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Hello, everyone, and thank you for attending today's webinar, Improving the Health of Mothers and Infants in Medicaid and CHIP [Children's Health Insurance Program].

Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets you can use. If you have any questions during the webcast, you can click on the Q&A widget at the bottom and submit your question. We will try to answer these during the webcast, but if a fuller answer is needed or we run out of time, it will be answered later via email. We do capture all questions.

A copy of today's slide deck is available in the Resource List widget that looks like a green folder at the bottom of your screen. You can expand your slide area by clicking on the maximize icon on the top right of the slide area or by dragging the bottom right corner of the slide area.

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I'd now like to take a moment to turn the floor to our moderator for this discussion, JudyAnn Bigby from Mathematica Policy Research. Judy, you now have the floor.

Thank you, Brice.

Good afternoon, everyone, and thank you for joining this webinar on Improving the Health of Mothers and Infants in Medicaid and CHIP. We're very excited to be able to discuss this important initiative with you today.

We have several speakers who will provide an overview of the initiative. We will provide background on why this initiative is so important.

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And we're also fortunate to have some speakers from several states who will briefly describe how they are working to improve the health of mothers and infants. We'll also review the importance of measuring progress toward meeting important improvement goals.

I'd like to turn now to Dr. Eliot Fishman – next slide – Director of Children and Adults Health Programs at the Center for Medicaid and CHIP Services [CMCS].

Hi, everyone. This is an exciting and long-anticipated day for us. And although it is the beginning of this initiative, it's also the culmination of a lot of thinking and emotional investment as well for us and for our partners in pulling this initiative together. So it is a moment to recognize accomplishment as well.

As you know, Medicaid and CHIP are now the nation's largest source of insurance coverage. We have new numbers in the pipeline that show us continuing to grow in the month of August, and we are, I think, over 68 million now in terms of the total number of people who are covered, and that includes coverage of 48% of all births in the county, and that's a number that will grow as we continue measure the percentage of births that we cover together with broader growth in Medicaid and CHIP. So we are particularly important as a payer in the area of maternal and infant health.

As those coverage increases take effect, in parallel the other improvements in the Affordable Care Act are taking effect as well. And those have had and continue to have large impacts on access to care and on the way that care is delivered and the way that care is paid for. And there are tremendous flexibilities

for states, both new and existing, as well as new support for states in taking advantage of those flexibilities in the Act.

We're trying at the federal level to take a population health perspective, both in terms of interventions and programming and in terms of measurement of improved quality and outcomes. In our current initiative, we are collaborating across agencies, both within CMS and across the Department of Health and Human Services to ensure that we support states and ultimately that we support our beneficiaries with resources and smart policy thinking that's needed to improved outcomes. That being said, this is an initiative that will ultimately stand or fall with the quality of the input that states give one another, and ultimately with the ownership of this initiative by our state partners. We're very much aware of that, and we are hoping in the content of the webinar today that both substantively and in terms of communicating a message that we are conveying how indispensable full state ownership is of this initiative. And for that reason, our presentations today focus on state-level collaborations that we believe will facilitate advancement of the goals of our new initiative.

It's really no exaggeration to say that the health of our nation's future depends on not just the quality of care received by Medicaid and CHIP enrollees in general, but specifically by our quality of care around maternal and infant health. And we've made a variety of investments here. This is our effort that focuses primarily on women's health, and in particular using the postpartum visit as a critical opportunity to address both health broadly and reproductive planning needs and to affect not only the woman's health but also the health of her future children.

So with that we are excited to begin.

Thank you so much, Dr. Fishman, for that overview and for stressing the importance of the role of states and the approach that you have taken to improve the health of women and infants.

I'd like to turn now to Dr. Mary Applegate from the Ohio Department of Medicaid, and she will discuss the challenges and opportunities in Medicaid and CHIP for improving the health of women and infants. Thank you, Dr. Applegate.

Good afternoon, everyone. Thank you very much for allowing me to come to present to you. What I'd like to discuss is our CMCS expert panel on improving maternal and infant health that convened back in June of 2012 and lasted a little over a year. We had this amazing chance to actually talk to anybody connected to women's and infants' health across the country, from nurse practitioners to public health systems to hospital administrators, and certainly, you know, many, many subject matter experts in the clinical field. We had some data reporting folks, but perhaps not all the world's financiers there because we really wanted to focus first on what does good quality actually look like and where are the opportunities, and then after that try to figure out how to pay for it.

So in conjunction with Dr. Jim Martin, who was the past President of the national ACOG [American Congress of Obstetricians and Gynecologists], we gathered this group with our partners and established a goal of trying to land on four or five strategies that could improve outcomes within the Medicaid system systematically and deliberately. So the observation has been made not only is infant mortality the mark of the health of the nation as Dr. Fishman mentioned, but we also noted that in our country it's the Medicare population who appears to be doing better, and the one thing that ties that together is the single payer and the notion that there actually might be a system. So within Medicaid, can we look at all of our programs together as a system realizing there are many differences. We still have lots of common federal legislation and requirements. So with that, instead of having just programs, could we actually have a system, having learned from Europe and other continents about what it actually takes to be well.

So we're aware that we pay for about half of the births as the Medicaid program. And we had a process, a very inclusive process, that basically broke the members into four subgroups. One related to data measurement and reporting is a foundation for knowing how we're doing as we go. We actually put every single measure that we knew out there, from public health, clinical practice, systems level as well as

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federal approval requirements, so that we could identify where the gaps were and where the opportunities were.

The next group related to being able to identify high risk populations and identifying core components of enhanced maternal care services. So, for example, those at risk for pre-term birth, for chronic conditions related to diabetes and hypertension, and those with mental health and substance abuse challenges, how do we actually get full integration of care for those women so that actually not everyone is treated exactly the same but it's according to need.

