

**Using Medicaid to
Support Preterm Birth Prevention:
Five Case Studies**

**By Elinor Hall, MPH
Michelle Berlin, MD, MPH**

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Executive Summary

Medicaid is a publicly financed and operated health insurance program that serves low-income women, children, the elderly and disabled.¹

In 2000, Medicaid paid for 1.4 million births or 37% of all US births and, therefore, is a significant stakeholder in maternal and child health programs throughout the country. Local and state organizations committed to improving birth outcomes need to view Medicaid as a potential partner in improving existing programs or funding new ones. The State Children's Health Insurance Program, or SCHIP, is similar to Medicaid. SCHIP covers children under age 19, though a few states are covering pregnant adults through SCHIP.

Medicaid and SCHIP are state-federal partnerships in which the states have considerable latitude to design and operate their programs within a federal framework. As a result, each state's Medicaid program is different: eligibility requirements and processes, covered benefits, types of providers, and payment rates and payment mechanisms vary. Some state Medicaid programs are particularly effective in supporting healthy pregnancies and improving birth outcomes for high-risk pregnant women. Maternal and child health advocates and state policy makers can learn from those states' programs and use their innovations to achieve better outcomes.

This study highlights programmatic interventions in five states that have demonstrated an impact on preterm birth rates and improved birth outcomes. Each of these interventions is supported by an innovative arrangement with the state's Medicaid program. These case studies can assist maternal and child health specialists to partner with Medicaid. The examples can be used to improve services by structuring Medicaid to provide support for serving low-income women. Recommendations on how to use these examples to create new programs and/or new public financing options for existing programs are provided at the conclusion of each case study.

The five case studies are as follows:

Comprehensive Prenatal Services: Florida's Healthy Start Program

Florida's Healthy Start program is a partnership between public health, Medicaid, communities and private health care providers. This comprehensive effort includes universal risk screening for all pregnant women and children to age three, streamlined access to Medicaid for pregnant women, quality standards for Medicaid prenatal services and care management and other services for at-risk pregnant clients. The State contracts with Healthy Start Coalitions in each county that are charged with improving MCH access and outcomes. The Coalitions assess community need, develop a strategic plan and use Healthy Start funds to contract for local service delivery.

¹ Medicaid (Title 19 of the Social Security Act) is a federal/state health insurance program for low-income families, elderly adults and persons with disabilities. SCHIP (Title XXI), the State Children's Health Insurance Program, is also a federal/state partnership that funds health insurance for low-income children in working families. Some States operate SCHIP as an extension of their Medicaid programs. Others have set up separate insurance programs. SCHIP pays for prenatal care for covered women under age 19.

The State Department of Health and Medicaid have an unusually close partnership. Medicaid helps to fund the entire continuum of Healthy Start services and relies on the MCH experts to administer aspects of the program. In Florida (as in all states) Medicaid administrative expenses are shared equally between the federal government and the state. Florida defines the planning, outreach, and coordination activities carried out by the local Healthy Start Coalitions as Medicaid administration and not only draws down federal match for the state's appropriation but also secures federal match for funds raised by the Coalitions. Florida Medicaid has structured its benefits to pay for risk screening and requires Medicaid prenatal providers to meet quality standards and engage in quality improvement activities.

Case Management Services: Louisiana's Nurse-Family Partnership Program

In 1999 the Louisiana State Office of Public Health began replicating the Nurse-Family Partnership program, an intensive home visiting program for pregnant women and their infants, based on a model developed by Professor David Olds and colleagues. Louisiana's Medicaid program includes a Targeted Case Management (TCM) benefit for pregnant women; each Nurse-Family Partnership home visit is billed to Medicaid and reimbursed at approximate cost. With Medicaid support, the State is expanding the home visiting program each year to serve additional regions and more women. Early data indicate that women enrolled in this program have a 52% lower preterm birth rate than a control group of women.

Targeted Case Management is an optional Medicaid benefit that states can offer to a defined group of beneficiaries (including pregnant women and infants). TCM services help beneficiaries access a wide variety of health and human services that they might not otherwise receive. The states determine provider qualifications and many TCM benefits reimburse non-medical providers, such as community health workers or social workers. Unlike most Medicaid benefits, TCM can be offered in a limited geographic area such as a specific county or city.

Tobacco Cessation and Maternity Case Management: Oregon's Cessation Services for Pregnant Women

Oregon Medicaid pays for maternity case management services, mostly provided by public health nurses employed by county health departments. The state Office of Child and Family Health is using a Smoke Free Mothers and Babies grant to coach and train a pilot group of maternity case managers in effectively using the 5 A's cessation counseling method with their pregnant clients. Using an effective brief counseling intervention such as the 5 A's increases the tobacco quit rate among pregnant women by 30-70%, which in turn reduces the preterm birth rate and other poor pregnancy outcomes. The Medicaid program further assists pregnant beneficiaries by paying for comprehensive tobacco cessation benefits including intensive telephone counseling that is accessed by the statewide toll free Quit Line.

Oregon has a comprehensive Tobacco Prevention Education Program funded with a special tobacco tax. The Tobacco Education program works closely with Medicaid in many areas. When the comprehensive tobacco program began in 1996, over 31.7% of Medicaid births were to mothers who had smoked during their pregnancy. Five years later, these rates had declined by nearly 28% representing 2,200 fewer infants a year who were exposed to tobacco prenatally.

Medicaid Family Planning Waiver: Rhode Island's Family Planning Expansion

In 1993 Rhode Island pioneered an expansion of Medicaid family planning benefits for low-income women. The State Medicaid program received a waiver from the federal government to extend family planning and primary care coverage from sixty days to up to two years for women who had delivered a baby on Medicaid. This increased access to family planning cut in half the number of women who delivered another baby within 18 months of a previous pregnancy and has helped to reduce infant mortality among Medicaid infants. "Short interval" pregnancies and unintended pregnancies are risk factors for preterm birth and other poor birth outcomes.

Medicaid family planning services in all states are 90% federally funded. The federal funding rate (or Federal Medicaid Assistance Percentage) for most other medical services, including prenatal care and childbirth, ranges from 50-83%. Thus the state's 10% contribution to a family planning service expansion is extremely cost effective. In the first three years, Rhode Island saved \$14.3 million in Medicaid expenditures based on a reduction of 1,400 unintended pregnancies. As of December 2003, 18 other states have received family planning waivers and four states have waivers pending.

Quality Care for High-Risk Pregnancies: Arizona's High-Risk Perinatal Program

While early intervention to prevent and support healthy pregnancies is ideal, many preterm births have no known risk factors and once labor starts are not preventable. Arizona has organized its medical care system to deliver optimal care to women in preterm labor and to preterm infants. The Arizona High-Risk Perinatal Program includes a system for assuring the quality of inpatient care, high-risk transports and community follow-up for at-risk infants. The program includes no-cost access to perinatology consultation for community-based practitioners who have a high-risk patient. The specialty consultants can easily arrange transportation and admission to tertiary care facilities when indicated. The program serves all women in the state and guarantees payment if the patient does not qualify for Medicaid or have private resources. This guarantee improves access to needed services and reduces family financial stress. The funding for the program comes from three sources: the State Health Department, Arizona Medicaid (known as AHCCCS), and the private hospitals which pay an accreditation fee.

In 2000, 98.7% of infants weighing less than 3 lbs 5 oz, the great majority of who are preterm, were delivered in High-risk Perinatal Centers. Survival and infant health are markedly improved when the birth occurs in a facility with specialized staff and equipment.

The Bottom Line:

The design and operation of Medicaid programs represent an opportunity to realize our societal interest in having all babies born healthy. Because of the volume of high-risk women who receive maternity care services financed by public insurance, the design of Medicaid programs at the state and federal level is crucial. Any organization working to improve birth outcomes should consider whether Medicaid (and possibly SCHIP) can partner in this effort. Medicaid can be structured to support existing community-based programs that improve birth outcomes. Medicaid can also work at the state level to configure program benefits, eligibility and reimbursement to create and fund new programs to ensure that babies are born healthy.

State and local governments are experiencing severe budgetary pressures. They cannot afford to let Medicaid be an ineffective, laissez faire program that results in costly high-risk births and disabled infants. Nor can states and local governments afford to leave federal dollars on the table by spending their own limited resources on services that could be incorporated into Medicaid and draw down of federal match.

State Medicaid policy makers and maternal and child specialists and advocates can work together to design and implement cost-effective programs that improve birth outcomes. Together they can identify the most powerful interventions and determine how best to finance them. Configuring Medicaid to take advantage of federal matching funds can be a win/win strategy. This study was designed to illustrate how fruitful this partnership can be and is intended to encourage dialogue, replication and creativity in every state.

Introduction:

This paper highlights programs which have effectively reduced rates of prematurity and improved outcomes of preterm births by creatively using Medicaid/ SCHIP² to finance services.

While other worthwhile programs exist, this document focuses on five Medicaid/SCHIP funded programs:

- Florida's Healthy Start Program
- Louisiana's Nurse-Family Partnership
- Oregon's Cessation Services for Pregnant Women
- Rhode Island's Family Planning Expansion
- Arizona's High-Risk Perinatal/Newborn Intensive Care Program

Our goal is to share information about these successful programs and to describe how Medicaid/SCHIP can be utilized to finance the types of services that make a difference. Policy makers, state executives, community providers and advocates for maternal and child health can evaluate the information presented in this study and determine if these strategies offer an opportunity to expand funding for existing programs and services or to provide funding for new programs.

Historically, State Medicaid programs have always been under pressure to reduce costs. Recent budgetary problems have intensified those pressures. The states highlighted in this report have a strategy to reduce overall Medicaid costs by reducing the much higher costs of providing medical care for newborns with serious health problems.

Individuals, the family and community health all benefit when babies are born healthy.

