

Maintaining Coverage and Access to Care During the Postpartum Period

Recorded January 27, 2021

Judy Bigby:

Thank you very much, Derek. Good afternoon, everyone, and thank you for joining us. This is the first in a series of CMS webinars on Improving Postpartum Care. Next.

Our agenda for today is to provide an overview of the Maternal and Infant Health Initiative, discuss the Postpartum Care Learning Collaborative, discuss why we focus on postpartum care, discuss Medicaid renewals and redeterminations as they relate to pregnant and postpartum women, and discuss health equity in postpartum care. We want to leave time for discussion and for question and answers at the end and we'll end with some announcements. Next.

The objectives of our webinar today are to familiarize the audience with the CMS Maternal and Infant Health Initiative, to describe the Postpartum Care Learning Collaborative, review the need to improve postpartum care for Medicaid and CHIP beneficiaries, and also review state Medicaid and CHIP program levers to improve care, review strategies to maintain continuity of postpartum coverage, and identify strategies to address disparities and achieve equity. Next.

I'd like to turn the webinar over now to Kristen Zycherman, from the Maternal and Infant Health Initiative in the Division of Quality and Health Outcomes at CMCS. Thank you, Kristen.

Kristen Zycherman:

Thank you, Judy. And on behalf of CMCS, I want to welcome you all and we're so pleased that all of you were able to make time for this and join us today during such a busy time but for such an important topic. Next.

Thank you. Okay. As a little background on the Maternal and Infant Health Initiative, CMS launched the Maternal and Infant Health Initiative in July of 2014. It was built on a foundation laid by the CMS Expert Panel on Improving Maternal and Infant Health Outcomes in Medicaid. And we wanted to focus on improving the rate and quality of postpartum visits, as well as increasing the use of effective methods of contraception, and that was the main focus over the course of five years.

In 2019, five years into the MIHI, CMCS wanted to take stock of where we were in light of increasing maternal mortality rates and increasing disparities and chart a course for the future. In 2019 CMS, through our contractor Mathematica, convened an MIH expert workgroup to identify and prioritize recommendations for improving outcomes for women and their infants in Medicaid and CHIP. Based on those recommendations, which were decrease the rate of cesarean birth for low-risk pregnancies, increase the use and quality of postpartum care visits, and increase the use and quality of well-child visits for infants zero to 15 months. CMCS has decided to focus on those areas and release TA on those topics through learning collaboratives. Next, please.

The MIH Workgroup focused on the importance of the care of the mother baby dyad. And this figure really shows the interconnection as well as the life course perspective in view of those focus areas and how they affect both a woman's health status and infant health status beyond the immediate pregnancy

and birth period. So, we felt like postpartum care is a real interconnection of mother and baby health outcomes. Next.

So, we've determined our first learning collaborative would be the Postpartum Care Learning Collaborative to improve the rate and quality of postpartum care. As you know, it includes a webinar series, starting with this webinar today on maintaining the continuity of coverage. And then, in the two subsequent months, we have two more webinars followed by the Postpartum Care Affinity Group, which we would encourage any states interested in the more action-oriented group. And if you would like to continue or start a quality improvement project, we would be interested in hearing about that and seeing how we can be of help through TA both in a group sense, as well as targeted one-on-one TA. So, the link is here for more information, and you would be able to sign up through the expression of interest form. Next.

And I will hand it back to Judy to explain more about why we are focusing on postpartum care.

Judy Bigby:

Thanks very much, Kristen. I'm going to spend a few minutes explaining why this initiative includes the focus on postpartum care. Next.

There are two major areas that we see are relevant to this focus. First of all, pregnancy related deaths and the relationship with postpartum care, and secondly, the opportunity to improve quality in postpartum care and also increase the postpartum care visit rates. Next.

I think everyone is familiar with the most recent information that shows that pregnancy-related mortality has been increasing in the U.S. And unfortunately, people are also familiar with the shocking data on disparities as demonstrated in this slide which shows that rates are three to four times higher among Black women and American Indian and Alaska Native women. Next.