The next group was all about effective reproductive health enablers. Medicaid has long been criticized for the burden of paperwork that comes along with every request, so this group really focused on a systems level of women's health, really landing on postpartum visits, adolescent well checks as major opportunities in addition to looking at some of the policies around LARCs [long acting reversible contraception] and other types of contraceptive measures.

The last group talked about payment strategies in addition to data systems to support the kind of collaboration that it takes to get a population advanced in health outcomes. So with that we used a modified Delphi scoring process that was weighted according to what do we really know improves birth outcomes, number one. Number two, what directly addresses disparities? So we realized that disparities – this is one of the populations where we have the highest disparities of any other. So it was very important that whatever we landed on actually addressed that.

There was major emphasis placed on the third factor, which is what can we do in a reasonable amount of time? What is the lowest-hanging fruit? What can we do in the next two years or so?

And the last one related to is there measurement support to actually support doing it in two or three years?

So with that we have six action areas, and I'll run through them very briefly. The first is number one, intentionality actually matters. What do we do to reduce the unintended pregnancy rate and improve the birth spacing? This is all about education including the schools, nontraditional avenues, shared decision making and access. And, again, getting adolescents to some kind of well check where there's even an opportunity is really important. So across the country, rates are in the 20 to 40% for both private and public payers, so there's opportunity here across all populations, not just Medicaid. In addition to when we're talking about planning for pregnancies, whether or not a benefit fits in the medical category or the pharmacy benefit package was identified as one of the barriers. Data and measurement related to birth spacing, and there will be additional discussion today about that.

The second area related to expanding and enhancing breast feeding. So at hospital levels, for example, the Ten Steps to a Baby Friendly Hospital might be a promising model. In addition, many women have decided long before they deliver what it is they're going to do, and our system may inadvertently not support the continued feeding of human milk to infants despite the logic of the five times fewer less infections, the shorter NICU stays, and etc.

The third action area related to reduced pre-term births and adverse pregnancy outcomes. This was probably one of the richest areas of discussion as it related to systems to identify those at high risk, particularly pre-term birth, with the promise of 17 Alpha Hydroxyprogesterone reducing pre-term births by up to 30%. How do you take the scale, how do you get access to the drug, how do you get home visits, how do you talk about this in a way that the women are willing to engage in a healthcare system that's not necessarily trusted. So lots of discussion around that, but the group as a whole felt that that was one of the best opportunities ripe for action at this time.

Next up we talked about global payment. Right now often what happens is the global payment happens after delivery and so no one's paying attention to that postpartum visit. In addition, when high-risk women show up in crises, there's a financial incentive not necessarily to have them move to a tertiary care center

and give up 90% of the payment. So this area gets us to value based purchasing as well as regionalization of care.

The next area related to policies and procedures driving early and regular adolescent and adult women's well checks so that there is an opportunity for some of that risk identification as well as the opportunity to address health equity issues and share decision making in a planned and deliberate way rather than as an aside.

The very last area that we discussed related to looking at population-based perinatal data systems, so particularly vital stats. We have this fantastic system across the country, and it's not necessarily used in a way that it could be so that folks know how they're doing as they go.

There are other opportunities as well, but in a nutshell I thought I would just highlight the main activities that we thought were ready for intervention over the course of the next couple of years.

So I'll actually leave it at that. We did have a publication related to this, and we identified each of these activities in the perinatal periods of risk to demonstrate that really the area that we need to focus in is that maternal health bucket, which is that moms actually are not healthy before they are pregnant. That's one of the largest areas for improvement since neonatal care really is quite excellent in this country. So focusing where we have maximum benefit.

So with that I'll actually honor my time guideline and actually stop at this time. So, again, thank you very much.

Thank you very much, Dr. Applegate. That overview of the expert panel's work was very informative, and I'm sure that the states will find it helpful as well.

I'd like to turn now to Lekisha Daniel-Robinson, who is the Coordinator of the CMCS Maternal and Infant Health Initiative.

Thank you. And that was actually a very excellent segue from Dr. Applegate. There were lots of fruitful discussions that occurred during the expert panel, and so we had to be kind of judicious and narrow things down a bit to focus on a set of initiatives that we could promote for states in the near term. And so the expert panel defined our objectives – next slide, please – for the current initiative, which are, again to increase the rates and content of postpartum visits among women in Medicaid and CHIP by ten percentage points in at least 20 states. And as well to increase the use of effective contraception.

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So over the next several years, we will be working with states in a number of different capacities. We'll engage with some of our federal partners to increase our reach with providers as well as beneficiaries. We're also engaging in current activities that will help with beneficiaries such as Text4baby pilot effort. But we will also strengthen the technical assistance that we provide the states in a number of areas, one of which will be an action learning series that will be focused on improving postpartum care. States will receive information about this in the very near term, but it will provide technical assistance facilitated by an improvement coach to work with states on improving postpartum visits.

Additionally we're working on providing promising practices related to payment that will help will achieving both of our goals in this effort.

So we'll be working with states in a variety of capacities. In addition we're thinking about additional ways to support states such as a funding opportunity that we are planning for in early to mid-December that will help states with reporting on core measures. You'll hear about the measures a little bit later in our conversation today. We have both the postpartum measure and a developmental contraception measure that we're collaborating with the Office of Population Affairs and CDC [Centers for Disease Control] on.

So with that I think what we should do is to turn it over to hear about some of the collaborative opportunities that are currently ongoing in states so that we can think about ways that states can engage with their stakeholders to advance all these goals.

Thank you very much. So you're going to hear now from representatives from three states who will be able to share with you some very exciting work that they're doing to improve postpartum care. I think there will be a lot of food for thought as we got through the next three presentations. And at the end of these we'll have a little bit of time to answer some of your questions.

I'd like to turn now to Kai Tao, who is a policy advisor to the Director of the Illinois Healthcare and Family Services Department. And she'll talk about some family planning initiatives that they've done.