The Problem of Preterm Birth:

Babies born too early, before 37 weeks of gestation, are often babies born too small.³ Low birth weight is a leading risk for an array of health problems ranging from infant mortality to developmental delays. Prematurity is also a cause of chronic respiratory problems and vision and hearing impairment. According to the American College of Obstetricians and Gynecologists, spontaneous preterm labor causes about half of all preterm births and is the leading cause of newborn death.³ The United States Preventive Services Task Force (USPSTF), in its recent evaluation of therapies to detect and treat preterm labor, indicated that prematurity is also a key

² Medicaid (Title 19 of the Social Security Act) is a federal/state health insurance program for low-income families, elderly adults and persons with disabilities. SCHIP (Title XXI), the State Children's Health Insurance Program, is also a federal/state partnership that funds health insurance for low-income children in working families. Some States operate SCHIP as an extension of their Medicaid programs. Others have set up separate insurance programs. SCHIP pays for prenatal care for covered women under age 19.

³ Goldenberg RL. The management of preterm labor. *Obstetrics and Gynecology* 2002;100:1020-37.

factor in neurological impairment in infants and that the risks are heightened with each younger gestational age at birth.⁴

While no single cause of preterm labor has been determined, previous delivery of a preterm or low birth weight baby is a risk factor for future pregnancies, and carrying multiple fetuses is one of the highest risks. The increased use of fertility treatments over the past decade has increased the number of “multiple births” (twins or more) and also increased the rate of premature birth by 10%. There are other known associated risk factors including: young or advanced maternal age, low education and socioeconomic level, underweight prior to conception, African American race, gaining too little or too much weight during pregnancy, smoking and other drug use, and uterine and periodontal infection.

In 2002 there were 480,812 preterm births in the United States, representing 12.1% of live births. For African Americans, the rate was 17.7% of live births, much higher than the 11.0% rate for non-Hispanic white infants. The rate of preterm births among Hispanic infants was 11.6%, also higher than the rate among non-Hispanic white infants.⁵ Not every baby born before the 37th week has health problems. Many that are close to full term do well. Very premature infants born at less than 32 weeks, or any baby that is less than 5 1/2 pounds, is likely to face health challenges.

Preterm birth results in substantial costs to the health care system as well. In 2001, total hospital charges for all births and infant care were \$29.3 billion; nearly half of that amount (\$13.6 billion) was spent on low birth-weight or premature infants⁶. Thus 12% of infants required 50% of the health care expenditures. Because a premature birth can cost up to 60 times more than an uncomplicated birth, even the short-term health care costs are substantial.⁶ In 2000 Medicaid paid for 37% of US births or 1.4 million deliveries; these numbers have been relatively steady since 1993.⁷

Clearly the state and federal Medicaid programs have a material interest in how society and medicine addresses the issue of preventing and caring for preterm infants. The Medicaid program at both the state and federal level has viewed itself as an insurer, a payer whose responsibility is to make good purchasing decisions based on what exists in the market place. This approach is slowly evolving; some Medicaid programs are taking a more proactive approach, assessing the health needs of their populations and using their purchasing power to create new services and tailored programs. Maternal and child health advocates thus have the opportunity to partner with Medicaid to identify and support programs and policies that result in fewer preterm births and/or reduce adverse outcomes when prevention is not possible.

⁴ Berkman ND, Thorp JM, Jr, Hartmann KE et al. Management of preterm labor. Evidence Report /Technology Assessment No. 18 (prepared by Research Triangle Institute under Contract no 290-97-0011 AHRQ publication no 01-E021. Rockville (MD) Agency for Healthcare Research and Quality. December 2000

⁵ March of Dimes, Nation’s Hospital Bill for Premature Births is \$13.6 Billion [News Release] November 18, 2003, WWW URL: http://www.modimes.org/aboutus/9564_10358.asp, accessed February 10,2004

⁶ March of Dimes, *ibid*

⁷ March of Dimes, *ibid*

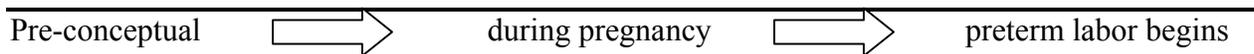
Can Preterm Birth be Prevented?

Once premature labor is fully underway, it has been very difficult to identify any medical intervention that will stop it. The medical care provided to the premature mother/baby however, can affect the infant's survival and health status over a lifetime. The provision of medical care and follow-up services can be thought of as "tertiary prevention:" not preventing the condition itself, but reducing morbidity and mortality (illness and death) that results from the condition. One of the featured programs, the Arizona High-Risk Perinatal Program, demonstrates how a statewide system can be created to assure that preterm labor and preterm infants receive optimal care.

As valuable as optimal medical services are, prevention of preterm birth is even better, as reiterated by the National Institutes of Health in its recent program announcement, "Reducing Preterm and Low Birth Weight in Minority Families."⁸ While it is difficult to prevent a preterm birth once labor starts⁹ ¹⁰ there are risk factors that can be modified pre-conceptually and during the prenatal period. Just as fertility treatments and higher rates of multiple births have contributed to an increase in preterm births, so programs to prevent unintended pregnancy, reduce tobacco use, and improve socio-economic risk factors as part of comprehensive risk factor reduction can improve birth outcomes and reduce the rate of preterm births.¹¹

The Prevention Continuum:

We envision opportunities to prevent preterm birth as a continuum beginning before conception (pre-conceptual) and continuing during pregnancy through the onset of preterm labor and birth.



The Preconception Period: Preventing Prematurity before Pregnancy

Interventions that occur prior to pregnancy must be directed to a larger segment of the population, namely non-pregnant females of child-bearing age. While these interventions have the potential to reduce prematurity rates substantially, the connection between the intervention and the outcome may take time to be realized. Interventions that occur prior to conception that could reduce preterm birth include:

- Reduce smoking among young people (ages 12-18)
- Reduce smoking and exposure to second- hand smoke among women of childbearing age
- Increase access to health insurance coverage and health services for teens and young adults (thus improving pre-conceptual health)

⁸ National Institutes of Health: National Institutes of Nursing Research, Child Health and Human Development, and Dental and Craniofacial Research. PA No. PA-04-027, released Dec. 1, 2003

⁹ Goldenberg RL. The management of preterm labor. *Obstetrics and Gynecology* 2002;100:1020-37.

¹⁰ Iams JD, Newman RG, Thom EA et al. Frequency of uterine contractions and the risk of spontaneous preterm delivery. *New England Journal of Medicine* 2002; 346:250-5

¹¹ Misra, D. Guyer, B. Allston, A. Integrated Perinatal Health Framework, a Multiple Determinants Model with a Life Span Approach. *Am J Prev Med* 2003;25(1)

- Reduce teen pregnancy (provide education, access to contraception, opportunities for youth)
- Reduce unintended pregnancy among all ages, but especially among high-risk women (including those who have delivered a baby recently, those with a previous premature birth, those with certain chronic diseases or conditions, those involved in substance abuse, those who are victims of domestic violence, etc.)
- Support adequate nutrition for young women including folic acid supplementation (nutrition education, school breakfast and lunch programs, food stamps, campaigns for fruits and vegetables, folic acid supplements etc.)
- Reduce sexually transmitted diseases/infections in men and women (education, promotion of healthy behaviors, screening, access to treatment services)
- Reduce multiple pregnancies that result from fertility treatment (work with health care providers and couples with fertility issues to increase awareness and reduce risk)
- Improve social parameters: increase work opportunities for teens/young adults, improve high school completion rate, increase mentoring, and opportunities for success, and reduce youth violence and substance abuse.

During Pregnancy: Supporting Women Prenatally

These interventions focus on women who are already pregnant. This is a smaller target group that is easily identified and is traditionally a high priority to receive services. Many of these interventions have been researched and evaluated with mixed results. Look for model programs that are shown to improve *outcomes*, not just improve the *process* of delivering care.

- Guarantee financial access to prenatal services for all low-income women
- Reduce barriers to prenatal care access: increase outreach, transportation, culturally appropriate services, childcare, reward participation in care
- Make tobacco cessation services an integral part of prenatal care, use approaches proven to make a difference, such as the “5 A’s” intervention model
- Make alcohol/drug screening and follow-up part of prenatal care for all women
- Increase access and utilization of substance abuse treatment services for pregnant women
- Educate pregnant women /families about signs of preterm labor and what to do
- Provide intensive RN home visiting to the highest risk pregnant women

Once Labor has Started: Improving Preterm Infant Outcomes

This intervention focuses on the 12.1% of pregnant women who deliver prematurely. Infants born prematurely can benefit enormously from appropriate medical care services prior to, during and after birth. A key problem is to identify the women who are experiencing preterm labor (or its warning signs) and effectively move them into a system of specialty care and additional services. Activities to prevent death and disability due to preterm birth include the following:

- Provide community prenatal care providers with easy access to specialty consultation including neonatologists and high-risk obstetricians
- Develop a statewide system to facilitate transport of women starting preterm labor to the closest appropriate hospital prior to giving birth

- Establish and monitor standards for hospitals caring for women/infants in preterm labor
- Educate providers about the benefits of corticosteroids and other clinical practices for preterm birth; monitor and report on use of this drug by region, by hospital, by practice
- Provide continuing education to all professionals working in the system
- Provide appropriate medical and developmental follow-up and community support services to families with preterm infants

Selecting Programs to Highlight:

This study presents five programs from along the prevention continuum and around the country. Programs were selected based on the following general characteristics:

- *Data and/or an evaluation showing effectiveness.* Published data or program evaluations demonstrate an impact on preterm risk factors, if not on the rate of prematurity itself.
- *A supportive, replicable partnership with Medicaid and/or SCHIP.* Programs illustrate how Medicaid can support effective services. Programs operated without any special relationship to Medicaid were not selected.
- *Geographic and demographic diversity.* Programs were selected from different states, representing urban and rural environments and serving women representative of the major ethnic groups served by Medicaid.

While the featured programs are innovative and exemplary, their selection is *not* intended to suggest that they are *the* best, *the* most effective programs that exist. With each program's description, contact information is provided to permit additional follow-up. Managers from each of the featured programs have agreed to answer questions and share materials from their work.

