Collaborative (PQC): **State or multistate networks working to improve quality of care for mothers and infants by providing opportunities for collaborative learning, rapid response data, and quality improvement to achieve systems-level change.**



State Examples

- **Louisiana:** provides **support to hospitals for continuous quality improvement** on perinatal outcomes, including work focused on: breastfeeding and infant nutrition; **reducing maternal mortality through the Safe Births initiative;** and **improving the identification, care, and treatment** of birthing persons and newborns affected by SUD.
- **Minnesota:** seeks to improve perinatal and infant health outcomes with an **emphasis on improving health equity for all birthing people.**

Universal Postpartum Home Visiting



State Examples

New Jersey: Family Connects NJ

- **3,600+** families served (Jun 2024–May 2025)
- **80%** of visits within 3 weeks of birth
- **50%** of families referred to programs
- **37%** of families spoke Spanish at home

Oregon Initiative

- Oregon SB 526 (2019): required development of home visiting for all newborn families; commercial plans must cover this service.
- Voluntary RN home visits for all mothers/newborns within two weeks; wellness checks, lactation support, SDOH assessments.

South Carolina Nurse-Family Partnership

- Expansion of the Nurse-Family Partnership home visiting services through [Pay for Success](#).
- Went from serving 1,200 mothers in 27 to serving a total of 3,794 mothers in 32 counties over the next four years.
- [Random control trial evaluation](#) found no positive impact on maternal health, but increased WIC enrollment and retention



Additional Considerations

- By enrolling a greater share of Medicaid and SNAP participants in WIC, states can support **healthier pregnancies, improve birth outcomes, and improve child health and cognitive development** for low-income families
- WIC provides **nutritious foods, nutrition education, breastfeeding support, and referrals to health care and social services** to low-income pregnant and postpartum people, infants, and children under age 5.
- Despite being adjunctively eligible, **more than half of WIC-eligible Medicaid and/or SNAP enrollees did not participate in WIC** in 2022.
- **Data matching** can help WIC State agencies measure the enrollment gap, identify key populations for targeted outreach, and simplify the WIC enrollment process
- Source: [WIC Coordination With Medicaid and SNAP](#)

Data Matching Funding

Federal funding to states to support match Medicaid/SNAP data and connect more eligible families to WIC is [available](#)

Questions

Thank You

Becky Lopez

Program Coordinator
State Health and Value Strategies
rebecca.lopez@princeton.edu

Sally Mabon

Director of Programs
State Health and Value Strategies
smabon@princeton.edu

Jamila McLean

Director of Health Equity
State Health and Value Strategies
jamila.mclean@princeton.edu

Heather Howard

Director
State Health and Value Strategies
heatherh@princeton.edu