



Issue Brief

Addressing Women's Health Needs and Improving Birth Outcomes: Results from a Peer-to-Peer State Medicaid Learning Project

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Commonwealth Fund pub. 1620
Vol. 21

ABSTRACT: High rates of maternal mortality, infant mortality, and preterm births, as well as continuing disparities in pregnancy outcomes, have prompted a number of state Medicaid agencies to focus on improving the quality and continuity of care delivered to women of childbearing age. As part of a peer-to-peer learning project, seven Medicaid agencies worked to develop the programs, policies, and infrastructures needed to identify and reduce women's health risks either prior to or between pregnancies. The states also identified public health strategies. These strategies led to a policy checklist to help leaders in other states identify improvement opportunities that fit within their programs' eligibility requirements, quality improvement objectives, and health system resources. Many of the identified programs and policies may help states use the upcoming expansion of the Medicaid program to improve women's health and thereby reduce adverse birth outcomes.

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OVERVIEW

High U.S. rates of maternal mortality, infant mortality, and preterm births, as well as continuing disparities in pregnancy outcomes, have prompted a number of state Medicaid agencies to focus on improving the quality and continuity of care provided to women of childbearing age. Many of these efforts have focused on implementing the national recommendations of the Centers for Disease Control and Prevention (CDC) and the Institute of Medicine, which call for expanding consumer awareness of pregnancy-related health risks, the expanded use of preconception care to reduce those risks, and the extension of public and private health care coverage to low-income women.

Such efforts are particularly important for state Medicaid programs, which finance at least half of births in each state and bear the financial burden of addressing adverse birth outcomes, including neonatal care for premature children. Design features of Medicaid programs have complicated efforts to

improve the quality of women's health care, as more than half of women whose maternity care is financed by Medicaid lose coverage 60 days after giving birth. When that happens, Medicaid agencies lose a critical opportunity to address health risks such as hypertension, obesity, and gynecological problems that can lead to high-cost, adverse birth outcomes. Because these risks pose challenges for individuals, families, providers, and states, many state Medicaid agencies are exploring opportunities to finance primary care that includes the use of evidence-based prevention services for low-income women.

To bolster these efforts, the Medicaid agencies of seven states—California, Florida, Illinois, Louisiana, North Carolina, Oklahoma, and Texas—participated in a peer-to-peer learning project jointly funded by the CDC and The Commonwealth Fund. The project identified four principal strategies states can use to improve reproductive health, including the use of family planning waivers and state plan amendments (SPAs). Other strategies include the use of interconception care waivers, managed care approaches to improve the quality and continuity of care, and data to identify unmet needs and monitor performance. The project also identified five core strategies that state public health agencies can use to improve women's health prior to pregnancy.

The project also produced a checklist designed to help other states identify improvement opportunities that fit within their approach to Medicaid coverage for women of childbearing age, their delivery models, ongoing quality improvement efforts, and public health resources. The checklist may benefit states as they look ahead to 2014, when Medicaid eligibility will be set at 133 percent of the federal poverty level and an estimated 8 million women under the age of 65 will join the program.

BACKGROUND: THE IMPORTANCE OF PRECONCEPTION CARE FOR WOMEN

Rising rates of maternal mortality, stagnant rates of infant mortality, high proportions of preterm and low birthweight births, and continuing disparities

in pregnancy outcomes in the United States have prompted a number of states to increase their focus on the health risks faced by women of childbearing age (here defined as ages 18 to 44).¹ These risks include diabetes, hypertension, obesity, smoking, heavy alcohol use, and depression, conditions and habits disproportionately affect low-income women and women of color.² (Data from the Pregnancy Risk Assessment Monitoring System—PRAMS—has found higher rates of tobacco use, obesity, diabetes, stress, and depression and less use of use of recommended multivitamin supplements compared with privately insured women.³) Unintended pregnancy and closely spaced births, which also disproportionately affect low-income women and women of color, are also associated with adverse pregnancy outcomes.⁴

Preconception care is recognized as a vital component of care for women of childbearing age.⁵ Experts have catalogued evidence-based interventions that can be delivered before a woman becomes pregnant or early in her pregnancy to improve her health and pregnancy outcomes.⁶ Based on this evidence, the Institute of Medicine and the CDC have recommended that preconception care be a component of the clinical preventive services delivered to women during well-woman visits.⁷

In addition to preventive primary care, the concept of preconception care includes intensive interconception care for women with identified risks and prior adverse birth outcomes.⁸ A study of interconception care for low-income women who had given birth to very low birthweight infants found that women in the control group had, on average, three-and-a-half times as many adverse pregnancy outcomes as women in the intervention group.⁹ An interconception care quality improvement project involving 104 Federal Healthy Start grantees in 16 learning collaboratives was conducted from 2008 to 2011. Grantees across the country refined their approaches for implementation of evidence-based practices through quality improvement projects focused on: risk assessment, healthy weight, maternal depression, family planning, case management, and/or linkages to primary care.¹⁰

In the current health care system, millions of women do not receive routine screening and services related to reproductive and childbearing risks because they lack health coverage outside of pregnancy and/or have limited access to high-quality preventive and primary care.¹¹ Implementation of the Affordable Care Act will likely reduce the number of uninsured women dramatically; however, the challenge of shaping benefits, financing, and delivery systems to improve women's health will remain.¹² To address these challenges, some states are seeking opportunities to change their policies and programs to improve women's health and pregnancy outcomes, particularly through Medicaid, prior to implementation of health reform law.