The Medicaid financing mechanisms for these programs have been accepted by CMS, the federal Centers for Medicare and Medicaid Services (formerly known as HCFA). These mechanisms are being used in other states and/or with other populations and should be available for replication. We have attempted to provide enough detail on Medicaid financing mechanisms to illustrate the opportunities that exist when Medicaid and MCH specialists work together.

Medicaid Support for Comprehensive Prenatal Care

Case Study: Florida's Healthy Start Initiative

Overview:

In 1992 the Florida Legislature created the Healthy Start Initiative and the Department of Health began implementing a comprehensive, integrated set of programs designed to enhance birth outcomes and infant health. In the following years, the program has been refined and expanded and in 2001 gained support from Medicaid when the State's request for a Medicaid waiver was approved. Now Florida Medicaid offers intervention and support all along the continuum from early pregnancy to post-pregnancy. The key components of Florida's "Healthy Start Coordinated Care System for Pregnant Women and Infants" are:

- Streamlined eligibility for Medicaid, including presumptive eligibility
- Medicaid eligibility up to 185% of federal poverty level for pregnant women and infants
- Healthy Start provider standards: physicians and other providers must provide a comprehensive set of services to all enrollees and must meet criteria for prenatal services developed by the Department of Health. Increased reimbursement for obstetric services
- Universal prenatal and infant risk screening to identify pregnant women and infants at risk for adverse outcomes. Medicaid pays \$100 for each prenatal risk screen completed in the first trimester.
- Healthy Start Coalitions are funded in each county. These community-based, non-profit groups assess local resources and needs, develop service delivery plans and allocate public and private funds. Coalitions sub-contract with direct care providers (including County Health departments) for services for at-risk pregnant women, infants and children to age three.
- Healthy Start care coordination and wrap around services include a needs assessment, case management and home visiting aimed at assuring access for high- risk women and children to such services as psychosocial and nutritional counseling, childbirth education, breastfeeding promotion, tobacco cessation and parenting education.
- A federal waiver permits family planning to be provided for up to two years for women losing coverage after a Medicaid birth or other pregnancy related service.

The Florida Medicaid program helps to support the Healthy Start Coalitions and the services they provide by paying for "choice counseling" to help pregnant women between 133% and 185% of poverty (known as SOBRA eligibles¹²) choose a provider and obtain appropriate services. Medicaid pays a monthly amount for each woman or infant enrolled in the Healthy Start program due to their risk status. The prenatal risk screens are reimbursed by Medicaid and higher prenatal reimbursement supports the increased standards of care required of Healthy Start providers.

¹² "SOBRA pregnant women" are those women with incomes between 133% and 185% of federal poverty; they are eligible for Medicaid coverage at the option of each state pursuant to the provisions of the Sixth Omnibus Budget Reconciliation Act (SOBRA).

The Problem of Providing Quality Prenatal Care to Pregnant Women:

Getting women into prenatal care early, keeping them in care and providing care that meets their medical, psychological and social needs is a complex process. Similar to other states, pregnant women were having difficulty finding a provider who would accept Medicaid reimbursement. Pregnant women with incomes between 133% and 185% of poverty had particularly poor access to care; women under 133% of poverty had Medicaid coverage even when they were not pregnant and were enrolled in managed care. Many providers were unwilling to serve the higher income women due to their complex social and medical needs. Additionally, Florida has a system of managed care which called for women to choose among competing health care providers. Florida wanted to increase access to quality prenatal care and to focus extra support on those women who could benefit from it the most.

Program Model:

Florida offers a variety of Medicaid and Title V programs and innovations designed to increase access to high quality prenatal care and improve birth outcomes. Pregnant women with incomes up to 185% of poverty are eligible for Medicaid and 47% of all births are financed by Medicaid. Florida's Medicaid eligibility process is structured to make it easy for pregnant women to enroll. A simple, streamlined Medicaid eligibility form reduces barriers to coverage. The one-page, mail-in form is submitted with proof of pregnancy and no in-person interview at the "welfare department" is required. The importance of streamlining eligibility for Medicaid for pregnant women is critical to improving early entrance to care.¹³ Most applications by pregnant women are processed in two weeks.

Florida also provides "presumptive eligibility" for Medicaid coverage of pregnant women. This means that pregnant women who meet some basic income criteria are presumed eligible for coverage while full documentation is gathered. Even if the patient is ultimately found not to be eligible for coverage, the provider will be paid by Medicaid for the care they have already rendered. This encourages approved providers to start providing prenatal care prior to final eligibility determination since they are not at financial risk. Presumptive eligibility helps prevent delayed entry into care while Medicaid coverage is pending. Many states have implemented presumptive eligibility (a federal waiver is not required); however "state only funds" (i.e. with no federal match) must be used to pay for the care of individuals who do become fully enrolled in Medicaid.

Prior to receiving the waiver that included Healthy Start, pregnant women with incomes from 133% to 185% of poverty were part of a traditional fee-for-service Medicaid system. The waiver allowed these women to be moved into managed care and entitled them to a package of Healthy Start services provided by local Healthy Start Coalitions. As part of securing the waiver, Florida agreed to assure an adequate panel of prenatal care providers who meet standards set by the Department of Health. Providers must offer a comprehensive package of prenatal services including a Healthy Start risk screen, alcohol, substance abuse and STD screenings, provision of folic acid and zinc supplements, adherence to caesarian section guidelines, access to genetic

¹³ National Women's Law Center, OHSU Center for Women's Health. Making the Grade on Women's Health: A State-by-State and National Report Card 2001.

counseling and transfer of high-risk women to the Regional High-Risk Perinatal network. Providers can have a maximum of 150 Medicaid pregnant women in their practices at any time (non-physician providers can have a maximum of 75 Medicaid women).

At the heart of Florida's program are the Healthy Start Coalitions. These Coalitions are community-based, nonprofit agencies charged with oversight of the maternal and child health system of care in their local communities. The 31 Healthy Start Coalitions (covering 65 of 67 Florida counties) are located throughout the state and are made up of over 3,600 community volunteer members. In the counties without a Coalition, the Healthy Start activities are carried out by the local health department. The Healthy Start Coalition role is established by state legislation; the State Department of Health (the Title V Agency) manages the Coalition contracting process and also provides technical assistance.

A local group with a diverse board of providers and community representatives can apply to the Florida Department of Health to be established as the local community-based Healthy Start Coalition for a specific geographic area. They have one year to perform a needs assessment and resource inventory. They go on to develop a strategic plan for providing services and then enter into a contract with the Department of Health to serve as the Healthy Start Coalition. Coalitions must meet various contractual standards. For instance, they must require their service providers to an internal quality improvement plan and they must monitor the providers' outcomes and efforts to improve quality.

Each Healthy Start Coalition is responsible for recruitment of public and private providers, education of the general community and case finding activities that target underserved populations and geographic areas. Coalitions ensure that trained staff members are available at convenient locations and times to assist women with the Medicaid eligibility process. Provider recruitment and retention is critical to the Healthy Start process. Coalitions develop and maintain a network of local service providers and encourage their involvement in Coalition activities. Activities to help recruit and retain providers include outreach, training, technical assistance, and support. Provider recruitment helps ensure adequate care is available to meet the needs of all pregnant women and infants in a timely manner.

In fiscal year 2002-2003, Healthy Start Coalitions reported generating over \$3.1 million of in-kind services and leveraging more than \$17.8 million in additional revenues for maternal and child health services.¹⁴ (Florida is able to provide federal match for locally raised funds.) Over 1,800 organizations are involved in Coalition membership including the Florida March of Dimes Chapter.

Medicaid provides information about SOBRA eligible pregnant applicants to the Healthy Start Coalition in their area. Women are contacted by local Healthy Start Coalition staff who offer "choice counseling" to help them understand Medicaid coverage and to choose a prenatal care provider from the panel of participating physicians. They also receive help making their first appointment and help with transportation and translation if needed. Healthy Start services include referrals and help accessing WIC, mental health services, substance abuse treatment,

¹⁴ Florida Department of Health Services Healthy Start. 2002 Healthy Start Annual Report, <http://www.doh.state.fl.us/family/mch/hs/hsreport2002.pdf>, accessed May 10, 2004

domestic violence intervention and smoking cessation. Nutrition education, breast feeding education and psycho-social counseling are also provided by referral if identified as a need for the pregnant woman.

Most Healthy Start Coalitions provide their own smoking cessation services; some refer to local cessation groups or counselors. Florida uses the “Make Yours a Fresh Start Family” cessation model. This is a version of the “5 A’s” that was developed by the American Lung Association. Healthy Start care coordination programs refer clients to the toll free American Legacy Quit Line for pregnant women for additional support. This service is available nationwide to any pregnant woman with no charge. The Oregon case study on cessation includes more information about the 5 A’s.

Healthy Start includes the goal of universal risk screening of all pregnant women and newborns. Universal screening means that everyone in these categories, not just Medicaid eligibles, is screened. According the waiver request that Florida submitted to CMS, each year 375,000 pregnant women, and newborn infants and children are eligible for screening to identify those with significant risk factors who can benefit from services to prevent and/or ameliorate adverse health and developmental outcomes. Florida’s prenatal screening form, which is available on their web site, contains 17 risk factors that have been shown to be associated with poor pregnancy outcomes including age less than 18 or greater than 39, black race, no high school education, having moved more than 3 times in the last 12 months, as well as measures of food insecurity, personal safety, substance abuse and current perceived level of stress. Risk factors are weighted and women scoring 4 or more points are determined to be “at risk.” Pregnant women and children can also be referred into the Healthy Start program by their health care provider, even if the screening form does not identify them as having high-risk status. Risk screening can be performed by public and private health care providers, county health departments and qualified staff working for the Healthy Start Coalitions. Medicaid reimburses \$100 for the prenatal risk screens completed in the first trimester.