Great. (Inaudible.) I'm here to share Illinois' early experiences for implementing family planning best practices which have culminated to what we call the Illinois Family Planning Action Plan, which I'll refer to as FPAP, and that's what I'll be talking about over the next four slides.

So this first slide here, slide 16, to give you a little background about Illinois, we are one of 27 states (inaudible) Medicaid. As of September, we have about 3.1 million enrollees, and at least one million women and girls are considered child-bearing age. And this, of course, doesn't include the males, and we know there are going to be a lot more new males with ACA [Affordable Care Act].

We did have a family planning waiver for the last ten years, but it expires at the end of this year. We are also in the process of moving more than 50% of our clients into some type of care coordination or managed care program by January 2015. So that kind of sets the background.

Throughout the last few years, Illinois has seen a slight increase in what we call non-normal births, like low birth weight, small for gestational age, etc. We all know throwing more money at prenatal care doesn't improve maternal neonatal outcomes. Nationwide, as many of you know, approximately half of all pregnancies are unplanned or mistimed, and with Illinois paying for more than half of all pregnancies and 94% of teen pregnancies, we decided that our goal was to increase family planning services for women and men in the Medicaid program by providing comprehensive and continuous coverage to insure that every pregnancy is a planned pregnancy. So that's our goal for FPAP.

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So what tools do you need? First I would say it's important to catalog the family planning issue in your state. Network and connect with your family planning providers, OB [obstetric] providers, family docs. Look for those LARC champions, especially ones that hold leadership positions. LARC, I believe everyone knows this, but LARCs are long acting reversible contraceptives, which means IUDs, intrauterine devices and implants. Usually if you have a LARC champion, you have someone who is up to date on the family planning evidence and is eager to make improvements in their facility or clinic.

Here in Illinois we have free family planning fellowships, so definitely reach out to your academic institutions. Also reach out to your medical directors from SBHCs [school based health centers], from health departments, and even insurance plans.

Locate your ACOG legislative director from your region or your state. Having formal ACOG support in writing will help move the needle. Our ACOG lead is also happy to be a vehicle to communicate in writing what their needs are, and they can also communicate with all the other OB-GYNs and have national support.

So what we did was we had our first face-to-face meeting with the HFS executive team. Concerns and obstacles were presented firsthand for the providers. We also invited three pharmaceutical companies, who are the makers of the four types of LARCs currently available. As we know one of the issues is

having these devices readily available for same day insertion has become a huge obstacle due to the high up-front costs, and I'll touch on that again at the end.

So everyone was on board with the goals, and we issued our first informational bulletin June 2014 with strong guidance that all Medicaid clients should be counseled and educated on all FDA-approved contraceptives, from most effective first to least effective, so the tiered-counseling method. We also reiterated that copays, prior authorizations, and step-therapy failure are not allowed for family planning services and that patients have a free choice of providers when it comes to seeking family planning services. Even in our managed care network, that they can go out of network and still have coverage.

We also reviewed several points of service reminders in the same bulletin in June. Essentially it was a very slimmed-down version of the document by Lorrie Gavin and her team providing quality family planning services, recommendations of CDC and OPA that came out April 25, 2014. So please, please, refer to this document if you aren't familiar with it, The Providing Quality Family Planning Services.

Meanwhile, University of Chicago, Family Planning Department, (inaudible), which Illinois' Maternal Child Health Association, were holding a statewide contraceptive equity summit which focused on reproductive access for all payer sources. While this served as a perfect forum for us, each of us, to announce a draft policy and payment reform proposal, that I refer to as the FPAP.

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So we realize that HFS must make changes in our policies and payments to support the providers, so the following are the FPAP recommendations. We posted these on our website and provided approximately four weeks for public comments as well. I'm going to go through each of the policy and payment changes.

The first one is to increase the reimbursement for provider insertion and removal of LARCs. This includes paying fairly for both the removal and reinsertion.

Second we allowed reimbursement for both evaluation management visit on the same day as the LARC insertion or removal. Thus, the woman who comes in for her annual exam can now get her preventative visits and her LARC device on the same day. The provider will get reimbursed for both CTC codes. This was also applicable when a patient comes in for an ENN problem visit and wants to get her LARC device. The provider will get reimbursed for both.

Third we allowed fee-for-service billing for any SQHC, federal qualified health centers or rural health centers that wanted to provide transcervical sterilization, in this case Essure. We wanted to make sure they can at least capture the cost of the actual device.

And four, we want to increase vasectomy reimbursement rates. We want males to have more options. We know this is a relatively low risk procedure with low overhead, meaning no expensive devices, and it needs to be more accessible to the underserved men. What we found here is that there are very few Medicaid providers for vasectomies due to a low reimbursement rate. So now we have adjusted the prices to be much closer to commercial rates.

And lastly we wanted to increase the medical dispensing fee for certain 340B birth control methods. Of course this only affects providers that dispense 340B, but the pill, the patch, the ring, also included emergency contraceptives and LARCs, so they would get a little extra fee for dispensing these on site. This change on assignment also allowed advanced provision of the emergency contraceptive pill, which is something new.

And one other side note about the emergency contraceptive pill I just want to mention, Plan B and its equivalent is available over the counter and also paid for by Illinois Medicaid.

My next slide, and my last slide for my series. Great.

So the policy and payment changes are being finalized, and HFS will be issuing a follow-up informational notice with more details about how to bill in the coming weeks. We are reviewing contracts for 20 managed care entities to ensure that they are consistent with our family planning requirements. This means working also with our external review organizations, that's what the EQRO is, to make sure that their audits also have these same requirements.

We have websites with details about the FPAP. It's hfs.illinois.gov. I believe at the end of this webinar there will be a folder of resource that you can find more information about this website.