ROLE OF MEDICAID IN THE HEALTH OF WOMEN OF CHILDBEARING AGE

Medicaid is an important source of health coverage for women. The program covers more than 12 million low-income women, or one of every 10 women in the United States, and on average it finances 40 percent of prenatal care and births.¹³

Despite this, significant gaps in care remain. For instance, women who gain access to primary care, family planning, maternity care, and an array of other services upon becoming pregnant often lose that coverage 60 days after giving birth. As a result, women whose coverage begins with a pregnancy (and women who regain coverage with a subsequent pregnancy) may begin those pregnancies with untreated or poorly managed chronic conditions that may affect birth outcomes. This loss of coverage is especially problematic for women with Medicaid-financed births who have complications or give birth to a preterm or low birth-weight infant.¹⁴ Many of these women will have a subsequent pregnancy with high-cost, adverse outcomes before their medical risks have been addressed.

Medicaid family planning coverage can improve reproductive outcomes by increasing access to health education, contraceptive services, risk assessment, and sexually transmitted disease screening and treatment.¹⁵ In more than half of states, Medicaid family planning waivers and state plan amendments

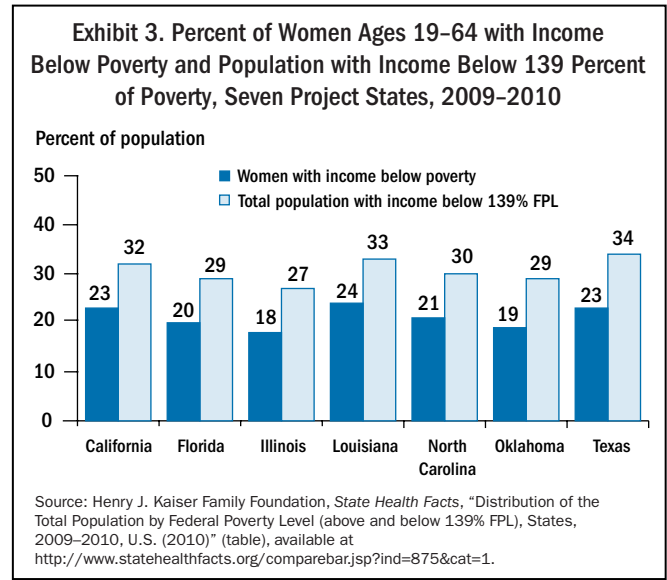
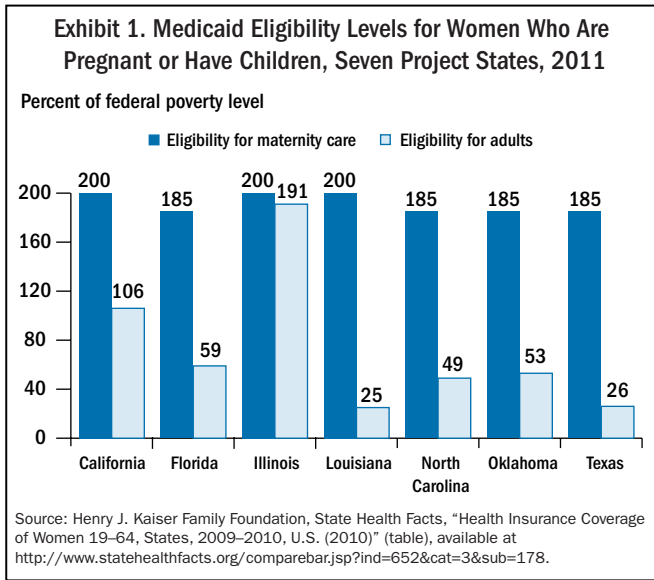
(SPA) have successfully increased access to contraceptive services. (As of July 2012, 23 states operate their programs under a waiver and eight states operate their programs through a SPA for a more permanent expansion.) However, a study of six states' waivers found that in 2008 none covered preconception health interventions such as folic acid supplementation, rubella vaccination, or management of diabetes or weight.¹⁶ A 2009 national survey found that only six states covered preconception counseling under family planning waivers.¹⁷

Until recently, other states' efforts to extend coverage by creating Medicaid demonstration waiver projects related to interconception care have been unsuccessful. A few waiver requests submitted to the Centers for Medicare and Medicaid Services (CMS) between 2006 and 2008 were denied. In 2011, Georgia became the first state to secure approval from CMS to conduct a waiver project that was designed to demonstrate the efficacy and cost effectiveness of interconception care for women who had a prior adverse pregnancy outcome financed by Medicaid. Louisiana also received approval for a waiver that provides such coverage for women in designated areas of New Orleans.