Program Outcomes:

Since 1992 when Healthy Start began, a variety of evaluation studies have been performed. During this time the percentage of women with first trimester prenatal care has increased from 78% in 1992 to 84% in 2001. Important gains for infants have also been documented. The infant mortality rate declined from 8.8 per 1000 live births in 1992 to 7.43 per 1000 live births in 2001. In 2000, 86.6% of 2 year olds completed their full set of immunizations compared to 63% in 1991. These number are similar to national statistics, but Florida’s child bearing population has more women of color (and thus more risk) than the national average.

In 2001, the relationship between Healthy Start services and low birth weight (i.e. birth weight below 5.5 lbs or 2500g) was investigated. For the 75,000 women delivering in 1999 for whom information was available (and after adjusting for appropriate risk factors,) women who received Healthy Start services experienced a statistically significant 9% decreased risk of delivering a low birth weight infant. A significant decrease in the risk of low birth weight delivery was also seen for each individual component of prenatal care service (i.e. nutritional assessment and counseling, psychosocial counseling, parenting education and support, childbirth education,

breast-feeding education and support, and smoking cessation counseling).¹⁵

In 2001, the most common risk factor, for both the prenatal and postnatal (infant) risk, was being an unmarried mother. The 36% of the pregnant women identified as high-risk accounted for about half of the low birth weight and premature births among screened women. Additionally the ability of the screening criteria to correctly identify pregnancies that will result in adverse effects to infants has increased from 48.2 percent in 1989 to 50.5 percent in 2002. An evaluation of the infant screening tool was also conducted for infants born in 1989, 1993, 1998 and 2000. These results suggest that the percent of at-risk infants has decreased from 13.3 percent in 1989 to 9.8 percent in 2000.

Florida's 2001 waiver application to CMS projected a dramatic 33% increase in the number of pregnant women receiving counseling and care management. In order to get the waiver, Florida had to project that the new services would be cost neutral for the federal government. They estimated that increasing services in the prenatal period would reduce hospital days for complicated deliveries, reduce inpatient and outpatient services for infants and reduce the number of disabled infants qualifying for SSI Medicaid. The actual data from the first year of the waiver have not yet been released.

The Role of Medicaid in supporting access to quality prenatal services

The Healthy Start program was initially funded in 1992 with State general funds and Title V MCH block grant funds which were administered by the local county health departments. There were only enough funds to serve about 50% the women in need and the services were not intensive enough to get the best results. In 2001, the Agency for Health Care Administration (which administers Medicaid in Florida), in collaboration with the Department of Health and the Healthy Start Coalition Association, developed a 1915(b) waiver aimed at improving prenatal care access.

The waiver, which was approved July 2001, allows Florida to utilize a streamlined one page Medicaid application and provides additional federal support for Healthy Start services for Medicaid eligible pregnant women between 133% and 185% of poverty. The Healthy Start 2002 Annual Report indicates that about \$10 million in federal funds have been obtained through this waiver. Outreach and care management are being reimbursed as Medicaid administration, the cost of which is shared 50/50 by the state and federal government. Community planning is also part of the administrative activity being reimbursed.

It is not necessary to get a federal waiver to utilize Medicaid administration as a tool for funding qualifying activities. States can update their administrative plans relatively easily. A number of states "sub-contract" with local health departments and schools to assist in the efficient administration of Medicaid and/or SCHIP. SCHIP administrative costs are capped at 10% of expenditures but Medicaid has no such limit. Activities which qualify for Medicaid or SCHIP administration (and federal support) include the following:

¹⁵ Florida Department of Health Services Healthy Start. 2002 Healthy Start Annual Report, <http://www.doh.state.fl.us/family/mch/hs/hsreport2002.pdf>, accessed May 10 2004

Marketing/Outreach

- Outreach about available Medicaid funded programs and referral of Medicaid enrollees to Medicaid covered services (local Medicaid participating clinics, physicians, dentists, etc.)
- Information and referral to Medicaid eligibility offices and/or assistance with completing applications
- Referral to entities in the community providing Medicaid services

Assisting with Access

- Assisting with the Medicaid program enrollment process
- Translation in order to enroll or access health programs
- Assisting with transportation to Medicaid services

Health Program Planning

- Analysis and planning of Medicaid/health services
- Collaboration with others to fill gaps in Medicaid/health services

States can reimburse a flat amount, such as Florida's \$12 a month per Healthy Start eligible, or can reimburse based upon costs. A program, such as March of Dimes sponsored Stork's Nest, which provides outreach, assistance with health care appointments and education about how to use the health care system, could be supported with Medicaid Administration funding. Medicaid Administration does not reimburse for educational services about specific medical conditions such as pregnancy. For more information about using Medicaid administration as a funding vehicle, see Appendix E.

Florida's Medicaid program also uses its ability to define benefits and set rates to support Healthy Start. The program reimburses providers \$100 for completing the prenatal risk screens in the first trimester in addition to standard payments for prenatal care. The rates paid for prenatal care were increased due to the higher standards of care that are required for Healthy Start providers.

Challenges, Room for Improvement:

Florida is concerned about reaching all of the high-risk women who need Healthy Start services. In 2002 over 2,000 pregnant women whose screenings showed them to be high risk, were not able to be contacted by their local Healthy Start Coalition. Since Healthy Start is a voluntary program, some of the women may have chosen not to receive services. Others may have moved or simply missed the outreach efforts of the program. Intensity of services is also an on-going issue. Very high-risk women benefit from receiving more intensive interventions based upon their particular risk factors. The Healthy Start program is not able to meet all the needs for residential substance abuse treatment, access to safe housing for women who are victims of domestic violence, or intensive nurse home visiting for teens without a support system.

Florida is also concerned about improving pre-conceptual health, which they see as the next frontier in improvement of birth outcomes. Florida's family planning waiver only offers services to women for two years after they have delivered a baby on Medicaid; greater access to family planning services could help reduce unintentional pregnancy.

Other States Using this Intervention:

Many other states have components of the programs and services seen in Florida. California began the Comprehensive Perinatal Services Program in the mid-80's, paying a higher MediCal (Medicaid) rate to qualified providers for enhanced prenatal services that include various assessments, prenatal vitamins and a range of educational services. California also reimburses local health departments and their sub-contractors for Medicaid administrative activities including outreach and care coordination. A number of states have presumptive eligibility for pregnant women. Washington State's First Steps program streamlined eligibility and added enhancements including maternity case management services for high-risk women. Oregon provides maternity case management for all enrolled pregnant women. Florida is an interesting case study because it has combined so many elements in one program: community planning and mobilization, risk screening, information and referral, and provider and care standards for participation.

Taking the Next Steps in your State:

Improve access to quality prenatal care in your state by identifying specific problems and implementing solutions. This can be the start of building a comprehensive program such as Florida's. Some options for action include the following:

- Create a working partnership with State Medicaid and the Title V Agency to evaluate issues pertaining to prenatal care access, quality and outcomes. A strong working partnership is key to all comprehensive approaches.
- Evaluate, and if needed, generate, data pertaining to the quality of prenatal care provided to Medicaid women.
- If problems are identified, research successful interventions in other states; find a model with positive outcomes. Perhaps like Florida, your state could increase coordination between the private and public sectors; adopt new state requirements for being a Medicaid prenatal provider; offer new types of reimbursement for specific services or provide wrap around care management and coordination services.
- Medicaid may be able to pay a portion of those costs under Medicaid administration as "program planning and development" and "care coordination." The state's 50% share of administrative costs may already be expended by another component of government or by local programs (but not be included in Medicaid).
- If solutions include increasing provider reimbursement, consider how the quality of care also could be increased and outcomes improved as a component of this change. Increased costs in provider reimbursement may have to be offset by projected savings from improved outcomes in order to be feasible.
- Would use of universal risk screening forms help identify high -risk women who need more services? Is the private sector interested in championing this for all women? Would paying for risk screening and follow-up be a way to increase Medicaid reimbursement and improve outcomes?
- Documenting the financial and social costs of poor birth outcomes may help to generate the political will to make improvements.

Additional Resources:

Annette Phelps, A.R.N.P., M.S.N.
Florida Department of Health
Director, Division of Family Health Services
850-245-4100, Email: Annette_Phelps@doh.state.fl.us

Deb Bara
Executive Director of Pinellas County Healthy Start Coalition
272-507-6330

Carol Brady, MA
Executive Director, Northeast Florida Healthy Start Coalition
(904) 270-0620 or 904-279-0880, Email: cbrady@nefhsc.org

Florida's Healthy Start website: www.doh.state.fl.us/family/mch/hs/hs.html

The Florida Association of Healthy Start Coalitions: www.healthystartflorida.com

Case Management for Pregnant Women

Case Study: Louisiana’s Nurse-Family Partnership

Overview:

In 1999, the Louisiana State Office of Public Health began to implement a new program, the Nurse-Family Partnership. The program replicates the nurse home visiting model developed and documented by David Olds, a well-known professor and researcher at the University of Colorado Health Sciences Center. Nurse-Family Partnership visits qualify as Targeted Case Management (TCM) services that are reimbursable by Medicaid. Targeted Case Management helps to link beneficiaries with a range of needed health and social services. Medicaid sets the rate per encounter to cover the comprehensive cost of implementing the program including staff training, supervision, home visits, record keeping, activities on behalf of clients, evaluation, etc. In Louisiana, the federal government pays for 74% of all Medicaid health care benefits, including these Targeted Case Management visits. Rigorous evaluation of this program model has shown its effectiveness; the Louisiana Medicaid program can confidently expect improved outcomes in many areas for participating women and their babies.

The Louisiana Nurse-Family Partnership provides nurse home visits to women who are having a first baby, qualify for Medicaid, and are prior to 28 weeks gestation. Pregnant women who agree to participate receive weekly visits during the first month of enrollment, biweekly visits for the remainder of the pregnancy and additional weekly or biweekly visits until the child approaches age two.