Really important I want to mention that we do also on this website provide a feedback form which allows anyone to report concerns or problems with contraceptive access. It's not perfect, but it serves as one platform to monitor with what is actually happening on the ground since we have so many moving parts of expansion in Medicaid. We will also be outreaching to several of our sister agencies, especially our Department of Public Health, to see how we can communicate these changes to our clients so they are aware of the family planning options and rights as a consumer or client.

And two last points. We are planning a webinar training at the end of the year for providers and front and back office staff to help them integrate comprehensive family planning, and we're working with an external training group who can offer technical face-to-face training as a follow up to the webinar.

And lastly, as I mentioned, with our pharmaceutical companies, we hope to have a pilot with one company by early next year for employing a technological solution for streamlined auto replenishing of the devices where the provider is not saddled with a high up-front cost, so we're very excited about that opportunity. Stay tuned. Apologies for the fast talking, and now I will turn it back to Judy.

Thank you very much, Kai, we really appreciate hearing about the very concrete strategies that your state is trying.

We'd like to turn now to Kate Berrien, who will discuss pregnancy medical homes in North Carolina, where she is the Director of the Pregnancy Medical Home Project.

Thanks so much, Judy, I really appreciate the opportunity to share our work with this group.

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The Pregnancy Medical Home Program was launched in early 2011 as a partnership with our state Medicaid agency. At the moment we now have a little over 85% of all the maternity care providers in North Carolina participating. That's about 1,700 individual providers. And that represents – they take care of about half the births in our state, and that's women who actually have Medicaid coverage during pregnancy.

One of the components of the Pregnancy Medical Home model who's primary focus is pre-term birth prevention is a focus on postpartum care. And we have incentivized postpartum care by adding \$150.00 incentive payment for completing the postpartum visit if it happens within 60 days of the delivery. Our Medicaid agency activated a unique billing code so that we could specifically capture the postpartum visit. Since so much of the care is billed bundled under the global fee, we did not have a data point to really confirm postpartum care was occurring. Using that data, in our first year we found that the rate was just under 50% based on paid claims for those incentives. We know that's an undercount because at the time we still had about 20% of our practices not effectively using that new incentive code, just hadn't been able to wire it into their systems yet. Obviously there's room for progress.

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Using the data we had from the folks who had billed for that incentive code, combined with birth certificate and other Medicaid claims data, we did some analysis to see what predicts actually not adhering to the

postpartum visit. Most of it should be pretty familiar to folks who struggle with postpartum care. Women who have poor birth outcomes are less likely to have a postpartum visit. And also women who are older or who are having anything but their first baby are less likely to come for a postpartum visit. We hypothesize that patients may not see the value of postpartum care. The visit may not have been meaningful to them the first time, so they may not come back for another one. We really want to focus on efforts to improve patients' perception of the visit as a good use of their time, especially those women who are facing significant other obstacles like an infant with health issues.

We do have a pregnancy care management program statewide in our state, and it does seem that that, using pregnancy care managers to promote postpartum care, has been helping improve the visit rate.

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Some other strategies around postpartum visit rate improvements. Disincentive payment seems to be driving a movement towards scheduling earlier postpartum visits than the traditional six-week visit, which is really just traditional and not especially evidence based. So we're now seeing a trend toward more postpartum visits scheduled at three to four weeks which allows the opportunity to reschedule. Still get that incentive payment if you can get it done within 60 days, and try some different strategies to get women in for postpartum care, such as early scheduling, scheduling before discharge, using phone reminders, addressing the barriers to keeping the visit.

We've also anecdotally been able to track an improvement in the rate of depression screening, which is another requirement for our program.

We do think that the trend toward an earlier visit may be helpful. It allows for earlier assessment of reproductive health needs and breastfeeding challenges.

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Speaking of reproductive health needs and the focus in this initiative on postpartum contraception, we've been looking at our data along these lines, and for Medicaid patients who delivered in 2012, we would get those women who received contraception in the first 60 days after delivery, and so we used paid claims to identify those who received contraception. Women who received contraception in the hospital, we were not able to include that data.

Just over a third of women had a paid claim for a contraception method. If this was a LARC, then we only accepted that if there was a paid claim for the insertion of the device, not just for the device itself. And you can see the rate of LARC in this population within 60 days of delivery was about 14%.

We are also tracking through a standardized screening tool we use which of these pregnancies was unintended, and unfortunately we found not much higher rate of postpartum contraception among women who had just come from an unintended pregnancy.

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One of the other strategies that we use in the Pregnancy Medical Home Program are care pathways that our clinical leadership develops. So Pregnancy Medical Home care pathways are the first time that statewide clinical guidance has been provided to the OB provider community in North Carolina. We have various academic medical centers. They have protocols that they share with their own provider communities. They are not always necessarily consistent with one another, and not really of benefit to providers who are not connected to an academic center. So we're really excited about this ability to create statewide guidance that's available across the entire maternity care provider community. They are posted to our website, and our next two pathways that are scheduled for release later this year are addressing postpartum care and reproductive life planning with a specific focus on postpartum LARC. Those pathways include detailed clinical guidance that is evidence based and also supportive materials,

and I think it's important that we address the use of other materials to help facilitate implementation of clinical guidance. Many providers know very well what best practice is or what the evidence is telling them, but the actual implementation, particularly in a challenging population, may not always be so simple. So technical assistance around reimbursement, tools such as checklists around postpartum care, all of those, I think, we just really are looking for ways to support the provider community around our quality improvement efforts. Those materials will be available on our website, I hope sooner than later, but definitely this year.

Thanks so much for giving me this opportunity to share with this group.

Thank you for sharing that really important initiative from North Carolina.

I'd like to turn now to Elena Cromeyer from the Northern Manhattan Perinatal Partnership. She's going to describe some community-based initiatives that her group is trying in New York.