Medicaid Coverage in the Project States

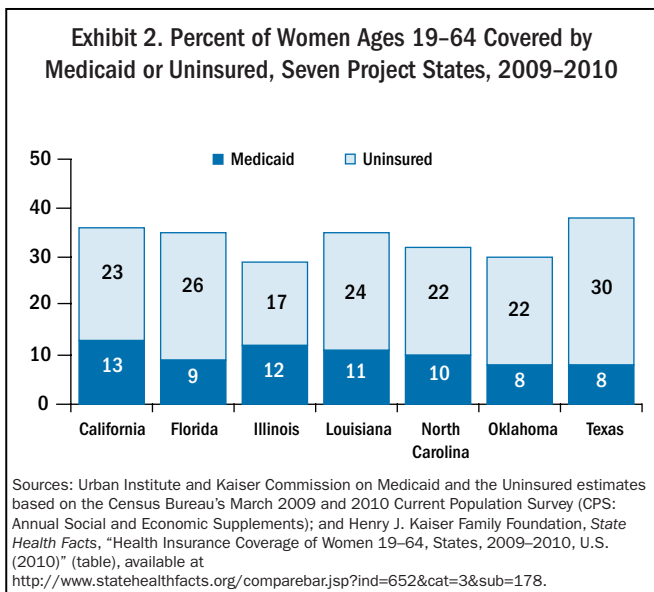
The importance of addressing the health risks of women prior to or between pregnancies prompted Medicaid agencies in seven states—California, Florida, Illinois, Louisiana, North Carolina, Oklahoma, and Texas—to participate in a peer-to-peer learning project that was jointly funded by the CDC and The Commonwealth Fund. Begun in 2010, the project enabled state teams representing Medicaid agencies, Title V Maternal and Child Health, women's health and private-sector programs to work together to develop the programs, policies, and infrastructures needed to identify and reduce women's health risks either prior to conception or following an adverse pregnancy outcome.

The states that participated in the peer-to-peer learning project had differing income requirements for Medicaid eligibility, which reflect variation in state



policies, the size of the population living in poverty, and employer-based coverage trends. Exhibit 1 shows the income eligibility limits for states in this project, comparing levels for nonpregnant women with children with those for women eligible for maternity care and coverage up to 60 days postpartum. Exhibit 2 provides estimates of the percentage of women who were covered by Medicaid as well as estimates of women who were uninsured between 2009 and 2010. Notably, in all project states except Illinois, 20 percent to 30 percent of women were uninsured. Exhibit 3 contrasts the percentage of women who are currently eligible for Medicaid coverage with the percentage of women

who would become eligible if the state uses its option to cover women whose incomes are at or below 133 percent of the federal poverty level with enhanced federal funding. (Note that with income offsets, known as disregards, the Medicaid eligibility threshold becomes 138 percent of the federal poverty level.) These data help illustrate the numbers of uninsured women living in poverty and are legal residents who will qualify for Medicaid in 2014 when uniform Medicaid eligibility levels set by the Affordable Care Act take effect. For example, in California, Louisiana, and Texas up to 31 percent of the states' female population would be eligible for Medicaid in 2014 if the state elects to adopt eligibility levels at 133 percent of poverty, as permitted under the Affordable Care Act.



STATE STRATEGIES TO ADDRESS THE HEALTH NEEDS OF WOMEN PRIOR TO AND/OR BETWEEN PREGNANCIES

Medicaid Strategies

This project identified the four principal strategies used by all or some of the seven state Medicaid agencies to improve reproductive health prior to or between pregnancies. Exhibit 4 shows which of these strategies are being employed by project states. The strategies include:

Exhibit 4. Project States’ Medicaid Strategies to Improve Women’s Reproductive and Preconception Health

State	Family Planning Waiver*	Family Planning SPA	Interpregnancy Care Waiver	Managed Care/ PCCM	Medicaid Data Project
California	Yes*	Yes	No		Yes
Florida	Yes	No	No		
Illinois	Yes	No	No	Yes	Yes
Louisiana	Yes	No	Yes	2012	Yes
North Carolina	Yes*	Yes	No	Yes	
Oklahoma	Yes*	Yes	No		Yes
Texas	Yes	No	No		

* States that previously had a family planning waiver and then applied for and received approval for a family planning SPA are making transitions from waiver to an SPA.

1. Maximizing opportunities afforded through Medicaid family planning waivers and SPAs to provide additional services such as preconception risk screening as part of covered family planning visits. Family planning SPAs require full coverage of family planning services and supplies but also permit states to cover “family planning-related services,” such as treatment for sexually transmitted diseases, human papillomavirus (HPV) vaccine, or reproductive risk screening or plans.
2. Developing Medicaid interconception care demonstration waiver projects that offer extended eligibility to women who have had an adverse pregnancy outcome. Services provided under these waivers are similar to disease management approaches that use targeted, intensive services to reduce modifiable risk factors and costs.
3. Using managed care approaches, including contracting health plans, health maintenance organizations, preferred provider networks, or primary care case management (PCCM) providers, to encourage delivery of prevention and intervention services through well-woman, postpartum, and other visits.
4. Using Medicaid data, linked Medicaid and vital records data, and public health survey data to identify gaps in services, monitor outcomes, and drive decision-making.