The program uses a set of protocols developed and tested by Olds and colleagues. The Nurse-Family Partnership target population is based on the theory that first-time motherhood is an important time of transition when women are motivated to make changes in their lives. The home visits are designed to educate and empower women to make healthy changes. Women are encouraged to set small manageable goals and are supported by their nurse to achieve them, in the process improving self-esteem and their sense of “self-efficacy.” Nurses link women with needed health and social services including housing, food, education, transportation and vocational services and work to involve the woman’s partner and extended family in caring for her and the baby.

The Problem of Social Risk Factors:

Studies have consistently shown a relationship between social disadvantage and poor birth outcomes including preterm deliveries.¹⁶ Lack of prenatal care, smoking, drug use, poor nutrition, periodontal disease, domestic violence and stress are all modifiable factors associated with higher rates of preterm birth.

¹⁶ Hodnett, ED “Support during Pregnancy for women at increased risk of low birth weight babies”, Cochrane Database of Systematic Reviews, Issue 4, 2002

The Program Model:

Louisiana is 48th in the nation in the number of children living in poverty and faces many maternal and child health challenges including a high rate of unintended pregnancy, a high rate of late or no prenatal care, a low rate of breast feeding at four months and a low rate of infants being put to sleep on their backs (which reduces the SIDS rate).¹⁷ The Louisiana Nurse Family Partnership program began in 1999 and has expanded geographically each year. The program is available statewide under Title V funding; Medicaid currently reimburses for services in four of nine regions within the state and is awaiting federal approval to expand reimbursement to three more.

Each year approximately 49,000 first-time Medicaid moms are eligible to participate in the Nurse-Family Partnership program but only a fraction of those are being served. A team of eight nurses and one supervisor is able to serve two hundred women; an average caseload of 25 women per nurse with individual caseloads adjusted for acuity. Since the program began in 1999, the nurses have made approximately 40,000 visits to more than 1,600 families.

The Nurse-Family Partnership is an intensive service aimed at breaking the cycle of poverty. The Louisiana State Office of Public Health describes the program goals as follows:

1. Improving maternal health and birth outcomes through services provided prenatally
2. Teaching parenting skills and helping parents learn how to help their children develop in the critical early years for brain development
3. Assisting women with getting their own lives back on track by returning to school and to the workforce

The National Center for Children, Families, and Communities (NCCFC) at the University of Colorado is assisting interested states and communities to replicate Professor Olds and colleagues' home visiting model. In order to use the name "Nurse-Family Partnership", or claim to be an "Olds model", the program must agree to certain conditions. These conditions, which the Louisiana program meets, include the following:

- Focuses on low-income, first-time mothers
- The home visitors are nurses
- Nurses follow program guidelines that focus on the mother's personal health, quality of care giving for the child, and parents' own life-course development
- Nurses begin making home visits during pregnancy (before the 28th week, ideally before the 20th week) and continue through the first two years of the child's life
- Nurses follow a visit schedule keyed to the developmental stages of pregnancy and early childhood
- Each nurse carries a caseload of no more than 25 families
- Nurses involve the mother's support system including family members, fathers, and friends; they help the mother and her family use other needed health and human services

¹⁷ Beck, I. Morrow, B. Lipscomb, L. et al, Prevalence of Selected Maternal Behaviors and Experiences, Pregnancy Risk Assessment Monitoring System (PRAMS), 1999, MMWR, April 26, 2002 1-26, CDC

- The organization implementing the program provides a well-prepared half-time nursing supervisor for every four nurse home visitors
- Program staff uses the Clinical Information System that has been designed to keep track of family characteristics, needs, services provided, progress toward accomplishing objectives, and to help nurses and program staff continuously improve the implementation of the program
- The program is located in and run by an organization known in the community for being a successful provider of services to low-income families

Program Outcomes:

The Louisiana program is showing excellent outcomes. Dr. Neil Boris of Tulane School of Public Health and Tropical Medicine randomized eligible women to a control group and to a program participants group. In July 2003, his preliminary evaluation report¹⁸ indicated that women who received the home visiting services as compared to women who did not, had:

- A 52% reduction in premature births. He describes this as, “a statistically significant reduction, representing a potential cost savings, particularly over the long-term as premature births are high-cost and associated with developmental delays.”
- A 50% reduction in emergency room use for any reason, also statistically significant

Other outcomes which did not reach statistical significance but were nonetheless important include:

- A 22% reduction in the number of births below 2,500 grams (5 pounds). There was an 81 gram increase in birth weights in home visited women under age 19.
- A 33% reduction in subsequent pregnancies by 14 months postpartum
- A 51% reduction in self-report of alcohol use to intoxication (alcohol use is one of the leading preventable causes of developmental delays in children)
- 35% reduction in hospitalizations for any reason by the time the child reached 15 months of age

These outcomes suggest that the Nurse-Family Partnership is making a positive difference in the lives of women and babies. All of the indicators cited above have the potential of saving the State and federal government Medicaid expenditures and of improving the health of Louisiana families and children. In addition to the Louisiana-specific outcomes we can also consider the research results of Dr. Olds (shown in Appendix A) which cover a longer period of time. Dr. Olds found that serving the highest risk women resulted in the greatest savings in health and social services expenditures. The independent analysis of the Olds home visiting model by the Rand Corporation concluded that the program saves four dollars for every dollar spent.¹⁹

This is not to say that the only home visiting program that is effective is the Nurse-Family Partnership. There are other programs that have a positive impact. However, we cannot anticipate the same outcomes in a program that encourages participation in conventional prenatal care or that provides a few unstructured home visits during the prenatal period.

¹⁸ Boris, N. Nurse-Family Partnership Preliminary Year-end Report, July 2003, provided by the LA Dept. of Health

¹⁹ Karoly LA, Greenwood PW, Everingham SS, et al, Investing in Our Children: What We Know and Don't Know about the Costs and Benefits of Early Childhood Interventions. Santa Monica, CA: The RAND Corporation 1988

Financing the Nurse-Family Partnership using a Medicaid Case Management Benefit

The Louisiana program was initially financed with Title V Maternal and Child Health block grant funds (which are received by all state health departments). In 2000, Louisiana Medicaid agreed to provide financial support to the Nurse-Family Partnership program as a Targeted Case Management (TCM) service. Appendix B contains a letter from CMS to the State Medicaid Directors regarding the definition and parameters of TCM. Nearly all the low-income mothers in Louisiana qualify for Medicaid since the state raised the income limit to 200% of poverty. The Nurse-Family Partnership bills Medicaid for nurse home visits prenatally and for 60 days after delivery. At that point, the infant becomes the client and Medicaid continues to reimburse for the home visiting services under TCM.

Case Management services do not include the direct provision of medical care services; rather they are intended to help Medicaid enrollees *access* health and social services. Typically a case management service involves a face-to-face encounter between the provider and the beneficiary. This encounter need not occur in the client's home; a clinic, church or community center could be the setting for service delivery. Covered activities include an individual client assessment and development of a service plan, provision of information and referral to a wide range of health and human services, arranging and coordinating care (including arranging transportation or translation), working with beneficiary's family or other social support system regarding client needs, consulting with colleagues or supervisors regarding client needs and monitoring and updating the service plan. Case management services must be documented in a client record (such as a medical record) and are billed like any other Medicaid encounter.

Louisiana could have elected to reimburse the Nurse-Family Partnership as either Maternity Case Management (MCM) or as Targeted Case Management. Both types of case management are optional Medicaid services that states can choose to provide to specific groups of beneficiaries. Initially states had to request a waiver to provide TCM, but since 1986 they have been able to simply amend their State Medicaid Plan. A State Plan Amendment (or SPA) is much quicker and less arduous than securing a full federal waiver. MCM must be offered statewide whereas TCM can be targeted geographically to a specific county or region.

Many states are utilizing managed care systems to deliver Medicaid health care services. Theoretically, TCM services could be added into monthly managed care rates; that is, they could be included in capitation payments. In fact, that is not usually done. Since TCM services are provided to a limited population, usually by an entity other than the medical care provider, they are almost always billed on a fee-for-service basis. In the world of managed care, this is known as a "carve out", since the service and its payment are separated or "carved out" from other health care service payments.

In setting up its TCM benefit, a state Medicaid program defines the criteria for organizations and individuals to provide the service to specific populations. A TCM service provider does not need to be a licensed health care professional: mental health workers, social workers, human services workers, community health specialists and even probation and parole officers deliver TCM services in certain states. The provider qualifications should relate to the services needed by the target population. Nurses may be uniquely prepared and qualified to address the health issues that arise during pregnancy and early infancy.

States have substantial discretion in how they set reimbursement rates for any Medicaid or SCHIP service, including TCM and MCM. Expenditures for these health care services are shared by the federal and state governments in the same ratio that other medical care services are shared. The federal share of Medicaid ranges from 50% in states with relatively high per capita incomes to a legal maximum of 83% in states with relatively low incomes.²⁰ The SCHIP federal sharing rate is an enhanced rate that ranges from 65% to 84%. Louisiana has one of the highest rates of federal assistance of any state: 75% for medical care expenditures during 2004.

The state's share of Medicaid or SCHIP expenditures does not necessarily have to come from the state Medicaid budget. The federal government permits states to utilize other qualifying "public expenditures", primarily from local governments, to draw down federal matching funds. For example, funds spent by a city, county, school or hospital district are equivalent to state dollars in regard to funding Medicaid expenditures. Funds spent in other state department budgets (public health, mental health, education, juvenile justice, etc.) are also potential sources of match for Medicaid program expansions. Federal funds, such as Title V or Title X, cannot be used to draw down Medicaid expenditures.

If local public funds are already being spent on a program that qualifies as a Medicaid service, the state can create a new benefit or pay higher reimbursement rates at no additional cost to the state's Medicaid budget. For instance, many local governments already spend their own general funds for programs that work with high-risk pregnant Medicaid women and teens and meet the definition of case management. If the State Medicaid plan is amended to offer case management to pregnant women as a benefit, those existing programs may bill Medicaid. The local public expenditures can be "certified" by the State Medicaid program as meeting the requirements to qualify for match. As long as Medicaid is reimbursing for a covered service furnished to a Medicaid beneficiary by a participating provider, the expenditure is matchable. Thus new federal dollars may be leveraged by existing expenditures to help support and expand programs at no new state cost.