In this slide, I've summarized information about the timing of pregnancy-related deaths and the causes of deaths. Here, we can see that more than 50% of deaths occur in the postpartum period beginning 1 to 365 days after delivery, but a full third of these deaths occur in the period after women leave the hospital, traditionally, from 70 to 365 days after delivery. We can also see if they look at the causes of death for each time period, that women are dying from treatable, recognizable conditions, and that this suggests that these deaths are preventable with better postpartum care. I must say that our experts estimate that about 60 to 65% of deaths are preventable. We also know that pregnancy-related deaths are just the tip of the iceberg; many, many more women experience pregnancy-related morbidity, and these can have long lasting effects on women's health and their circumstances. Next.

Medicaid and CHIP beneficiaries have unique postpartum care needs. We know that Medicaid and CHIP is a very important means of health care coverage for the most vulnerable women in the United States. So, it's not surprising that these women are more likely to have comorbidities such as obesity, smoking during pregnancy, and chronic diseases. Women who are Black or Hispanic, who are overrepresented in Medicaid, have lower educational attainment, more coexisting morbidities, and lower postpartum follow up for diabetes and hypertension, which are two conditions that when treated appropriately can prevent death and also morbidity and long-term chronic disease.

Women of color and low-income women also have the highest rates of postpartum depression, which we know is increasingly a significant issue both in terms of mortality and morbidity. And women with public insurance also have lower breastfeeding rates, affecting infants. So, we see here that the reality is these

conditions signal the imperative to make sure women are receiving care that is appropriate to their circumstances. Next.

Another reason that we want to focus on postpartum care is because of the changing concept of postpartum care. Postpartum care is not simply a six-week postpartum check, but the American College of Obstetricians and Gynecologists and other experts recommend that women have contact soon after they deliver, and that they also have individualized ongoing care that depends on their own circumstances, that they have a comprehensive visit at least at 12 weeks, but that they also have timely follow-up but with a regular provider, if they've had pregnancy complications or chronic medical conditions. So, this is a far cry from the one time six-week postpartum checkup.

The content of that checkup has also changed over time. As you can see, it is not just about recovery from childbirth and delivery, but also an assessment of multiple factors that you see on the slide including physical, social, psychological well-being, chronic disease management, health maintenance; it's really about providing comprehensive women's health. We also know that discrimination, systemic inequities, and social determinants of health contribute to poor postpartum outcomes for Black women and other women of color and any interventions that are designed to address the needs of women have to address these issues. Next.

One way that CMS tracks quality of postpartum care is to review the postpartum care visit rate as reported by state Medicaid programs, and as it has been defined by the NCQA. As you can see on this map, the postpartum care visit rate ranges from about 22.9% to 75.3%, with the state median of 61.2%, suggesting that there's an opportunity for improvement in the visit rate. I want to acknowledge that the specifications for what counts as a postpartum care visit has changed recently. NCQA recently decided to include visits on or between seven and 84 days after delivery, which is more consistent with the most recent guidelines for when and how care should be delivered. Next slide.

As Kristen mentioned, the webinars that we plan over the next few months will try to address some of the levers that we think that states have to improve postpartum care, including equitable access care and service, continuity of coverage, state options for support services and benefits, and managed care plan and provider partnerships for designing care for postpartum women who are at highest risk. Next.

I'd like to turn the webinar over now to Shannon Lovejoy who is a Health Insurance Specialist with CMCS, who's joined by her colleague, Jessica Stephens, who is the Director of the Division of Enrollment Policy and Operations at the CMCS. Thank you, Shannon.

Shannon Lovejoy

Thank you, Judy. And hi, this is Shannon Lovejoy in the Division of Enrollment Policy and Operations at CMCS. And we appreciate the opportunity to speak with all of you today about guidance that we recently released related to Medicaid renewals and redeterminations and how that guidance also supports the coverage transitions for pregnant and postpartum women. Next slide.

