Opportunities for States to Improve Women's Health and Birth Outcomes through Medicaid Incentives for Effective Contraceptive Use and Postpartum Care

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Introduction

States finance nearly half of all births and a higher proportion of preterm or low-weight births than private insurers.[1] The high number of Medicaid financed births, particularly unplanned, preterm and low-weight, births is a key driver for states to incentivize effective contraceptive use or postpartum follow up care. Unplanned and complex births carry potentially avoidable health complications and costs. For example, there is the potential for an estimated $15.5 billion in cost savings for helping publicly insured women avoid unplanned pregnancy.[2]

Performance incentives and quality improvement are central components of state Medicaid efforts to improve health outcomes and the consumer experience, as well as reduce health care costs. As part of broad health care delivery and payment reform initiatives Alabama, Colorado, Ohio and Oregon include performance-based measurement and incentives for effective contraceptive use or postpartum care to drive improvement. Incentive strategies include withholding money from providers or accountable entities that can be earned back through high performance. Additionally, Medicaid agencies see opportunities to partner with state Title V maternal and child health programs (Title V MCH) or public health divisions to maximize the reach and effectiveness of their efforts.

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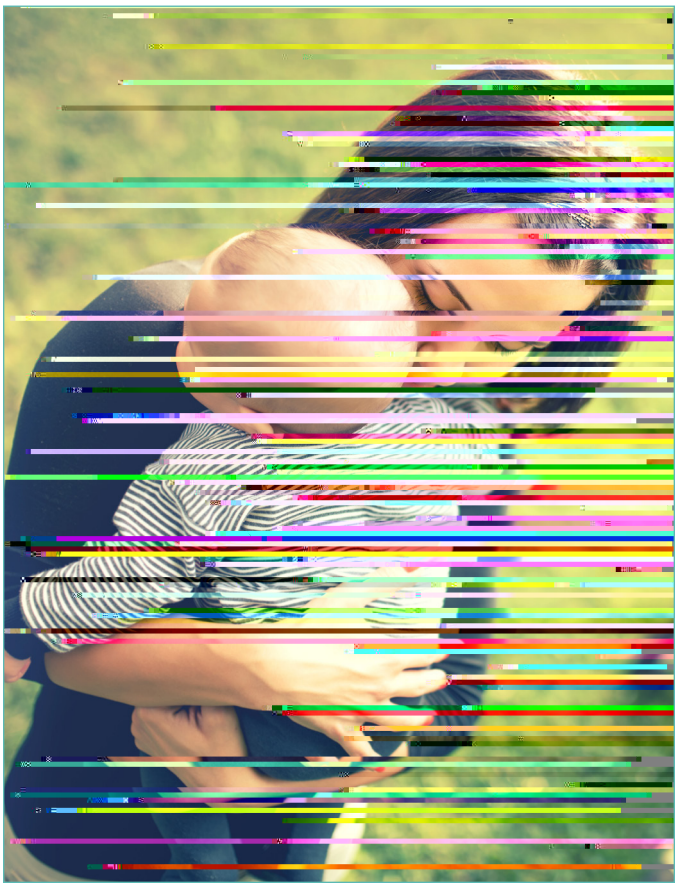
Alabama, Colorado, Ohio and Oregon are all transforming the way they pay for and deliver health care across their Medicaid programs to improve the quality and cost of care, often in alignment with changes among commercial payers. Specifically, these state Medicaid agencies have or are in the process of implementing new payment models that increase provider accountability, often through accountable care initiatives and or patient-centered medical home (PCMH) initiatives (see text box). These Medicaid initiatives include performance measurement, reporting and performance-based payment for a variety of health care services, including for family planning or postpartum care. Colorado, Ohio and Oregon are leveraging federal State Innovation Model (SIM) grants[15] to support these Medicaid transformation efforts. The important role of Medicaid agencies in financing pregnancy and delivery has been an impetus for implementing provider incentives for planned or healthy births. Table 1 highlights incentives and broader initiatives in the four states.