Thank you, Kate, and folks in North Carolina. Good afternoon. My name is Elena Cromeyer, and I'm the Project Director of the New York City Department of Health's new Center for Health Equity to decrease Health Disparities Community Health Worker Initiative at Northern Manhattan Perinatal Partnership in Harlem, New York. Previously I served as the Consortium and Policy Manager for Merck for Mothers, Maternal Mortality Reduction Initiative at NMPP. I want to thank CMCS for inviting NMPP to present on its new Maternal and Infant Health Initiative.

To give you a brief overview of what NMPP does, we are a perinatal and maternal health nonprofit organization comprised of a network of public and private agencies serving as a fixture in the community for pregnant women seeking health services for over two decades. NMPP is a maternal and child health life course model organization offering over 22 services and programs. And I'll go into a little more detail on the MCH five course model on the next slide.

Some recent and current NMPP programs include Healthy Start, Head Start Infant Mortality Reduction Initiative, Merck for Mothers, Healthy Families New York Central Harlem, the Maternal and Infant Community Health Collaborative, or MICHC, the HRSA [Health Resources and Services Administration] MCHB [Maternal and Child Health Bureau] Healthy Behaviors and Women and Families Thrive (inaudible) Conception Program, and the news program, the New York City Department of Health Center for Health Equity to Reduce Health Disparities Community Health Worker Initiative.

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I'm sure a lot of people are familiar with the life course models. I won't go into too much theoretical detail about it. An organization with such an model considers interplay of risks and protective factors such as socioeconomic status, toxic environmental exposures, health behaviors, stress and nutrition, and how they influence health throughout one's lifetime. NMPP promotes the maternal and child health life course model and uses it to guide our programmatic goals and activities.

Three periods of the MCH life course model include the third trimester, the postpartum period, and the interconception period, and include the postpartum visit with risk assessment and care plan for high risk women, family planning, well woman visits, and chronic disease management. Moreover, the MCH life course emphasizes the importance of building stronger connections between the postpartum period and the interconceptional space, which is when we lose a lot of women who fall out of the system.

Applying the MCH life course to the maternal and child health framework would enable a continuum of care between these three periods and improve overall health and reduce costs.

What maternal and child health experts have observed for a while is that a disconnect currently exists between these three periods, which many leading groups and advocates for maternal health have identified and addressed, such as ACOG, Merck for Mothers, HRSA, MCHB and many others.

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Some of NMPP's MCH life course programs would not have been possible without Medicaid funding. A program which lasted a couple of years and which ended in 2011 is the Teenage Services Act Program for Pregnant and Parenting Teenagers and/or At-Risk Teenagers who were recipients of public assistance and included case management and home visiting services to assist teens with accessing medical, education, employment and other services.

Our MICHC program, which targets Medicaid-eligible women, includes family planning activities as a mandated component and comprises 25% of its budget. Some of the activities include training for community health workers, education, individual case management, connecting women to family planning services in hospitals, clinics and other settings, peer education training to negotiate with women's partners about contraception and information on where to find affordable family planning services for undocumented workers.

MICHC currently has in the community health worker program also included health education programs for women's health including information on pregnancy, breastfeeding and chronic conditions such as diabetes and hosts conference combining entertainment and education with workshops on prenatal and postpartum depression and the importance of postpartum visits and mental health.

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Finally, and based on what we've learned as a maternal and perinatal health organization in the last couple of decades. I'll discuss some potential partnership and policy opportunities to promote CMCS's maternal and infant health initiative. In the interest of time, I'll only go over a few of these bullet points.

A program that ran about five years, NMPP, and ended in 2008, is *Círculo de Mama* or *Baby Mama's Class*, which was a 12-session, 80-page curriculum that NMPP developed with a focus on prenatal, postpartum depression and intimate partner violence. It grew out of the Harlem Strategic Action Committee on Infant and Maternal Mortality, which is funded by the New York City Department of Health and evaluated by an independent DOH evaluator a couple of times and found effective. (Inaudible) was successfully implemented by several groups across the nation.

Medicaid New York State put in place a new payment for long acting contraceptives in April of this year so that women can get them postpartum. A lot of people don't know about this yet, so a public education campaign around this would be helpful.

For adolescents there could be more nontraditional events around sexual health and family planning including visual arts performances, use specific campaigns, and physical activities.

We've found here at NMPP that group work, workshops, conferences and events have been more well received by women of color in Harlem than individual case management.

A resource guide for postpartum health, such as the one we put together with the Harlem Strategic Action Committee in 2007, which was distributed among the various groups that made up the committee and mental health providers in the community focusing on prenatal and postpartum depression.

Promoting the dissemination of a pre- and interconception care clinical tool kit for providers such as the great toolkit we use for a lot of our programmatic activities, which is *Mary Kay* (inaudible), *Before, Between and Beyond Pregnancy* toolkits.

Medicaid financing for interconception care through flexibility in Medicaid state plan amendments and waivers such as Section 1115. This is especially vital since Medicaid runs out a couple of months after a woman gives birth, which is when we lose a lot of the women in the healthcare system and is a very crucial time to keep track of these women and continue to provide care to them.

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In addition, a few cities are relying on municipal funding for waivers, which is a good option to complement state and Medicaid funding.

And finally, developing systems of care which do not allow women and indigents to fall through the cracks, which can be mitigated by implementing the MCH live course to the maternal and infant health framework.

Thank you, and please let me know if you have any questions or comments. I'll hand it back to Judy. Thank you.

Thank you very much. I want to thank all three of the presenters representing states for giving us really concrete examples of initiatives that are going on that are very informative for other states.

We're going to take a few minutes now to go through just a couple of questions. We're running a little bit behind schedule, but we will answer questions on the website if we don't get to them during the Q&A period.