So, on December 4th, CMCS released an informational bulletin on Medicaid and Children's Health Insurance Program renewal requirements. And federal renewal regulations require states to periodically renew eligibility for all Medicaid and CHIP beneficiaries, and these requirements are codified in regulations at 42 C.F.R. 435.916 and 42 C.F.R. 457.343.

For the vast majority of beneficiaries, renewals occur only once every 12 months and this informational bulletin outlines the renewal process. But one thing that we were very pleased about is that we were also

able to take the opportunity to include a section that really outlines how redetermination policies intersect with the unique eligibility requirements for pregnant and postpartum women in Medicaid. Next slide.

So, before we walk through some of the considerations that are specific to pregnant and postpartum women, we want to take some time to level set about the renewal process and how to support coverage transitions. So, in order to initiate a renewal, states must attempt to renew eligibility for all beneficiaries based on available information, and this can include information the state has accessed through electronic data sources, or other information that's contained in the beneficiary's account or that the agency may have received from another program. And we refer to a renewal that a state is able to complete based on available information as an ex parte renewal. If the state has sufficient information available to determine that eligibility continues, then they must renew eligibility. And this initial step of the renewal process is important for continuity of coverage because it helps alleviate administrative burden for both beneficiaries and states and minimizes churns that might otherwise occur at renewal like keeping eligible individuals enrolled.

And if there's not sufficient information to make an eligibility determination, or if the information indicates that the individual might be ineligible then the state must send the beneficiary renewal perform and request information from the beneficiary. And for certain beneficiaries whose eligibility is based on modified adjusted gross income methodologies, that renewal form must be pre-populated with the most recent available information the state has. Next slide.

So, if an individual is no longer eligible for the group or category in which they're enrolled, the state must consider whether that individual is eligible for another eligibility group that's covered by the state. And while the state is doing that, they must continue to furnish Medicaid benefits to the individual until a determination of ineligibility is made or until a beneficiary does not timely provide any requested information. And to promote transitions of coverage, states are required to assess individuals for eligibility and other insurance affordability programs if they are determined to be ineligible, and this can include coverage that's available in the marketplace or coverage through the Children's Health Insurance Program. And the state must transfer the beneficiaries account to the Insurance Affordability Program as appropriate. Next slide.

In addition to doing renewal, states must also redetermine eligibility in between renewals, when a beneficiary experiences a change in circumstances that may affect their eligibility; states must promptly act on changes that are either reported by the beneficiary or identified by the state. States must also act on anticipated changes at the appropriate time and this could be something like the individual is reaching an age limit for the group in which they're enrolled or in the case of a woman enrolled in a pregnancy-related groups anticipating the end of the postpartum period. If the state has information that may impact eligibility, then the state must determine whether or not the information that they received back from the beneficiary supports continued eligibility, or the state would need to run through similar processes at renewal for those that have been found ineligible for the group to redetermine eligibility on all bases. Next slide.

So, for individuals that may continue to be eligible following a change in circumstances, states do have the option to start a new 12-month renewal period if the state has enough information available to renew eligibility with respect to all eligibility criteria. Otherwise, the state can retain the beneficiary's current eligibility period and conduct the renewal as originally scheduled when that occurs. Now, while states must redetermine eligibility based on changes in circumstances, there are times when that would not necessarily need to occur, and that's for individuals who have provided continuous eligibility. The

pregnant women who are covered under Medicaid, even if they aren't covered through a pregnancy related coverage group are entitled to continuous eligibility through the end of their postpartum period. And for the purposes of Medicaid eligibility, the postpartum period extends through the end of the month in which the 60th day after pregnancy occurs. Next slide.

So, because the continuous eligibility period for pregnant women is tied to the end of their postpartum period, and as we mentioned earlier because most beneficiaries have eligibility periods that last 12 months, the two don't necessarily intersect in the way that we would normally anticipate. And so, the steps that a state must take to redetermine eligibility at the end of the postpartum period or to conduct a renewal would really depend on when the renewal date is scheduled to occur in relation to the postpartum period. So, if a woman's renewal date is scheduled to occur before the end of her continuous eligibility period, the state must wait to conduct the renewal until the end of her continuous eligibility period.