Even if a state Medicaid program already covers case management, rates may be set far below the actual cost of providing the service. In this case, local programs must make-up the shortfall. When California created its Targeted Case Management program, it identified nine different populations that could receive services. Each county creates a cost report showing what it spends to serve each TCM population. Medicaid then reimburses based on actual costs, which change from year to year and vary from county to county. The counties pay for the state's share of Medicaid expenses (approximately 50% in California) and the federal government pays its share.

Louisiana is not using local expenditures to pay its share of Medicaid costs for the Nurse-Family Partnership; the state share is budgeted as a part of the state Medicaid budget. Louisiana Medicaid pays a single rate statewide for TCM for pregnant women. It sets the TCM reimbursement rate for the Nurse-Family Partnership taking into account program costs that include salaries and benefits, staff training, program evaluation, travel, supervision and other administrative costs. Because of the high federal matching rate in Louisiana, the state's share of the TCM payment is approximately 24%.

²⁰ State Medicaid matching rates for 2004 were published in the *Federal Register* on Tuesday, June 17, 2003 pp. 35889-90, accessible through www.gpoaccess.gov.

Challenges, Room for Improvement:

Louisiana is currently serving only a small fraction of the 49,000 women who qualify for home visiting each year. In order to fully realize the benefits of this program, and see statistically significant changes in maternal and child health outcomes, the Nurse-Family Partnership program will need to operate on a larger scale. Medicaid support makes this a possibility, but that support will need to be maintained over the considerable time it will take to hire, train and deploy enough nurse teams to meet the need.

In the first four regions of the state, the Nurse-Family Partnership staff members are employees of the State Office of Public Health. Future programs will be operated by contractors including the Louisiana State University Health Sciences Center, nursing schools and local health and human services providers. While this model will have some advantages, there may also be duplicate administrative expenses and maintaining and monitoring the extensive program requirements will be more complicated.

The Medicaid rate per home visit is slightly less than the actual cost for state MCH staff to deliver the intervention. It will be important for the Medicaid rate to keep pace with actual costs, over time, if the program is to expand. Currently, the gap between cost and rate is being made up with State Health Department funds. If Medicaid paid the full cost of program, it could secure the matching federal contribution and free-up limited MCH dollars.

Other States Using this Intervention:

By the end of 2003, there were 23 states that had Nurse-Family Partnership programs in place. Four states were implementing statewide programs: Alabama, Oklahoma, Louisiana and Wyoming. Many other Nurse-Family Partnership programs are being implemented on a county, parish or other regional basis. Large cities with Nurse-Family Partnership programs include New York City, Denver, Baltimore, Seattle and Los Angeles. A full listing of program locations is available on the Colorado Nurse-Family Partnership web site.

Programs being implemented in a limited geographic area can best be supported with a Targeted Case Management benefit. Programs being offered statewide can be supported as either Maternity Case Management or as Targeted Case Management. Medicaid programs in 37 states cover some type of case management, many offer home visits, though pregnant women are not always covered. Even when services are targeted to pregnant women and infants, the reimbursement rate and the frequency of services may need reconsideration in order to support an intensive program.

Taking the Next Steps in your State:

If you seek Medicaid payment for TCM or MCM services to improve birth outcomes in your state, here are steps to consider.

- Find out if your state's Medicaid program currently offers an MCM or TCM program in its existing benefit package. Determine whether new or existing programs for pregnant women could bill for services under that benefit.

- If Medicaid is already supporting case management services directed to pregnant women, determine whether the rate covers the full cost of care. If not, could a rate increase be negotiated?
- Are state health officials open to creating new TCM or MCM billing options for services for pregnant women/infants? Ask if they will partner with MCH professionals and advocates regarding the potential structure and goals of such a benefit.
- Be sure there are providers interested in starting new TCM programs if a billing source becomes available.
- Is the State willing to budget funds for the state share of TCM costs or will they look to local governments for those funds? [Consider that the state may save costs if the program improves birth and maternal outcomes.]
- Is a Nurse-Family Partnership program right for your state or community? Visit www.nursefamilypartnership.org to learn more about the replication process. Perhaps there are there other proven MCH program models that could be supported with TCM billing.
- For either an existing or new program TCM is of maximum use if a high proportion of the target population be eligible for Medicaid. If non-Medicaid women would also be served by the program, what would be the source of funding for their services?
- Evaluation results can be used to improve and refine your intervention. They can also document the program's value, thus preserving it during times of budget pressure. How will new programs or program changes be evaluated?

Additional Resources

Paula Zeanah, R.N. PhD, LA Nurse-Family Partnership Program Consultant
504-568-5073, Email: PZeanah@dhh.La.gov

Cheryl Williams, R.N. MN, LA Nurse-Family Partnership Program Consultant
504-568-5073, Email: Cwilliams@dhh.La.gov

Jean P. Melanson, Department of Health and Hospitals, Bureau of Community Supports and Services, Case Management Administrator
225-219-0200, Email: jmelanso@dhh.la.gov

Websites with program information:

The Nurse-Family Partnership Central Office Colorado: www.nursefamilypartnership.org

The Nurse-Family Partnership in Louisiana: <http://oph.dhh.state.la.us/maternalchild/nursehome/>

Medicaid Support for Smoking Cessation

Case Study: Oregon's Smoke Free Mothers and Babies Program

Overview:

In 1996, Oregon began implementing its comprehensive statewide Tobacco Prevention and Education Program (TPEP) funded by a special tobacco tax. The State Medicaid program has been a strong partner and has supported tobacco cessation in a variety of innovative ways.

This case study will focus on Oregon's efforts to promote tobacco cessation among pregnant women. One particular focus is the relatively new Smoke Free Mothers and Babies program, financed by the Robert Wood Johnson Foundation, Smoke Free Families National Dissemination Office.²¹ This program is coaching and supporting maternity case managers and primary health care providers in the use of the "5 A's" model for cessation counseling.

Oregon's Smoke Free Mothers and Babies program is building on the statewide maternity case management program which is a Medicaid-funded benefit for all pregnant enrollees. Medicaid also pays for cessation counseling and pharmacology. Medicaid regularly notifies beneficiaries about the availability of cessation services and publicizes the statewide Tobacco Quit Line that is an integral component to Smoke Free Mothers and Babies. Medicaid has required health plans and providers to develop infrastructure that supports cessation and has provided technical assistance to help them do so.

The most effective tobacco control programs are comprehensive, using a range of programs and strategies to attack the problem from all angles. Focusing on a special population group such as pregnant women is more effective in the context of a comprehensive approach. Information about Oregon's comprehensive approach to tobacco prevention is available on the state's web site (www.ohd.hr.state.or.us/tobacco).

The Problem of Tobacco Use during Pregnancy:

According to the Surgeon General, smoking is the most important modifiable cause of poor pregnancy outcomes, with some 20% of low birth weight births linked to smoking during pregnancy. Eliminating smoking during pregnancy might lead to a 10% reduction in all infant deaths and a 12% reduction in deaths from perinatal conditions²². A number of studies have found that smoking is an independent risk factor for preterm birth, especially among African American women.²³ ²⁴ New research has shown that smoking during pregnancy may impair

²¹ www.smokefreefamilies.org

²² Women and smoking: A report of the Surgeon General. Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, Office of the Surgeon General; Washington, DC, 2001, p 296.

²³ Ahern J, Pickett KE, Slevin, Abrams. Preterm Birth among African American and white women: a multilevel analysis of socioeconomic characteristics and cigarette smoking. J Epidemiol Community Health 2003 Aug; 57(8) 606-11

²⁴ Lumley J, Oliver S. Waters, E Interventions for promoting smoking cessation during pregnancy, Cochrane Database of Systematic Reviews 1, 2003

normal fetal brain and nervous system development²⁵, and babies whose mothers smoked during their pregnancy are more likely to die from Sudden Infant Death Syndrome than those whose mothers did not smoke.²⁶

Beyond the toll that smoking takes on health, there are serious financial costs of smoking during pregnancy. Neonatal health care costs attributable to smoking are approximately \$228 million a year.²⁷ The direct medical costs of a complicated birth are 66 percent higher for smokers than for non-smokers, reflecting the greater severity of complications and the more intensive care that is required.²⁸

Tobacco use is not evenly distributed across the population of pregnant women. In Oregon, women on Medicaid are three times as likely to use tobacco during their pregnancy as women with private insurance (25% vs. 7%). This is similar to national data showing that pregnant women receiving Medicaid are 2.5 times more likely to smoke than pregnant women without Medicaid.²⁹

This means Medicaid pays for a disproportionate share of the higher costs of poor birth outcomes due to smoking, including the costs of preterm births. Medicaid programs should have a strong interest in any program that prevents tobacco “uptake” by youth or that increases the quit rate among current women smokers. They should enthusiastically support and/or develop programs that reduce beneficiary smoking during pregnancy. The Federal Medicaid Director wrote a letter to all State Medicaid Directors in 2001 explaining the minimum federal requirements for Medicaid covered tobacco cessation services and urging state programs to provide additional services (Appendix C).

The Program Model:

More than 6,000 studies indicate that treating nicotine dependence as a part of routine medical care is an effective way to address tobacco addiction. Clinics, doctors and case managers can help patients by recommending that they stop smoking and by offering and arranging further assistance. Oregon has implemented a number of efforts aimed at increasing health providers’ focus on tobacco cessation.

In 2002, the Oregon Office of Family Health (within the Oregon State Department of Human Services) received a Robert Wood Johnson Foundation financed grant from Smoke Free Mothers and Babies for \$200,000 a year for three years. Oregon is one of three states (along with Maine and Oklahoma) to receive these funds. Grant activities are focused on 10 relatively rural counties

²⁵ Dempsey DA, Benowitz NL. Risks and benefits of nicotine to aid smoking cessation in pregnancy (review article), *Drug Safety* 2001 24(4):277-32

²⁶ *Women and smoking: A report of the Surgeon General*. Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, Office of the Surgeon General; Washington, DC, 2001, p 307.