The first question is for Kate Berrien, and it's a question related to explaining how the \$150.00 enhanced fee worked. Does that come out of the global fee or is it an additional thing?

Yeah, it sounds too good to be true, but it is in addition to the reimbursement for the global fee. And we do have a couple of requirements to complete that postpartum visit and receive that incentive including standardized depression screening, addressing the patient's reproductive life plan, and ensuring that there's a warm handoff if the maternity care provider will not be her source of ongoing care during the postpartum period. Those are all sort of standard of care type of interventions anyway. But, yeah, so that is in addition to global fee reimbursement.

Thank you. The next question, Lekisha, I think is for you. It's a question about have the 20 states been selected for the two goals or will the 20 states be determined through a funding opportunity?

So the 20 states have not been selected, however, we will work with states, as I mentioned earlier, in different ways. So there could be the states that are part of the action learning series, or it could be as part of our efforts related to the funding opportunity that should be forthcoming in the next couple of months.

And how would you describe the timeline for rolling out the initiative to states?

So that's actually covered in the last slide, however, we will plan to inform states about the action learning series by the end of this week. The funding opportunity announcement comes out – well, it's planned to come out in December. And there are other incremental dates that we have in mind. Again, as part of our last slide, November 5th meeting about our measure, and then finally we are planning a learning series, a quarterly learning session, so our next one is planned for February, but there will be more information that will be forthcoming over the next couple of weeks.

Great. So the next one is also for you, Lekisha. Concurrent with this CMF initiative, HRSA MCH bureau is promoting the infant mortality coin. How well connected, coordinated are these initiatives at the federal level?

So the initiatives actually quite connected, although I would say certainly each agency has their own mission. During the Infant Mortality Summit I actually presented about our initiative, this initiative that we're talking about today. As part of the infant mortality work and the coin, states will have the option to select the strategy areas of interest. We're working collaboratively, again, with HRSA on that. And as well I think this initiative aligns with the Healthy Start effort with their focus on women's health. So we're definitely collaborating and working together. And so I think states will have a number of opportunities to connect on these issues in different ways and at different levels between the different agencies.

Thank you.

We're going to move on now with our agenda. And as I said, we will answer other questions that have come through that we didn't have time for after the webinar.

We're going to move on now to the important topic of tracking progress on improving care. Our first speaker is Dana Rey, who is the Senior Healthcare Analyst at NCQA, and she's going to review existing measures.

Hi. Thanks. In the interests of time, I'm going to briefly go over the existing postpartum care measure.

Next slide.

This measure is included in the Medicaid Adult Core Set, along with various other measures. It assesses whether women who had live birth deliveries received a timely postpartum visit after delivery. It's based on a HEDIS measure for postpartum care, and the measure rate may be calculated using either administrative or hybrid method data collection.

Next slide.

So this next slide shows you the HEDIS 2013 regional variation in postpartum care rates for Medicaid plans. There were about 191 plans that reported in that year, and you can see from looking at this data that there's slight variation across regions, most of the rates hovering around that greater-than-60% range. But the performance is pretty static, and that indicates to us that there's definitely room for improvement. But we did see that the highest performing plans are tied for the Northeast region and the Midwest region, and the lowest performing plan is the South region, by just a few percentage points.

Next slide.

So what can we conclude from this? What does this mean for this Maternal and Infant Health Initiative? Well, the goal of the Maternal and Infant Health Initiative is really to increase the rates for their postpartum visits for women in Medicaid and CHIP by at least ten percent. We saw from the previous slide that the data shows that there is definitely room for improvement in this area and it's been pretty static for Medicaid plans across regions in 2013.

The challenges to collecting this measure are twofold. First, the use of global billing for maternity care services. So meaning all aspects of care are kind of bundled into one and there's no real differentiation between prenatal and postpartum care.

The second challenge to collecting this measure would have to be with the method that is chosen to collect the measures data. We have seen over the last two years four Medicaid plans that they are able to get as much as a ten percent lift in the performance rate from using the hybrid method alone. So those are the things that need to be considered as we move forth with this measure.

And that's all I had for that.

Okay. Thank you very much. We're going to move on now to a measurement that's in development, and I'll turn to Lorrie Gavin, from CDC's Division of Reproduction Health, Office of Population Affairs.

Good afternoon, and thank you, Judy. I'm delighted to be able to talk about these developed measures for tracking the use of contraceptive services.

Next slide, please.

I have two main objectives. First I'm going to describe the new measures which, of course, as you've noticed, have been noted are still developmental, and second I'm going to describe plans for supporting use of the measures in state Medicaid programs over the coming year.

Next slide, please.

You've already heard about the health burden that the Maternal Health Initiative is designed to address, but this slide reiterates some of the related health goals that we hope will be advanced by use of these same performance measures. They concern Healthy People 2020, the National Prevention Strategy, and then priorities on teen pregnancy that have been set, both by the President and the Director of CDC.

Next slide, please.

This slide describes or lists the two performance measures. Both measures are based on the type of contraceptive method that a client decides to use, and on the fact that some methods of contraception are more likely to fail, or in other words result in a pregnancy, than others. The figure on the right side of the slide shows the contraceptive methods broken up into three tiers. The most effective methods, on the top of the chart, are the top tier, and they include sterilization, intrauterine devices, and contraceptive implants. These methods have a failure rate of less than one percent with typical use.

The moderately effective methods in the second tier include a shot, pill, patch, ring, and the diaphragm. These methods have a failure rate of six to 12% under typical use.

The bottom tier include condoms, withdrawal, sponge, rhythm and spermicide. And these methods have a failure rate of more than 18% with typical use.

Given this background, the first, and we'd consider the primary, performance measure is the proportion of female clients age 15 to 44 years at risk of unintended pregnancy that a doctor continue use of the most effective or moderately effective methods of contraception. In other words, the top two tiers that you can see in this figure. We consider this an intermediate outcome measure because it represents the client's choice at the end of the clinical encounter. It's desirable to have a high proportion of women at risk of unintended pregnancy using a most or moderately effective method of contraception.