So, for example, if a woman's continuous eligibility postpartum period ended this month but her renewal was due back in October, the state would not conduct the renewal in October 2020, instead, they would wait and make sure the renewal is conducted in January. But for women whose renewal is scheduled to occur after the continuous eligibility period, but really the end of the postpartum period represents a change in circumstances, and so, the state would process the redetermination based on the change in circumstance at the end of the postpartum period. And when the state is considering changes, they are supposed to act on the change in the eligibility criteria impacted by the change and assume that all other eligibility criteria remain the same.

So, in the case of a woman who may be enrolled in a pregnancy-related coverage group, where the end of the postpartum period might represent that she's no longer eligible for the group in which she's enrolled, the state would go through the normal processes to determine eligibility for other Medicaid groups. And if a woman is eligible for another group, the state would move her to the appropriate coverage group. And request additional information only if that is required to complete the redetermination. Next slide.

And so, I think we were able to open it up for a few questions right now. And if there aren't any questions, we can hold up and answer any that may come at the end of the webinar.

Judy Bigby:

Yes, thank you very much. If people have questions, you can ask them now. Okay, I think we will move on then. Thank you very much, Shannon. I'm now going to introduce Tom Curtis, who is the Michigan Medicaid Manager of Quality Improvement, and he's going to talk to us about what Michigan is doing to address health equity and postpartum care. Thanks very much, Tom.

Tom Curtis:

Thank you, Judy, for the opportunity. We can actually move right into the next slide. So, I'm going to just give a quick overview of Medicaid units here in Michigan, and then dive right into what we were looking at as it relates to health equity and postpartum care. So, we've got a managed care state for several decades, Michigan has, and we have over, at this point given COVID, we have not been just annoying folks during the COVID period, we have over 2 million people in our managed care program. Currently, over half a million are in managed care as part of Medicaid expansion. We have 10 Medicaid health plans across our 10 regions here of our state. And just give you a sense, Region 1 has one health plan and Region 10 has eight health plans. So, want folks to understand that variation across our program, and that

we have one contract, essentially, an identical contract for all Medicaid health plans, so just some programs specifics to consider when thinking about health equity. Next slide.

So, our vision or our commitment to our belief as a Medicaid agency is that we are and can be a driving force to identify and reduce racial/ethnic disparities in our state, and that is done by working closely in collaboration with our partners, namely the Medicaid health plans to identify and address inequities as we identify them. Next slide.

So, a key component of our work with our Medicaid health plans is the Medicaid Health Equity Report. We require our health plans to submit audited rates for 13 HEDIS measures stratified by race/ethnicity each year. And then, we trend these rates by race/ethnicity over time, and we run two calculations; one is a pairwise comparison. In this case, we are comparing the African American and the Hispanic population to the White reference population. And we also run an index of disparity where we compare each subpopulation rate to the overall health plan rate to get a sense of just how different is each racial subgroup compared to the overall health plan rate that's driving that overall health plan performance. Year over year, we see the African American population experiencing disproportionately poor or lower in many cases, depending on the measure quality of care when compared to all comparisons including the White reference population. Next slide.

So, here, hopefully that's big enough for folks to see. But this is straight from our Medicaid Health Equity Report. The top measure here, I'll start with is postpartum care. So, we've been trending that measure since 2012, right here, you'll see 2012 through 2017, and by race, ethnicity, as well as the overall program average which is that green line. The blue line at the top is the White reference population, that's gone a little up and down between 2012 and 2017 but it really began and ended at about 63% during that time period. So, that is postpartum care for White women in our Medicaid managed care program in Michigan. And compare that to the African American rate, which is the red line at the bottom of the graph, that rate started at about 46% in 2012. So, nearly a 20-percentage point difference in 2012. And we've seen improvement in that subpopulation over the measurement period to ending at about 54% in 2017, so really of reducing the racial disparities by half in that postpartum care measure between 2012 and 2017. I wanted to include chlamydia screening measure at the bottom of this slide to give folks a sense of how we conceptualize racial disparity in our Medicaid managed care program in Michigan.