²⁷ CDC. Smoking-Attributable Mortality, Morbidity and Economic Costs (SAMMEC): Maternal and Child Health Sammec software, 2002b. Available at <http://www.CDC.gov/tobacco/sammec>

²⁸ Centers for Disease Control and Prevention Medical-care expenditures attributable to cigarette smoking during pregnancy -United States, 1995. *Morbidity and Mortality Weekly Report*, 46(44), 1048-1050

²⁹ Lipscomb LE, et al. PRAMS 1998 Surveillance Report. Atlanta: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Communicable Disease Control and Prevention , 2000.

that employ public health nurses as maternity case managers (MCMs) to work with low-income women, most of whom are on Medicaid. The Oregon program is a collaborative approach between the state's MCH, Tobacco, and Medicaid programs, local public health departments, private providers, managed care organizations, the March of Dimes and the American Cancer Society.

Oregon's goal is to increase use of best practices for tobacco cessation for pregnant women. State staff support and coach MCMs in the use of the 5 A's, a brief counseling model endorsed by the Public Health Service and proven to double or triple the number of patients who stop using tobacco.³⁰ While the intervention is relatively simple and based on scientific evidence, putting new clinical guidelines into practice is a challenge for most clinicians and health care systems.

The 5 A's, which should take under 15 minutes to perform, are:

1. **Ask** the patient about her smoking status
2. **Advise** her to quit (in clear, unambiguous language)
3. **Assess** her willingness to stop smoking in the next 30 days
4. **Assist** with counseling, social support and materials
5. **Arrange** to follow-up to ensure successful quitting

One of the first grant activities was to conduct a baseline survey of cessation knowledge and practice among MCMs and primary care providers. National data show that 81% of obstetricians/gynecologists ask pregnant women about their tobacco use but that only 22% proceed to counsel those women who smoke.³¹ The Oregon survey confirmed that many maternity case managers and providers were not using the 5 A's model effectively. They were afraid their clients would see them as nagging and they didn't know how to help clients who said they wanted to quit.

The Smoke Free Mothers and Babies Program provides training and support to help the MCM become expert and confident in using the 5 A's counseling method. During quarterly project meetings, an MCM leader from each county participates in the training program. She learns the compelling facts about cessation for pregnant women; learns ways to engage clients, watches presentations of others using the five A's and role plays the interventions. This leader then teaches the other MCMs in her county and primary care providers what she has learned.

The program has created a clever approach to increasing client receptivity. Case managers ask their smoking patients if they will participate in the Smoke Free Mothers and Babies program; let their case managers "practice" their new skills and then provide feedback on how effective the case manager is at teaching and counseling. Changing the paradigm so that women assist their case managers has made the whole cessation counseling process more effective. The State sends a regular newsletter to the case managers and the health care providers. Case managers receive brochures, posters and incentives for their clients. The State created a simple one-page form so that MCM could track a client's cessation efforts over five visits (See Appendix D).

The Smoke Free Mothers and Babies program depends greatly on the existence of Oregon's bilingual, toll-free Tobacco Quit Line to which it refers clients who are ready to quit. The Quit

³⁰ Information about the program is available at www.helppregnant smokersquit.org/care/methods.asp

³¹ Belodoff J, Sudhu J, Schulkin S, et al, "A survey of obstetrician –gynecologists on their patients' use of tobacco and other drugs during pregnancy. *Prenat NeonatMed* 2001;6-201-207

Line is operated by The Group Health Cooperative of Puget Sound in Seattle, Washington under contract with the state. A Maternity Case Manager can fax a referral to the Quit Line with details about the pregnant smoker's situation. The Quit Line will call the woman and provide personalized counseling and mail her a "Quit Kit" that includes tobacco substitutes, referrals, and information specific to her needs. The Quit Line helps callers access additional counseling and medications available through their managed care plan or their community. The Quit Line calls clients back on their quit date and then at intervals to determine their success and to provide more support. The Quit Line sends information about the client to the referring case manager or health care provider which helps to inform further in-person follow-up.

Program Outcomes:

In general there is good data supporting the cost effectiveness of tobacco cessation services for pregnant women. For every dollar spent, three dollars are saved in perinatal services.³² Additional savings accrue as the child grows older. It is also clear that smokers, including pregnant women, who receive support in quitting, have a higher rate of success than smokers who try to quit on their own.³³

In 1996, Oregon birth certificate data showed that 17.8% of all pregnant women, smoked during their pregnancy. This was substantially above the national rate of 13.6% of all pregnant women. By 2001, 12.8% of all pregnant women in Oregon smoked. This is a 28% decline; the rate of decline has been increasing and is occurring more rapidly than the national rate of decline in pregnant smokers. The rate of tobacco use among Medicaid pregnant women was 31.7% in 1996. By 2001, there had been a 23% reduction to 24.5%. While this is still substantially above the rates for privately insured women, the decline in this population is continuing. The change in Oregon rates suggests that 2,200 fewer infants were exposed prenatally to tobacco smoke in one year and that the comprehensive program reduces smoking during pregnancy.

The Smoke Free Mothers and Babies program is seeing positive results from its work. During the baseline survey period, the MCMs in the target counties were not confident in their ability to help their clients using the 5 A's model. After one year of coaching and education, they showed positive changes. For example, the MCMs who rated their ability to refer clients to the Tobacco Quit Line as excellent increased from 20% to over 60%. Their ability to answer questions about tobacco use and cessation during pregnancy and their confidence in handling "counseling resistance" also increased.

The follow-up survey of MCMs and Prenatal Care Providers showed that their use of the 5 A's best practices has increased substantially. After one year of participating in the Smoke Free Mothers and Babies program, MCMs in participating counties assessed their patients' readiness to quit 40% of the time versus only 5% of the time during the baseline period. They increased their offers to assist in quitting from 35% to 65% of the time and they arranged to follow-up with clients in the future 55% of the time versus only 10% of the time during the baseline. Because

³² Marks JS, Koplan JP, Hogue CJR, et al A cost-benefit/cost-effectiveness analysis of smoking cessation for pregnant women. 1990:282-91. American Journal of Preventive Medicine, 6

³³ Mullen PD, Maternal smoking during pregnancy and evidence-based intervention to promote cessation. In: Spangler J, ed. Primary Care; Clinics in Office Practice. Philadelphia: WB Saunders; 1999:577-89

research has established that consistent use of the 5 A's will increase cessation rates, the increased utilization of these techniques is a significant success.

Data from the second year of the program has been collected and is being analyzed. It will be available on the Smoke Free Families and the Oregon TPEP web sites.

The latest evaluation shows that Oregon's comprehensive Tobacco Prevention and Education Program is having an impact. Compared with 1996, today in Oregon there are:

- 75,000 fewer adult smokers
- 25,000 fewer youth smokers
- 1.5 billion fewer cigarettes sold annually
- 60,000 fewer adults using smokeless tobacco
- 2,200 fewer pregnant smokers

More than 60,000 people have called the Quit Line for help. In follow-up surveys, three-fourths of those reached reported they had success in reducing their tobacco use. Twenty percent are tobacco-free after six months. This success rate is more than double that of people who try to quit on their own. The number of Quit Line callers that were referred by healthcare providers has increased dramatically each year. In 2002, referrals from health care providers accounted for 20% of the calls.

The Role of Medicaid in Financing Cessation:

Oregon demonstrates many of the ways that Medicaid can support cessation. The Smoke Free Mothers and Babies program is possible because maternity case management is a statewide covered benefit available to all pregnant enrollees. Every pregnant woman can receive up to four visits which are reimbursed at \$40 a visit. Women with risk factors, including tobacco use, can receive up to six additional visits. "Full service" case management can be reimbursed up to \$520 a pregnancy and partial service reimbursement is also available.

Maternity case management is similar to Targeted Case Management (see Louisiana Case Study). Both types of case management focus on managing the care and services for clients. Case management is an optional benefit that states can choose to include in their Medicaid programs. Both benefits receive federal matching support in the same proportion as do other Medicaid expenditures for medical services in that state. The federal Medicaid guidelines require most benefits, including Maternity Case Management, to be offered statewide, whereas, TCM can be targeted to a particular geographic area and only offered in that area.

As with other benefits, Medicaid has substantial discretion in how much it pays and how it structures reimbursement for case management services. Oregon's reimbursement model provides an incentive to deliver intensive services over a longer period of the pregnancy. Some states pay a "case rate" for each enrolled client, others pay a monthly rate.

Local governments could contribute the required matching funds to Medicaid to help fund maternity case management services. It could be difficult to get support for a statewide benefit

however, and MCM must be offered statewide. If structured as targeted case management, the service could be offered only in those regions that choose to contribute funding.

Medicaid covers cessation counseling as a Medicaid benefit for all enrollees. Fee-for-service enrollees are eligible for four to five phone counseling sessions provided by the Free and Clear Program (which is affiliated with the Oregon Tobacco Quit Line) and will have materials mailed to their homes. All managed care companies contracting with Medicaid are required to offer tobacco cessation counseling. About half contract with Free and Clear to provide cessation counseling. The other HMOs pay for local programs or even operate their own cessation programs. When a Medicaid beneficiary calls the Oregon Tobacco Quit Line, the counselor can advise her about the additional cessation counseling offered by her particular managed care plan. Medicaid also covers nicotine patches, gum, medications and other tobacco-related pharmacology items when they are prescribed by a provider.

Since cessation counseling is a covered benefit in Oregon's Medicaid Plan, Federally Qualified Health Centers (FQHCs)³⁴ are able to bill for an encounter when a counseling session occurs. FQHCs generally receive higher rates per encounter than Medicaid pays other providers. If a state's Medicaid benefits include cessation counseling, FQHCs should be aware that they can receive the FQHC encounter rate when they provide that service.