Public Health Strategies

This project also identified five core strategies used by state public health agencies and Title V Maternal and Child Health (MCH) programs to improve the reproductive health of women. Exhibit 5 summarizes the use of these strategies in project states. They include:

1. Strategic planning in five project states, with over-all state plans to improve the health of women of childbearing age and birth outcomes. Some state planning processes were conducted within one or two governmental agencies, while others engaged a wide array of public and private stakeholders to define and recommend needed action.
2. In five states, the assignment to preconception health of public health agency staff whose roles typically include convening public and private stakeholders, planning, interagency collaboration, and data analysis.
3. In six states, using measures from a core state preconception health indicator set to monitor preconception health on a population basis.¹⁸
4. In three states, engaging the U.S. Health Resources and Services Administration’s “First-Time Motherhood, New Parent Initiative” projects to advance knowledge, awareness, and access to care among new or prospective parents.¹⁹

Exhibit 5. Project States' Public Health Strategies to Improve Women's Reproductive and Preconception Health

State	Strategic Plan	Staff	Indicator Project	First-Time Motherhood	Cross-Sector Collaboration
California	Yes	Yes	Yes	Yes	Council
Florida	Yes	Yes	Yes	Yes	Interagency
Illinois	Medicaid	No	No	No	Interagency
Louisiana	Yes	Yes	Yes	No	Secretary-level initiative
North Carolina	Yes	Yes	Yes	Yes	Council
Oklahoma	Yes	Yes	Yes	No	Interagency
Texas	No	No	Yes	No	Interagency

5. Establishing an entity to guide cross-sector collaboration in all seven states. These entities may be a public–private council or interagency governmental group. As described in state-by-state summaries below, these entities are typically driving change in the areas of clinical practice, public health programs, consumer awareness, and public policy.

PROFILES OF STATES' EFFORTS TO IMPROVE WOMEN'S HEALTH THROUGH MEDICAID PROGRAMS

California

Annual births: More than 500,000

Percentage financed by Medicaid: 47%

Percentage of women who lose Medicaid coverage 60 days after giving birth: 73%

Number of low-income women and men receiving family planning coverage following a Medicaid-covered birth, 2008–09: 1.5 million

In 2006, the California Department of Health's Maternal, Child and Adolescent Health division set a goal of enhancing preconception care by integrating it into health practice, developing supportive policy strategies, and promoting preconception health messaging for women of reproductive age.

Strong public–private partnerships and the momentum generated by the release of the CDC's

national recommendations in 2006 prompted the creation of the Preconception Care Council of California. The independent, nonprofit entity has three working groups, which focus on reproduction-related clinical practices and research, finance and policy, and consumer-oriented public health campaigns. As part of its work, the council has created educational materials for health providers and informed state legislators about the importance of preconception care. With assistance from California Department of Health staff and financial support from Title V Block Grant funds, the council also developed the Web site www.everywomancalifornia.org, which offers information for women as consumers and providers of health care, as well as links to an array of resources.

The Interconception Care Project of California has developed provider and patient materials to retool the postpartum visit and focus on interconception risks and care, with support from the March of Dimes and the American Congress of Obstetrics and Gynecology (ACOG) District IX. The project led to development of an extensive set of evidence-based algorithms and tools for screening and risk assessment during postpartum visits.

To assess the prevalence of important preconception behaviors and measure the impact of social marketing campaigns, programs, and policy changes, the state's health department relies on Maternal and Infant Health Assessment (MIHA) survey data. (MIHA builds upon the PRAMS survey used in many states.)

California also relies on a Medicaid family planning waiver, known as Family PACT, serving tens of thousands of women. An evaluation found that between 1999 and 2000, the program helped to avert an estimated 21,335 unintended pregnancies at a savings of more than \$76 million.²⁰ Selected Family PACT providers also participated in a study that demonstrated the feasibility of integrating additional preconception counseling into family planning visits and informed guidance for federally funded Title X family planning providers. In addition, the state is now taking advantage of a new federal option to convert the family planning waiver to a state plan amendment to cover additional services for men and women and avoid having to renew a state waiver demonstration project.

Florida

Annual births: 240,276 in 2007

Percentage financed by Medicaid: 52%

Percentage of women who lose Medicaid coverage 60 days after giving birth: 56%

Number of low-income women receiving family planning coverage after a Medicaid-financed birth in 2007: 56,788

In 2001, Florida's Title X Family Planning and Title V Maternal and Child Health programs identified opportunities to better coordinate women's health care, which led to the use of interagency and public-private partnerships to formulate policy, implement new initiatives, and measure women's health status. These collaborations, which focused on improving women's health, reducing adverse pregnancy outcomes, and generating efficiencies inside government that would result in savings in public expenditures, led to a number of policy and environmental changes and an array of initiatives for women's health.

Through a multiyear process of interagency planning and mergers, a strong Infant, Maternal, and Reproductive Health Program (IMRH) emerged. The Department of Health issued a preconception health indicator report, which documents women's health status and access across an array of measures related to reproductive, preconception, and overall health. The

state also embarked on a social marketing campaign entitled "Every Woman Florida (EWF) to raise awareness of the importance of using health care visits to screen for pregnancy risks that could lead to adverse birth outcomes.