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Results to Date in Colorado

Colorado phased in the withhold process; in the first year of the program, no money was withheld from RCCOs and PCMPs, and the withhold began in year two. The 2015 annual report notes that, "Postpartum care increased significantly with the amount of time spent in the ACC program" from 60 percent in the first six months spent in the program to 70 percent for seven to 10 months spent in the program.[45] Four RCCOs met either a tier one or two target in the October 2015, January 2016 and/or April 2016 quarterly reports[46,47,48] RCCO improvement strategies include developing and distributing patient tip sheets and other educational materials; collaborating with Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics to share postpartum information with women; and implementing enhanced care management or outreach. The RCCO in the Colorado Springs area, for example, has a pilot with the state's health information exchange that uses daily data reports to identify families for care coordination or outreach in the postpartum period.

Colorado is embarking on a second phase of its Accountable Care Collaborative to improve health and control costs through further emphasis on whole-person care, care integration, care coordination and accountability.[49] The implications of Phase II for women's health are to be determined; however, Colorado already has examples of promising partnerships (see below) and is committed to value-based payment.

Partnerships in Colorado

An innovative example of cross-agency partnership and alignment is the Colorado Opportunity Project (Project).[50] Through the Project, multiple Colorado agencies—including the Departments of Health Care Policy and Financing (Medicaid), Public Health and Environment (Title V), and Human Services—are aligning efforts to efficiently and collaboratively deliver evidence-based programs along the entire

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to eligible beneficiaries.[51] The initiative is newer, with RCO networks in place as of April 2015, and capitated payments from Medicaid to RCOs originally scheduled to begin in October 2016. Alabama plans to withhold a portion of payment to create a quality of care incentive pool, but phase it in. The timeline is to be determined due to budgetary constraints, however performance measurement will begin one year before withholding begins. The prenatal and postpartum care metric is from the CMS Adult Core Set, and it includes timeliness of prenatal care and postpartum care. Each incentive measure will be worth 10 points, and the percent of withheld money earned back by RCOs will depend on the number of measures they meet. (Meeting 8 measure benchmarks will result in an 80 percent withhold return; 10 points is the minimum to earn back any (in this case, 10 percent) of the withhold). The prenatal and postpartum care metric have a benchmark for both the prenatal and postpartum care element of the measure. RCOs will be able to get half credit (5 points) for meeting just the postpartum (or prenatal) benchmark. RCOs also will have annual improvement goals and a five-year goal based on regional performance.

RCOs will replace the Alabama Medicaid Maternity Care Program through which eligible women receive case management for pregnancy-related care through locally coordinated systems across 14 districts.

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All episodes are determined retrospectively or after the fact, and the perinatal episodes are identified through Medicaid claims data analysis. Specifically, the perinatal episode is identified and triggered by a live delivery (live birth diagnosis code and delivery procedure code); the episode is calculated as beginning 40 weeks before that delivery date and ending 60 days after hospital (or other delivery facility) discharge.[53] The prenatal, delivery-related and postpartum services received by the woman during that entire time period are part of the episode. The PAP is the delivering physician. Like all of Ohio's episodes, the perinatal episode has associated quality metrics—some metrics are tied to eligibility to receive a positive incentive payment, while others are "reporting only", meaning they are reported to the PAP for informational purposes but not linked to payment. PAPs who have lower risk-adjusted average (or "commendable") episode costs and meet all the associated quality measures across their episodes are eligible for a positive incentive payment. One of the four quality metrics that must be met to be eligible for the positive incentive payment for the perinatal episode is the percent of episodes with a follow-up visit within 60 days of birth.[54]

Like other states Ohio has phased in implementation by beginning with a "reporting only" period,

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identify priority MCH needs, which may overlap with Medicaid priorities. Alabama's public health

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Conclusion

With increased attention in the health care system on accountability for high-value care and greater flexibility for locally-driven and community-responsive improvement strategies, there is perhaps more interest and opportunity for Medicaid agencies to partner with Title V to support women's health and birth outcomes. Medicaid incentive measures for effective contraceptive use or postpartum care in Alabama, Colorado, Ohio and Oregon show how Medicaid agencies are working to improve the cost and quality of care for women before and after pregnancy. With payment for improvements in effective contraceptive use or postpartum care and new phases of Medicaid transformation still unfolding in these states, there will be more lessons and insights to come. However, preliminary results from Colorado and Oregon indicate improvement in effective contraceptive use and postpartum care in support of planned births and healthy birth outcomes. These states' experiences also demonstrate opportunities for cross-agency collaboration through payment and delivery reform to meet shared goals. Initiatives such as HRSA's IM CoIIN offer a means for shar ' ' o 3 orm

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