The second proposed developmental measure, which we consider a sub-measure of the primary measure, is the proportion of female clients age 15 to 44 years who are at risk of unintended pregnancy that a doctor continues the use of a long acting reversible method of contraception. As you've heard, that's an IUD or a contraceptive implant. We're treating this differently than we do the primary measure. We consider this one to be an access measure with the focus being that making sure that a minimal proportion of women have access to LARC methods. So, for example, you would interpret this by calculating the mean or median across different health centers or state providers and then focus your attention on those that are performing well below the mean to make sure there aren't barriers that could be overcome to increase women's access to these methods.

We're not seeking an upper benchmark because of the potential concern that this could lead to coercive practices.

Next slide, please.

We've been piloting the measure in state Medicaid programs, and I'm quite confident that they will be feasible to calculate. The measures use existing claims data to identify the type of contraceptive method used. It also draws on estimates from a national survey, called the National Survey of Family Growth, or the NSFG, to help fill gaps in what we can learn from claims data. In the case of these measures, NSFG data will help identify the proportion of Medicaid clients who are at risk of unintended pregnancy because they're sexually active and are not seeking pregnancy.

Next slide, please.

On November 5th – next slide please – on November 5th there will be a webinar designed to provide a detailed description of the measures. We'll walk through the background information about how we selected the measures, our plans to seek NQF endorsement, and illustrate in detail how to calculate it using data from the Medicaid program in Iowa. As I mentioned above, the measures are developmental. They've been piloted in Iowa and several other states have reviewed and commented on the specifications, but we know we need to learn more and we're looking forward to having ongoing dialogue with the states that use the measure in the coming year.

Over this first year of use, we intend to provide ongoing support to state Medicaid programs as they apply the measure, and will be inviting states to participate in discussions about their own experience using the measure, and this experience will lead to possible refinements to the measure at the end of the year based on state's experiences.

That's all I have today. Thank you so much for your attention.

Thank you very much. We're going to move now to our last Q&A session. First I'm going to allow Lori and Dana to answer any questions that have come to them. And then we'll move into some other questions that have come in that are a little bit more general and relate back to some of the other content that we've reviewed.

So, Lorrie, I have a question for you. And it is, How does CDC define women at risk of unintended pregnancy in these measures? Who would be excluded outside women who are known to be infertile?

Right. So we're excluding women who are pregnant, seeking pregnant, never had sex, and if there's not (inaudible) people to get pregnant.

Okay. Thank you. I'd like to go back now to some of the other questions we have related to the content we heard in the last session. And this relates to postpartum care and who is providing it and also how we're engaging women or marketing these visits to them.

So the first one is, How are interconceptional visits being marketed to clients? And, Elena, maybe that's something that you could take. You might be on mute.

Sorry about that. Here I am. So internally here at NMPP we have various community health workers and case managers who, you know, through their caseload and their face-to-face interactions, their outreach, we speak about interconception health and care and the various services that we offer related to that. Did I answer the question?

Yeah.

(Inaudible.)

Thanks.

Okay.

Yeah. I also wonder if you might have some insight into this question, Kate, from the Pregnancy Medical Home Project?

Yeah, it's an area of challenge that we're looking at. And I was excited to hear about some of the work in Illinois around promoting really high-quality family planning services in the primary care setting because I think that is a missed opportunity that we all are looking to address. So we do have a pilot project now looking at improving the interconception care focus in our primary care model as opposed to our

Pregnancy Medical Home model. I don't know that we specifically have figured out the solution to how best to market the interconception care visit. I think any opportunity any time the woman is encountering the healthcare system, we want to use that as an opportunity to provide interconception interventions and address her reproductive health needs, and the question just becomes very complex around how best to do that. But that is one of the areas we're really looking to move forward around and kind of coordinate between the maternity care setting and the primary care setting to make sure that any good work that's being done to improve this area in the maternity care setting is equally matched in the primary care setting. I hope that helps.

Thank you, Kate, for that. There's another question about postpartum visits and who provides them that I'm going to pose to the group. Are we talking about postpartum visits through medical providers who are under contract with the state's Medicaid program? Does this include agencies that provide Medicaid prenatal care, coordination services that work with the pregnant women up to 60 days postpartum?

So, Lekisha, maybe you could address that question.

Sure. I'll just start by saying that in terms of capturing postpartum visits, we're thinking about those that are covered by Medicaid, so in whatever capacity that occurs.

So it's wherever women are getting their care, your goal is to make sure that they have access to postpartum visits by also the increased content of those visits?

So, yes, in part. I think we're focused on, for the women who pregnancies are covered by Medicaid, that they are getting the postpartum care that is necessary, so they are attending those postpartum visits, and the quality of that care is appropriate.

Okay. Thank you.

We have a question about the draft measure that I'd like to pose. Will the draft measure be incorporated into the CMS core measures through Medicaid and CHIP? And –

So right now –

Go ahead.

So right now we are considering these measures to be development. There's a separate process for incorporating measures into the Core Set, but we will be collecting it as a part of the same submission vehicle as we do the adult Core Set measures.

Okay. Thank you.

We have another question that I think several of our presenters might be able to answer. Have any of you evaluated whether the quality of services that a woman receives is a factor in why women don't attend the postpartum visit? And, Kate and Elena, is that something that you could address?

This is Kate. I'll just briefly reflect back on the slide that I showed where we analyzed factors associated with not keeping the postpartum visit and the fact that – and we were not the people to discover this but that there is a trend that (inaudible) women are less likely to keep their postpartum visit, older women are less likely. The other thing I did not put on our slide that was a surprising finding to us is that more educated women, women with higher levels of education, were less likely to keep the postpartum visit. So we have not been able to sort of dig deeper beneath the service yet to try to get a better understanding of what's driving that, but it does lead to some questions about if they kept the first postpartum visit and none of the ones thereafter, what happened during the first postpartum visit. So that's where our current focus is on driving the quality of that visit when it happens.