To address the needs for interconception care, the March of Dimes' Florida chapter is supporting a multiyear demonstration project that provides interconception health services to high-risk women who have already experienced a fetal or infant loss, or who have had a baby hospitalized in the neonatal intensive care unit.

And in 2009, the Florida Agency of Health Care Administration (the state's Medicaid agency) and the Department of Health extended the state's Medicaid family planning waiver, which helped to avert an estimated 1,650 unplanned births in 2006, saving more than \$13 million. Local county health departments and others assist with outreach to enroll eligible women in the family planning waiver.

Illinois

Annual births: 176,634 in 2008

Percentage financed by Medicaid: 46%

Percentage of women who lose Medicaid coverage 60 days after giving birth: 5%

Number of low-income women receiving family planning coverage between 2008 and 2009: 32,658, including 7,122 women who had a Medicaid-financed birth

Over the past decade, public and private sector leaders in Illinois have worked collaboratively to implement a series of policy and program changes aimed at improving women's health and birth outcomes. In 2003, the Illinois General Assembly passed legislation that required the Department of Healthcare and Family Services (DHFS), the state agency that operates the Medicaid program, to provide recommendations for improving perinatal health. In response, DHFS created a new bureau for Maternal and Child Health Promotion dedicated to improving birth outcomes. DHFS next launched the "Healthy Women" initiative, a five-year demonstration project that expanded coverage for adult preventive care and risk assessments, recommended

the content of annual preventive visits including elements of preconception care, and extended outreach to high-risk pregnant women. The Medicaid program has piloted a preconception risk-screening tool and implemented an initiative to improve levels of postpartum depression screening. These strategies are linked to the state's family planning waiver program. Illinois is evaluating a more targeted approach to interconception care, which includes the use of a medical home, the identification of risks or chronic conditions, and case management.

Through a public-private partnership, the Chicago Healthy Births for Healthy Communities Interconceptional Care Project (ICCP) enrolled women who had experienced adverse birth outcomes and provided them medical and social support services intended to improve future pregnancy outcomes. Results indicate that the program engaged women for 12 months after giving birth, supported the use of effective contraception, and had a positive effect on pregnancy intervals.

More recently, the state has used existing Medicaid administrative data and vital statistics in a new approach to monitor and project the impact and cost of adverse pregnancy outcomes—the results may encourage primary care providers to take advantage of prevention opportunities. Illinois is moving toward a real-time Medicaid perinatal data system. As part of the same effort, Illinois Medicaid has used these data to inform primary care/medical home providers about their patients' reproductive and interconception care risks.

Louisiana

Annual births: 65,076 in 2008

Percentage financed by Medicaid: 70%

Percentage of women who lose Medicaid coverage 60 days after giving birth: 73%

Number of low-income women receiving family planning coverage: Not available

Louisiana ranks unfavorably to every state except Mississippi in rates of infant mortality, low birth-weight birth, and premature birth. Because individual

programmatic approaches to addressing the problem failed to have a major, positive impact, the state's governor, Bobby Jindal, and two successive Department of Health and Hospitals secretaries have implemented the Louisiana Birth Outcomes Initiative (BOI), a targeted, cross-departmental, and public-private effort to improve the outcomes of Louisiana's births.

The BOI used the same process employed by Childbirth Connections and a partnership of leaders in maternity care to create The Blueprint for Action Toward a High-Quality, High-Value Maternity Care System.²¹ Using this process and a needs assessment completed by the state's Office of Public Health, Maternal and Child Health Program, the BOI team identified five priorities: improving care coordination, increasing use of data and measurement, improving patient safety and quality, reducing health disparities, and enhancing behavioral health. Five action teams were deployed to achieve the goals. Their work complements the governor's Perinatal Commission and has engaged more than 80 stakeholders, including private physicians, birthing hospitals, nursing leaders, public health agency staff, academic experts, data analysts, the March of Dimes, managed care organizations, and philanthropic leaders, as well as experts in quality improvement from across the country.

In June 2012, the BOI had begun implementing of a number of key initiatives, including:

- a statewide project focused on quality and safety of maternity care;
- the use of new indicators for hospital quality monitoring;
- the introduction of Medicaid payments and a new risk screening tool related to behavioral health among pregnant women;
- the use of provider incentives to reduce elective deliveries prior to 39 weeks gestation;
- a Medicaid interpregnancy care demonstration project through the Greater New Orleans Community Health Connection (GNOCHC) and in partnership with New Orleans Healthy Start; and

- efforts to strengthen the state's Medicaid family planning waiver through improved outreach and eligibility processes.

North Carolina

Annual births: 126,785 in 2009

Percentage financed by Medicaid: 52%

Percentage of women who lose Medicaid coverage 60 days after giving birth: 66%

Number of low-income women receiving family planning coverage in fiscal year 2009: 29,566 low-income women, including 10,874 women who had a Medicaid-financed birth

Following the 2006 release of the CDC's preconception care recommendations, North Carolina's Department of Public Health (DPH) inventoried the state's activities related to women's health care prior to pregnancy. The results were published in the report, *Looking Back, Moving Forward*.

DPH has staff dedicated to working on preconception health. The state also has a university-based center that serves as the hub for a regional initiative known as "Every Woman Southeast," a coalition of leaders and agencies from nine states who work together to improve the health of women and infants in the South.