So, we do look that disparities are not always classified as one who's getting less than another, in this case for chlamydia screening, we have African American women in Medicaid Managed Care in Michigan. At the top of the graph, the screening at between 74 and 76% across 2012 to 2017 time period, versus the White reference population at a rate between 56 and 58% during that 2012 to 2017 period. And we do look at this as I guess maybe reverse racial disparity isn't the right term necessarily, but it does signify different treatment of women based on color of skin and it is a discrimination that we do look at in that way, so still a disparity relative to racial discrimination. Next slide.

So, this is a more recent data. This is postpartum care racial disparities in 2018. So, in 2018, the postpartum care rates for the White population was 64%, and the African American rate was 54%, so that's a rate difference of about 10% as was the case in 2017. And then, we also see the 2018 Hispanic rate was just shy of 61%, so also a racial disparity there and 3%. Those are the two rate differences are highlighted because they are statistically significant differences. That next bar graph we see is really looking at that index of disparities calculation that I mentioned earlier. So, we take each subpopulation rate and we compare it to that overall health plan rate, which, for postpartum care was just shy of 61%.

And so, what we see here is that African American rate is below all racial groups and is below the national 50th percentile rate. There are some measures when looking at an index of disparity, that the overall differences from each subpopulation, when aggregated won't look very big. So, if we take an index of disparity approach, we don't always notice that just one population is lagging significantly. So, it's important to look at the data in this way to make sure that we're not missing any specific racial disparities when aggregating differences across all subpopulations.

And lastly, I'll end with in terms of data with the updated slide that we that we were looking at earlier for 2012 to 2018. So, you see here, the green line represents sort of the program average that's increased over time to be just about 60%. Still lagging behind the 50th percentile, which is the purple line. But we do see that White population rate, it has been right about at the 50th percentile between 2012 and 2018, and the Hispanic rate falling below the White rate between 2017 and 2018. And again, that African American rates consistently lagging below all comparisons. And they consistently had about 10 percentage point below the White reference population the last two years at this slide. Next slide.

So, how do we use health equity measures in our contract and in our incentive programs in Michigan? I think that maybe one of the neat things that we're looking at and doing in our state. So, we have a 1% capitation withhold in our state and we withhold those dollars and create incentive and performance improvement programs that plans compete for getting back the dollars that they put in the pool, and even getting back more than what they put in, essentially, sort of taking from other plans in the pool, so to speak. So, we assigned specific measures to each health plan, postpartum care is one of those measures that some health plans are showing large racial disparities in, and we reward statistically significant reduction in racial disparities year over year.

So, we essentially take the gap from one year between African American and White reference population for that given plan and the gap for the next year. And we measure whether that gap reduced and whether that reduction was a statistically significant amount. And where that happened, we reward points. Actually, for Fiscal Year '21, given the impact of COVID-19 on the general quality measurement process, the uncertainty related to utilization and performance rates, the uncertainty of the integrity of benchmarks, we have shifted our quality improvement to be almost entirely health equity for Fiscal Year '21.

And we are using our claims and encounters to measure whether that change overtime was done in a statistically significant way. So, while utilization may drop during a pandemic period, the gap between White and African American for example, can still be measured even in the context of a drop in utilization overall in the program, so that's what we're measuring, that gap itself. And since that gap is relative to the specific health plan, we are sort of benchmarking the plan against itself over time to incentivize reduction in racial disparities at a plan level year over year. Auto assignment algorithm, we have a quality-based algorithm that assigns members to a health plan, if that member does not take a health plan.

And in this case, we have developed a regional weighted average using our claims and encounters for access measures, and we are rewarding achievement in meeting or exceeding the regional weighted average. And in this case, for Region 10, which is are this the City of Detroit area, we are measuring only access to care for African American adults in this population, and incentivizing plans in the City of Detroit area or Region 10 for improving access for African American adults. And the better they do at that, the more likely they are to receive higher member assignments, which in that region, which essentially means more capitation payments to them moving forward.