Thank you. Elena, do you have any reflections on that question? Might be on mute.

First of all, yeah, I would like to defer maybe to Lekisha if possible. It sounds like more of a policy-related question on cost controls, which I'm not familiar with.

Uh, no. The question is whether or not your program has looked at the relationship between a woman's satisfaction with the quality of the visit that she receives as an indicator of whether or not she'll participate in postpartum care.

Sure, yes. And through focus groups, different education workshops, and health information sessions, and various program here NMPP conducts, we do have some information on that. And to provide a general overview, a lot of the women that we have spoken to have not felt entirely comfortable with their providers or the care they received, and I actually led a consortium of experts including clinicians, community health workers, policy makers, and this is something that constantly came up, is the quality of care, like the bedside manner that physicians have with some of our clients. That's definitely an issue that we see here at NMPP in central Harlem.

Thank you. So we have another question about whether or not through there are Medicaid cost controls on the number of postpartum screenings a provider can conduct. And, Lekisha, I'm going to turn that question over to you.

Can you repeat that question for me please, Judy?

Sure. Are there Medicaid cost controls on the number of postpartum depression screenings a provider can conduct? For example, limited to three in a year.

I would think that the answer to that question would be state specific, so I don't have an overall Medicaid response regarding that.

Yeah, and I would think that it may vary state to state.

Right.

How those things might be implemented, so it's not an answer that would apply to all programs.

Right.

The next question is, Have any states been able to implement the changes within Medicaid's managed care plan. The questioner says, We've been successful with fee-for-service, but the Medicaid managed care is increasingly about, well, since most births, for now, are increasing in Medicaid managed care, it's important to be able to implement these changes in managed care programs.

So I'm not sure if our presenters can answer that, but what I can say is that we do have a couple of improvement projects with managed care organizations that are implementing that or those kinds of efforts. In different states.

And this is Kai from Illinois. Like I said, about 50, 60% of our clients are going toward managed care by January 2015. So what we have done is really look at their contract because we have a lot of new ACA family population contracts. And to really spell some of these things out for them, whether it's in the postpartum visit or in provision of family planning services. And that a lot of the changes that I talked about in the S path, we are basically telling them, you need to be on board. And that just came from my director, who feels that this is important. And so far there hasn't been that much pushback. But, of course, like I said, we'd like to see what plays out and to hear from our providers and patients since we can't be everywhere. Or it's easy for them to say, Yes, we get it. We'll do this. And so we're trying to create a lot of checks and balances.

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Thank you, Kai. I think that that type of strategy will be helpful to other states as they pursue some of these options.

And I'm going to continue with a question for you. The question is, Illinois expansion of family planning services, how did your slimmed down Medicaid family planning clinical services differ from the CDC, OPA, Title X clinical service recommendations?

Oh, no. Yeah. I mean, basically, when I used the word "slimmed down" meaning, we sent out what we call these informational bulletins. I think everyone has their own what they call, you know, how you communicate with all your medical assistance providers, and what I meant by slimmed down was just that it kind of touched upon different points of service, things like, Reminder, you do not need to have a pelvic exam if someone used contraception. Reminder, you should be doing age-appropriate, risk-appropriate GCCT screening. Reminder, you should have reproductive life planning questions at every annual exam. Those type of things, but they were completely consistent with both CDC's quality family planning guidance as well as anything, like the medical eligibility criteria. So it was all consistent with that. And we referred folks, providers, to look at those links on our website. We have like a two-segment website, one's for consumers and then one's for providers, and we refer to all these national governing body guidelines. When I say slimmed down meaning the one or two-page sheet was sent out with just sort of a brief overview of it, but it was not anything different.

Okay. Thank you, Kai. That was a very helpful explanation.

We're going to move on now to the conclusion of this webinar, and Lekisha Daniel-Robinson will come back to tell us about moving forward with this initiative.

Great. So I just wanted to say thank you for all of your questions. It demonstrates how much interest and excitement there is around our initiative, and so we certainly appreciate that and hope that this meeting spurs additional conversations and really pushes us forward.

So in terms of our next steps – next slide, please – state Medicaid agencies will be invited to participate in the Improving Postpartum Care Action Learning Series. Again, you'll receive – state Medicaid agencies – will receive notification of that by the end of this week. States will then be able to submit their very brief letter of interest, and we will determine by the beginning of next month the participants in that series. Again, we are projecting to release a funding opportunity announcement in December that will help support states with reporting on the two measures for the initiative. Please be on the lookout for a quality improvement webinar series. You know, I would expect those to begin at the beginning of next year. Tools and information will be posted on our website, which is Medicaid.gov, under the Quality of Care Maternal and Infant Health section. In addition, the recording of this particular webinar will be posted there as well as other things and dates of forthcoming webinars, etc.

And finally just wanted to remind everyone to save the date if you're interested in learning more information about the contraception measure that Lorrie Gavin reviewed, that will be held on November 5th from 2:00 to 3:30 Eastern time. And we'll look forward to continue to work with everyone. Thank you.

Thank you. I want to thank all the participants for your excellent presentations. The specificity and the very usefulness of the information that you shared about the work that you're doing in your states, and for the information that we had about measuring the quality using the postpartum care visit and the new developments of the contraceptive care measure.

As I said, there were some questions that came in that we didn't have time to get to. We will try to post the answers to those questions on the website. And we thank you all, again, for participating in this webinar about this exciting new initiative.

This concludes the webcast for today. Please submit feedback to our presentation team in your browser window when the event concludes. If you are unable to provide feedback (end audio)