In 2007, the state formed the North Carolina Preconception Health Coalition, which brought together representatives of the state's education department, its health and human services department, its health department, public and private universities, community-based organizations, and consumers, who were charged with developing methods of:

- increasing consumer and community awareness about preconception health;
- ensuring quality preconception care and practice among health care providers and community outreach workers;
- expanding access and affordability of preconception care; and

- advocating for policy changes that support preconception health.

The coalition has four working groups that were launched in 2008. The first, a consumer work group, developed a reproductive health life planning tool designed to help women determine whether and when they want to have children. A provider work group conducted a survey on practice needs and training. A work group on access and affordability developed legislation as a step toward enactment of a Medicaid interconception care waiver and a workgroup on environmental policy and program change focused on employee benefits, including maternity leave.

In 2008, North Carolina received a federal "First-Time Motherhood, New Parent" grant that was used to develop a social marketing campaign, deployed through partnerships with faith-based organizations, as well as to support training for 84 area health providers. Project leaders worked through an interagency collaborative comprising DPH, university, and local county staff, among others.²²

The state's Medicaid agency has also achieved success with its family planning waiver. Through a five-year demonstration, the waiver is estimated to have averted as many as 2,706 unintended pregnancies at a cost savings of \$27 million. The state is now transitioning to an SPA.

The Medicaid agency also restructured its perinatal case management to fit within the care management programs of Community Care of North Carolina, a public-private partnership that brings together regional networks of health care providers, health departments, social service agencies, and other community organizations to provide coordinated, team care based on the medical home model. And in 2011, it launched Pregnancy Medical Home and Pregnancy Care Management programs, which focus on providing high-quality maternity care to Medicaid recipients and care management to women by a prenatal medical provider during pregnancy and for two months after giving birth. North Carolina provides the designated Pregnancy Medical Homes with financial incentives to complete a postpartum visit for all of their patients,

which includes depression screening using a validated instrument, reproductive life planning, and referral for ongoing medical care if the patient will not be seen by the maternity provider beyond the postpartum period. Pregnancy care managers are expected to assist women with applications for Medicaid coverage beyond the 60-day postpartum period, including applications for the family planning waiver.

Oklahoma

Annual births: 54,946 in 2007

Percentage financed by Medicaid: 57%

Percentage of women who lose Medicaid coverage 60 days after giving birth: Not available

Number of low-income women receiving family planning coverage: Not available

In 2007, the Oklahoma State Department of Health (OSDH) launched its Commissioner's Action Team on the Reduction of Infant Mortality. The team brings a variety of partners together—among them, representatives from professional associations, the hospital association, universities, the March of Dimes, Chambers of Commerce, local health departments, Indian Health Services, and child advocacy organizations—in a state-wide collaborative to reduce infant mortality, other adverse birth outcomes, and racial disparities for such outcomes. As a result, preconception health is a public health priority for the state of Oklahoma, where a 2010 study using Oklahoma PRAMS data found that only 12 percent of the state's women received advice or counseling to prepare for becoming pregnant. (The study also found such preconception care visits were associated with increased regular multivitamin use before pregnancy, receiving first trimester prenatal care, and reduced smoking during pregnancy.²³)

The Oklahoma Health Improvement Plan (OHIP), released by the state in December 2009, includes an emphasis on both adult and child health. OHIP calls for increased use of preconception care to improve the health of women and children.

As a result of the work of the Action Team on the Reduction of Infant Mortality and the plan, the state launched the initiative “Preparing for a Lifetime,

It's Everyone's Responsibility,”²⁴ which helped to determine how women perceive health and pregnancy before, during, and after pregnancy. This multifaceted initiative includes health promotion, pilot projects for risk screening, provider training, hospital-based projects, and an effort to reduce elective deliveries before 39 weeks of pregnancy.

Oklahoma had operated the SoonerPlan family planning waiver and now operates a CMS-approved family planning SPA to implement a long-term Medicaid family planning coverage expansion for individuals with income up to 185 percent of the federal poverty level, regardless of age or gender.

Texas

Annual births: 385,746 in 2010

Percentage financed by Medicaid: 56 percent in 2009

Percentage of women who lose Medicaid coverage 60 days after giving birth: Not available

Number of low-income women receiving family planning coverage in 2010: 183,537

Texas Commissioner of Health David L. Lakey, M.D., has placed a high priority on improving birth outcomes and reducing infant mortality both inside his state and across the nation. As current president of the Association of State and Territorial Health Officials (ASTHO), he has issued a “Healthy Babies Presidential Challenge,” which aims to accelerate progress in improving birth outcomes. This priority is reflected in the state's Healthy Texas Babies initiative. Sponsored by the Texas Department of State Health Services (DSHS) in partnership with the March of Dimes, the initiative convened a multidisciplinary panel of experts to identify priorities such as the importance of increasing access to preconception care, the number of planned pregnancies, and the availability of medical homes. Other priorities are developing a regional perinatal system of care and a coordinated, data-driven plan to reduce infant mortality. In 2011, the state's legislature approved “exceptional item” funding of \$4.1 million for the “Healthy Texas Babies Initiative,” with the goal of decreasing preterm births by 8 percent over the next two years.