And lastly, contract compliance, we are again using claims and encounters to pull a few of the specified measures from our warehouse, we have validated those rates that we pull out of our warehouse over a period of several years by collaborating with our health plan, and then using the index of disparity and setting benchmarks in the contracts to hold health plans accountable to reduce racial disparities. So, taking both an incentive approach but also just a contract compliance approach, to signal to our health plans that racial equity and quality of care is a requirement to do to do business with Medicaid HMO. Next slide.

I'll end here with a little bit of the future. So, what we want to do is continue to expand use of performance rates that were used that were deriving using claims and encounters and stratifying by race/ethnicity and expanding that by adding more weight in the incentive pool. So, you saw in the last slide that I just talked to you about 10 million of what has historically been around \$65 million performance school. We want to continue to ratchet that up because the more dollars we put behind this is the higher the priority is in our program. We want to expand efforts that we started around low birth weight by defining a racial disparity regionally rather than defining it by health plan membership to drive overall population health improvement.

So we acknowledge that racial inequity especially if it's beyond specific health plans per view, if beyond a medical system per view. It is a cultural and a community problem. And so, we are defining that problem more at a regional level and we will be using incentives to drive health plan collaboration at a regional level to reduce those racial disparities at a regional level, rather than just at their health plan level. So, really looking at how we can encourage health plans to not just look at their own membership, look at the community as a whole and look at each other as partners in addressing this problem at a population level.

And lastly, we're looking at and we've started actually incorporating a racial disparity lens into our physical-behavioral health integration efforts, specifically, follow up after emergency department visit for alcohol and other drugs, being an area where there's a pretty similar disparity as what we originally saw in postpartum care in our state between White and African American numbers. Nearly a 20-percentage point difference depending on where we're looking in our state. So, adding incentive dollars to that. So, that is essentially our health equity program. It is based on a lot of years working with health plans, validating these data, making sure we all agree we're looking at the right data and looking at the problem the right way so that we can really talk about what the actual problem is which is racial disparities and racial discrimination of our members and how health plans can be partners in addressing those types of issues in using incentives.

And we've seen progress, as you saw on postpartum care has gone from 20-percentage point disparity to 10-percentage points. We're not done there. We have more work to do. But progress has been made. And we even have some health plans, achieving reduction of racial disparities over time in other measures like cervical cancer screening, for example, and receiving incentive dollars because of their efforts in that progress.

So, I think that's my last slide and that looks like I've saved enough time for questions. Thank you.

Judy Bigby:

Yes, thanks very much, Tom. We have quite a bit of time for questions. I'm going to start with some questions for Tom. The first one is about your requirements that plan report data stratified by race and ethnicity. How long did it take for them to be able to report that data back to you?

Tom Curtis:

Well, that actually started long before I got asked in this position. So, I don't have that answer. I do know that generally speaking, the effort was almost two years from the idea itself and working with the health plan to decide on the measures to work with our plans on the reporting tool, to validate that reporting tool, and then to publish those initial data in 2012.

Judy Bigby:

Okay, thank you. The other question I'd like to ask is more broad, and that is the state issue on incentives and accountability to ensure that plans are paying attention to disparities. What are some of the mechanisms that they've implemented to address the disparities to reduce the gap in visit rates for African American and other women?

Tom Curtis:

Also, a great question we often get. We don't generally look under the hood of what health plans specifically are doing to achieve their progress. It would definitely be something that Michigan could and should consider doing. Should the resources be there to evaluate that type of specificity? But at this time, we do not run evaluations on each health equity measure or even what each health plan is doing for each health sector measure that would be quite an undertaking. But it is definitely something that should be considered at some point, should health plans or specific health plans or the program overall starts to see consistent improvement over time.

Judy Bigby:

Sounds like we might need to invite someone from the plan to help us out with that.

Tom Curtis:

I think that would be a good approach. It would be interesting to see just how forthcoming they would be, but yeah.