In Texas, the state's Medicaid Women's Health Program (WHP) provides low-income women with family planning exams, related health screenings, and contraception. An evaluation of the Texas Medicaid family planning waiver found that the state saved \$10 for every \$1 it spent and that in 2008 the program helped to prevent more than 5,700 unplanned pregnancies.²⁵

A CHECKLIST OF OPPORTUNITIES FOR STATES

As part of the peer-to-peer learning project, the states developed a checklist to help others assess opportunities for improving women's reproductive health and birth outcomes. It begins with a series of questions that are designed to assess the scope and impact of the state's Medicaid program by reviewing patterns of

IMPROVING WOMEN'S HEALTH AND BIRTH OUTCOMES: A STATE CHECKLIST

Measure the Challenge and Opportunity

How many women are covered by Medicaid in our state and what is the pattern of birth outcomes they experience? What is the cost?

- ✓ What percentage of prenatal care and births are financed by Medicaid?
- ✓ What percentage of low birthweight and/or preterm births are financed by Medicaid?
- ✓ What proportion of women with a Medicaid-financed birth lose their Medicaid coverage 60 days after giving birth?
- ✓ What proportion of women who lose coverage 60 days after giving birth transition to a family planning program?
- ✓ How many women have repeated low birthweight or preterm births financed by Medicaid? What are the direct Medicaid costs for medical care to the infant and mother for the first and subsequent births?

Improve Health Care Quality

How can our state increase the use of evidence-based preconception care through primary care, well-woman, and postpartum visits for Medicaid-covered women?

- ✓ Does the state support the development of medical homes or health homes as a starting point for improving the quality of services delivered during well-woman or postpartum visits?
- ✓ What are the incentives for Medicaid providers and health plans to provide high-quality, evidence-based care during well-woman and postpartum visits?
- ✓ Could the state develop quality improvement projects (e.g., learning collaboratives, pilot demonstrations) for primary care providers who serve high concentrations of women in the Medicaid program (e.g., federally qualified health centers, obstetrician-gynecologists in poor urban areas)?
- ✓ Does the state have existing contracts with Medicaid managed care plans, primary care case management providers, community care networks, or accountable care organizations that could be used to increase provider focus on the quality of care delivered during well-woman and postpartum visits?
- ✓ What measures are available at the state, local, or plan level to monitor system performance (e.g., HEDIS postpartum visit rates)?
- ✓ Do the state's Medicaid billing codes or related procedures need to be modified to permit billing for preconception care as part of well-woman visits?

Increase Use of Screening

How can our state promote use of evidence-based preconception and interconception screening assessments?

- ✓ Has the state identified or developed evidence-based screening tools?
- ✓ Does the state have access to electronic medical records or other data that could be used to monitor of the frequency of risk-factor screening?
- ✓ Building on quality improvement projects, could screening be a topic of a learning collaborative of providers?
- ✓ Is the state using evidence-based home visiting programs or federally funded Healthy Start projects to screen for interconception risk factors and refer women with interconception risk factors for treatment of chronic disease, mental health problems, or other conditions?
- ✓ Could the state use an approach similar to those employed to promote use of developmental screening in early childhood (e.g., the National Academy for State Health Policy's Assuring Better Child Health and Development (ABCD) program)?

Expand Access to Quality Interconception Care

How might our state finance interconception care for women who have experienced a Medicaid-financed birth with an adverse outcome (e.g., fetal loss, preterm or very low birthweight birth, infant mortality)?

- ✓ Could the state participate in a Medicaid interconception care waiver demonstration project to extend eligibility to additional women?
- ✓ How could the state use targeted case management programs to develop care plans and serve women with continued eligibility following a birth?
- ✓ How could the state build upon an existing family planning waiver or state plan amendment to add interconception care services?
- ✓ Does the state have existing contracts with Medicaid managed care plans, primary care case management providers, community care networks, or accountable care organizations that could be used to increase provider focus on interconception care?
- ✓ What strategies might be used to improve the quality and utilization of postpartum visits, which are a key point for assessing risk factors and intervening to address them?

eligibility, service utilization, costs, and outcomes. The checklist then focuses on methods of improving the quality of care using existing federal programs, relationships with Medicaid managed care plans, financial incentives for Medicaid providers, and data or health information technology, among other methods.

The third section of the checklist prompts states to consider different approaches to promoting evidence-based models of preconception and interconception care, while the fourth and final section suggests

methods of financing interconception care for women whose previous Medicaid-financed birth has resulted in an adverse outcome.

Implementing this checklist may present some challenges for states. Through this project, it became clear that data are not always readily available to study patterns of eligibility, service utilization, costs, or outcomes. In particular, most states have not organized data in a way that would allow them to look across the continuum of perinatal services and follow individual

women from prepregnancy visits and prenatal care to birth services, newborn care, postpartum and well-woman visits, or through a subsequent pregnancy should one occur. Linking vital statistics to Medicaid administrative data may help produce information on Medicaid birth outcomes and infant deaths. Such a dataset would also provide a state with information needed to improve the quality of care and outcomes for women and infants, including through analyses to identify health care utilization patterns and cost drivers.