Judy Bigby:

Tom, there was a question from the audience about the use of doulas to improve postpartum care visits and care for women, are you in a position to answer that question about the use of doulas?

Tom Curtis:

The doula is something our state is looking at from a policy perspective and even in the absence of policy or requirements from a state level, health plans do have the flexibility, that's kind of one the great things about managed care, to look at specific interventions like doulas or community health workers or other types of home visitors that are showing evidence of improving on specific measures. So anecdotally, we do know that some health plans are looking at these types of interventions. The scope and scale, I think we are less certain about, but as an overall state in Medicaid policy approach, we are looking at doulas as an opportunity for increasing postpartum.

Judy Bigby:

Okay, we have another question from the audience. What kind of pushback was there, if any, from the managed care plans about the measures and the rewards? Do you have any words of wisdom for other state Medicaid agencies?

Tom Curtis:

Well, of course, there's pushback. I think, for other agencies, be prepared to spend some time and be transparent from the get-go on what measures you're considering, let them weigh in. Maybe they want to add a measure or maybe they have reasons not to do a specific measure; let them sort of chime in and all every step of the way, including what measures should we look at. And then, make sure there's clarity around data collection or reporting in your case, and be transparent about the calculations that are being ran about the data that were received and the analysis that's being done. Let them look at your queries, look at your calculation formulas and have them ask questions or pick them apart however they would like to.

Be prepared in the beginning to try to address data integrity questions. So, the questions are going to be more about that the racial disparity must be due to some sort of data problem and not about actual inequity in care. But once there's a couple of years of data that support that this is a consistent thing that's happening, then it can really be more about the racial inequity and less about data integrity. And then if states are going to use claims and encounters, take the time to validate those measurement rates in conjunction with health plans to make sure our system and our rule of engines match their systems in their rule of engines so that everybody is sort of operating from the same set of data, so to speak, and validate those with health plans.

So, that when we are pulling rates by race/ethnicity, and calculating a sense of dollars, they can't really argue with that, because they've already been through that collaborative exercise in making sure and validating and saying, "No, you're right, those grades are correct," and it's just a matter of moving forward; we all agree and trust that the data is what the data is. And that takes time too. But all of that upfront collaboration and transparency makes for much less push-and-pull once we're actually incentivizing and seeking improvements.

Judy Bigby:

Okay. And then, there's another question or comment about the use of the term reverse disparity. It seems that what you were trying to communicate that there may be differences in attitudes about which women are at risk for sexually transmitted infections, and so a lower rate among some women, a higher rate among others might reflect those attitudes. Is that consistent with your thinking?

Tom Curtis:

That is accurate. I mean, what I was trying to allude to is making sure that when we say disparity, we don't automatically mean one group is getting less than another to make sure we don't miss instances like chlamydia screening and even cervical cancer screening is the other one in our state, where African American and Hispanic women are screened at higher rates than the White women in Medicaid. And that does not mean there is no disparity, that just means there's discrimination that's still happening and then effective just leading to a higher incidence of screening amongst the population.

Judy Bigby:

Okay. I'm going to ask the audience if you have any additional questions, especially about the coverage and redetermination issues. Otherwise, there might be one or two questions that have come up that we could push on. One last question for you, Tom, what percent of your Medicaid beneficiaries are not in managed care? Do you have mechanisms for looking at quality for the fee for service population?

Tom Curtis:

Yes. I think generally, we say about 75% are in managed care. Because we have a fleet of certified rule engine that quarterly pulled over 400 specified measures including data from our claims and encounters database and automatically stratified by race/ethnicity for every measure, and that's so for fee for service versus managed care, we can look at those rates. The challenge becomes what sort of mechanisms and fee for service do we have to pull the system, so to speak, accountable for performance on those rates. Managed Care is just an opportunity for accountability for performance in a different way than the fee for service environment is.

Judy Bigby:

Okay, great. Well, I don't see any additional questions in our Q&A box. Thank you, Tom and Shannon and Kristen for your presentations today. I think that you provided some very... Okay, we have one more question for you. And that is on the 18 HEDIS measures that you have managed care plans stratify, how did you determine which ones to use and what was the process used to select them?

Tom Curtis:

Yep. So, those were all selected again before my time, so I can't really comment on that. But what I do know is they essentially are sub. They're measures from each sort of category of care, so to speak, so we have pregnancy care, we have chronic disease management, we have access to care, children and prevention services. So, we have different domains and we make sure we're looking at key measures from each domain. And those haven't changed since the beginning of the report, so that we have those reliable trends over time. And we're looking at key measures in each domain of care. But I unfortunately can't comment on the process by which that was done, but I would guess it was looking at taking a domain of care approach and working collaboratively with the health plan on which measures are important to look at in each domain.

I do want to try to take a second here because often in these kinds of conversations, especially with space, I hear questions about race/ethnicity reporting and the completeness of data as sort of a barrier or a possible barrier question at least from a state perspective. So, we have about 85% of our Medicaid managed care program participants who do report their race/ethnicity upon application for Medicaid, so that's a pretty high rate in and of itself, 85%. And we don't look at incompleteness of data as a barrier because as long as we have enough people in a measure for each racial group, that are included in the measure itself, it is a good proximity of how people with black or brown or white skin are being treated in the healthcare system.

So, even if folks refuse to report their race/ethnicity, we have enough people who are that we can still drive provider performance related to racial equity. So, it doesn't require everybody in a program recording their race/ethnicity to do this work. As long as you as long as you have enough of them, have enough proxy to begin trying to move with it.

Judy Bigby:

Okay. Thank you. And then we have one last question for Shannon and someone wants you to repeat the difference of rules between postpartum period ending prior to and after the renewal date.

Shannon Lovejoy:

Sure, I am happy to do that. So, the steps the state should take really depends on again when that renewal date would occur in relation to the continuous eligibility period. So for example, if a woman's renewal is due in October of 2020 but her postpartum period ends this month, the state would not conduct the renewal or send paperwork in October; instead, the state would push back the renewal to align with end of the continuous eligibility period, which aligns at the end of the postpartum period and initiate the renewal process starting with attempting to renew eligibility based on available information. And this usually tends to work out for women who were enrolled in Medicaid and then became pregnant while they were enrolled.

The other situation is that the renewal date is scheduled to occur after the end of the continuous eligibility of postpartum period. So for example, let's say that the end of the continuous eligibility period is scheduled to end this month. But the woman's renewal is not scheduled until May or that's when her renewal would normally occur. And this typically is the case for women who enroll in Medicaid when they are pregnant. So, instead of trying to conduct a renewal or requesting audit information, immediately, the state would act on the change in circumstance, which is the end of the postpartum period and then go through the steps to redetermine eligibility by first looking at any eligibility based on the information that they have available and seeing if they can just move the woman to the appropriate coverage group, and then can be waiting to conduct her renewal in May as they normally would. Of course, if they need additional information in order to make that determination to move the woman to another group, at that point, they would request information.

Judy Bigby:

Okay, thank you, Shannon. And I'll remind people that the December 4th, 2020 informational bulletin does go through this. Let us quickly now just go to next steps, Ruth.

Ruth Hsu:

Hi, everyone. So, I'll just fly through these slides. Our next webinar will be on February 17, at 2:30 on Improving The Content Of Care During Postpartum Period and Using Value-Based Payment. And you can register for the next webinar as well as our other upcoming webinars at this link right here. We'll also be having a Postpartum Care Affinity Group informational webinar on March 1st, and our final webinar on Models of Women Centered Care on March 11th. And then, we also want to encourage everyone to please review the Postpartum Care Affinity Group Fact Sheet and the EOI on [Medicaid.gov](https://www.Medicaid.gov) if you're interested in participating in the affinity group. And EOIs will be due March 12th, 2021, at 8pm. And on your way out, when you exit the webinar, please complete the evaluation survey. And if you have any questions, you can email us at MACQualityImprovement@mathematica-mpr.com. And thank you for participating. We hope to see you next time