CONCLUSIONS

A large-scale U.S. initiative to promote use of preconception care and improve women's health will require the same level of attention and effort that was provided to improve access to prenatal care under Medicaid.²⁶ It will require changes in eligibility, provider behavior, billing arrangements, and data-driven decisions. Implementation of recommended preconception care could also be accelerated in a patient-centered medical home, including more objective risk screening, use of electronic medical records, and emphasis on continuity of care.²⁷ Most importantly, such a transformation will require action on the part of states, which will continue to shape Medicaid programs under the Affordable Care Act.

The implementation of the Affordable Care Act will have an impact on coverage, benefits, and access to care and make it feasible to link preventive, preconception, prenatal, family planning, and other medical care as part of a seamless continuum of care for women.²⁸ This will create multiple opportunities for states to design Medicaid strategies to improve women's health.

For some states, this process may begin with expanding eligibility for low-income, nonpregnant women or implementing interconception care and family planning waivers or state plan amendments to further expand coverage.²⁹ Other states may want to focus on enhancing the quality and value of the services they finance for women already enrolled in Medicaid using relationships with Medicaid managed care plans, performance monitoring, quality improvement programs, patient-centered medical home initiatives, and/or

financial incentives that encourage providers to deliver evidence-based preventive services that are based on CDC and IOM recommendations.

States may wish to take advantage of the multiple opportunities health reform creates for states to improve women's health and pregnancy outcomes. These include:

- Grants from CMS's Center for Medicare and Medicaid Innovation (CMMI) to test the effectiveness of patient-centered medical homes that address the unique health needs of low-income women of childbearing age. The use of medical homes could accelerate the use of more objective risk-screening methods and electronic medical records and improve continuity of care.³⁰
- Using grants from CMMI to focus on improving the delivery of evidence-based preconception or interconception services to Medicaid-enrolled women. Such projects could build upon the approach of the Strong Start Initiative, which aims to test new approaches to prenatal care (a joint effort between CMS, the Health Resources and Services Administration, and the Administration on Children and Families). Medicaid innovation projects can lay the groundwork for state activities following Medicaid expansion in 2014.
- Using the Medicaid state option created under the Affordable Care Act to finance Medicaid "health homes" (also commonly known as medical homes) with a 90 percent Federal Medical Assistance Percentage (FMAP) match level. Medicaid health homes are for people who have: two or more chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition. For women of childbearing age in Medicaid with such risks, the health home would offer comprehensive care management, care coordination, health promotion, comprehensive transitional/follow-up care, patient and family support, and referrals to community and social support services.³¹ It would be an appropriate means to reduce interconception risks for

women with a prior adverse pregnancy outcome and at least one chronic condition and/or mental health condition. This funding could be used to provide patient-centered, integrated health homes with access to a designated provider and a team of health professionals skilled in serving women of childbearing age.

- Designing a well-woman standard of care for Medicaid enrollees that focuses on women's clinical preventive services, as recommended by the IOM. The HHS regulations on women's clinical preventive services provide a framework for parallel changes in Medicaid.³²
- Applying a set of Medicaid quality measures that focuses on the continuum of perinatal care and risk, not just a focus on prenatal care, delivery procedures, and newborn outcomes in isolation.

States could also use their Medicaid programs to focus on health disparities by improving the cultural

and linguistic competencies of Medicaid perinatal providers. Monitoring health disparities among women of childbearing age and pregnancy outcomes is also important.

The ideas in this issue brief can help fill the gap and lay the groundwork for 2014, when the expansion of Medicaid eligibility to cover adults with incomes below 133 percent of poverty (138 percent with income disregards) has the potential to cover more than 8 million additional women under age 65.³³ For women in their childbearing years in particular, health reform changes make it feasible to link preventive, preconception, prenatal, family planning, and other medical care as part of a seamless continuum of care for women.³⁴ The era of health reform can and should be the time to provide all women with a lifetime of adequate health coverage and to implement a comprehensive "well-woman standard of care."³⁵ Evidence suggests that we would thereby improve the health of women, children, and families.

NOTES

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ACKNOWLEDGMENTS

This project was supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services, and by The Commonwealth Fund. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or the CDC or their staffs. Nor do they represent the official views of any state described in this report.

The author is extremely grateful to The Commonwealth Fund, in particular to Edward Schor, M.D., former vice president of the Fund's State Health Policy and Practices program, who provided ongoing guidance and insights that enriched this work. Pamela Riley, M.D., M.P.H., program officer for Vulnerable Populations program at The Commonwealth Fund, also provided valuable support and guidance. The support of Alison Johnson, deputy director of the CDC's National Center for Birth Defects and Developmental Disability, for this project and work on preconception health has more generally been invaluable. Carter Consulting, Inc., the prime contractor for CDC work, was a willing and supportive partner in this endeavor. The administrative and operational support of Robin Fordham is acknowledged and deeply appreciated. The coordination of a multistate project is intensive work, which requires particular attention to detail.

Finally, this project would not have been possible without the participation, intellectual contributions, and engagement of health policy leaders from seven states. Collectively, they reflect the energy and talents of state leaders across the nation who want to improve women's health through Medicaid.

Editorial support was provided by Sarah Klein.



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