There are other ways that Medicaid can support cessation programs. For example, Oregon Medicaid mails health and benefits information along with enrollment cards to each beneficiary on a monthly basis. These mailings regularly tell beneficiaries of the importance of not smoking, let them know that Medicaid covers cessation services and urge them to use the Quit Line. Each time Quit Line information is included in a mailing 300-500 Medicaid clients call the Quit Line. Many of them go on to get in-depth counseling.

Each year the Medicaid program selects one health condition as the focus of its Project Prevention. The Medicaid Medical Director and the Medical Directors of the participating health plans, review effective interventions and learn how to build infrastructure into their plans to support those interventions. Since 1998, tobacco use has been a focus of Project Prevention with three main goals: educating providers and clients about the existence and use of a cessation benefit; informing clients and providers that "help helps" when it comes to cessation; and focusing on getting pregnant women and people with chronic disease to stop smoking. A survey of providers showed that only 46% of them knew that Medicaid funded cessation services. Project Prevention developed an explanatory mailing recently sent to 15,000 providers explaining the benefit. Medicaid's commitment to tobacco prevention and cessation helps all the participating health plans to collaborate and share best practices in providing cessation services to their pregnant members.

³⁴ Federally Qualified Health Centers are non-profit (and occasionally public) clinics that receive a Bureau of Primary Care 330 grant to meet the needs of underserved populations. They are entitled to a cost-based reimbursement from Medicaid, which is usually higher than regular Medicaid rates.

Challenges, Room for Improvement:

In April 2003, the Quit Line contract, along with many other aspects of the comprehensive program, was suspended due to Oregon's budgetary crisis. [The national Legacy Foundation Quit Line continued to be available to all pregnant women.] Due to revenue shortfalls, many counties were forced to reduce public health staff and some MCMs were laid off or reassigned. Enrolling in Medicaid became more difficult and other maternal and child health programs were cut as well. These financial barriers have slowed down the implementation of the Smoke Free Mothers and Babies program.

Currently the Smoke Free Mothers and Babies pilot project relies on Maternity Case Managers to work with and teach health care providers the "5 A's." In some regions this is working well; in others there is very little collaboration between the MCMs and the providers. If the Smoke Free Mothers and Babies project in Oregon had the resources, it would work more directly with the health care providers. The manager for the Smoke Free Mothers and Babies program states that,

"The Public Health systems need to focus on developing strong links with private providers as pharmaceutical companies do. There is a role for public health to take the lead in providing health education and information to providers, but it needs to be done as a full-time focused activity targeting all providers using a chronic care model."

Medicaid is considering a requirement that maternity case management statewide will utilize the 5 A's in teaching smoking cessation and will use the documentation form developed by the Smoke Free Mothers and Babies Program. This will insure that Medicaid is paying for an intervention that has been proven effective.

Oregon could increase the use of Medicaid funds to support the Smoke Free Mothers and Babies Program. For example, the state is currently using grant dollars to fund the training and coaching of Maternity Case Managers. Activities to improve the quality of care provided to Medicaid beneficiaries could be considered part of administering Medicaid. For more information on using Medicaid administration to fund programs, see Appendix E.

Other States Using this Intervention:

In 2000, approximately 33 states and the District of Columbia provided some type of Medicaid support for tobacco treatment.³⁵ Ten states provided special programs under the Medicaid program for pregnant women; all but one of these offered counseling. Thirteen states offered home visit counseling regarding tobacco use.³⁶

Creative ways that Medicaid can support cessation include the following:

³⁵ Centers for Disease Control and Prevention. (2001) State Medicaid coverage for tobacco-dependence treatment—United states, 1998 and 2000. *Morbidity and Mortality Weekly Report*, 50(44), 979-982

³⁶ Ibrahim,J. Schaffler, *American Journal of Public Health* Dec. 2002, Vol. 92, No.12, pgs. 1940

- In Utah, Health Program Representatives (Medicaid eligibility staff) ask each person enrolling in Medicaid if they smoke. If so, they counsel them to stop; provide them with self-help material, a referral to their local health department and the toll free quit line. Pregnant women who stop smoking are rewarded with baby t-shirts and baby hats. Health Program Representatives are part of the cost of Medicaid administration; their costs are thus reimbursed 50/50 by the state and federal government.
- Medicaid in Utah also provides funding for various media activities around smoking cessation. They provide funds for posters directed at pregnant women and pay a share of the cost of the statewide media campaign.
- In Maine, Medicaid pays \$20 when a provider addresses tobacco use with any smoker. This service can be billed three times per patient per provider per year. Maine is working to increase delivery of this benefit.

Taking the Next Steps in Your State:

First and foremost, support comprehensive statewide tobacco education and prevention programs; the best results come from programs targeting the entire population using a variety of interwoven strategies. Programs that target one population group (for example youth or pregnant women) are more effective in the context of a comprehensive program.

Then consider the following:

- Where does the expertise in tobacco cessation exist in your state? Does the state Medicaid program have a focus on tobacco cessation? Look for allies in Title V, the private medical community and the non-profit community.
- Review the elements of a model comprehensive program for pregnant smokers. The Action Plan of the National Partnership to Help Pregnant Smokers Quit at www.helppregnant smokersquit.org/documents/Actionplan.pdf is a good reference.
- Identify effective programs now in place (quit-lines, maternity case management services, media campaigns, etc.). Could maternity case management or Medicaid administrative claiming help to pay for those activities?
- Identify gaps in the programs directed to pregnant smokers. For example, is there training for providers in cessation counseling? Is reimbursement available? Do beneficiaries and providers know that cessation is covered?
- Evaluation results can be used to improve and refine your intervention. They can also document the program's value, thus preserving it during times of budget pressure. How will new programs be evaluated?

Additional Resources:

Lesia Dixon-Gray, Smoke Free Mothers and Babies Program Manager, Oregon Department of Human Services, Center for Family Health
503-731-8606, Email: Lesia.Dixon-Gray@state.or.us

Judith Van Osdol, Prevention Coordinator, Oregon Department of Human Services, Office of Medical Assistance Programs
503- 945-6547, Email: Judith.Van-Osdol@state.or.us

Catherine Rohweder, Research Associate, Smoke-Free Families National Dissemination Office,
916-966-6879, Email: catherine_rohweder@unc.edu

Web sites with program information:

www.helppregnantmokersquit.org

www.smokefreefamilies.org

www.nga.org/cda/files/071101SMOKING.pdf The National Governor's Association, Issue Brief, Preventing Maternal Smoking June 2001

Medicaid Family Planning Waivers

Case Study: Rhode Island's Rite Care

Overview:

In 1994, Rhode Island (along with South Carolina), pioneered a new approach to funding family planning services with Medicaid. Rhode Island received a federal waiver that permitted pregnant women and children in families with incomes up to 250% of the federal poverty level to qualify for Medicaid and required non-disabled Medicaid recipients to enroll in managed care plans. In working on the waiver request, the state realized that most pregnant women in working families who qualified for Medicaid under the waiver would lose coverage after two months postpartum. Once a woman was no longer pregnant, she would be evaluated under a different eligibility standard and if her income was above the cash assistance limit (which was below the poverty level), she would no longer qualify for coverage.

In a collaborative planning process, the Medicaid agency and the Title V MCH agency requested permission to offer a limited Medicaid benefit of family planning and primary care services for two years to women who had delivered a baby and would otherwise lose coverage 60 days postpartum. By securing access to family planning services, these women would be better able to plan subsequent pregnancies, including increasing the interval between births.

Prior to requesting a waiver, Rhode Island Medicaid and MCH officials reviewed birth certificate data and discovered that 42% of Medicaid moms had a subsequent Medicaid-financed delivery within 18 months compared to 31% of women who had delivered babies with private insurance. Rhode Island was concerned about the health implications of this pattern for both the mother and infant along with the impact on family self-sufficiency, independence and preservation.

Medicaid family planning services are funded with a much higher federal share than any other Medicaid covered service: 90% of services are paid by the federal government, 10% by the states. Therefore an expansion of eligibility for family planning services is relatively inexpensive for a state. The financial savings and positive health outcomes gained by providing access to family planning services are well-documented.

The Problem of Unintended Pregnancy:

A number of studies have documented that closely spaced births are associated with higher risks of low birth weight, small size for gestational age and prematurity.^{37 38 39} For example, a Scottish study reviewing 89,000 second births, determined that “a short inter-pregnancy interval

³⁷ Zhu, et. al. Effect of the interval between pregnancies on perinatal outcomes. *New England Journal of Medicine* 1999; 340 (8): 589-594

³⁸ James, Bracken, Cohen, Saftlas, Liberman, Interpregnancy interval and disparity in terms small for gestation age births between black and white women, *Obstetrics and Gynecology* 1999; 93(1) : 1182-5

³⁹ Fuentes-Afflick E, Hessel, N.A., Interpregnancy intervals and the rate of premature infants, *Obstetrics and Gynecology*, 95(3) 383-320, March 2000

[conception at 6 months or fewer after the previous birth] was an independent risk factor for extremely preterm birth and neonatal death unrelated to congenital abnormality.”⁴⁰

Unintended pregnancies (regardless of interpregnancy interval) are more likely to have poorer outcomes, including more preterm births, than intended pregnancies.⁴¹ Beyond the health care impacts are the potential high social costs for families. Families with short spaced and unintended births experience greater levels of economic and personal stress. Particularly when family resources are limited an unintended pregnancy that is closely spaced can be very destabilizing. Access to family planning and other primary care services has the potential to reduce the incidence of unintended pregnancy by improving pre-conceptual health, reducing STD's, reducing teen pregnancies and reducing other high-risk, unintended pregnancies.

Losing Medicaid coverage after delivery of a baby is a common scenario. All states are required by the federal government to cover pregnant women up to 133% of poverty and may cover them up to 185% at their discretion. As of October 2002, 34 states cover pregnant women at or beyond 185% of the federal poverty level.⁴² Once a woman has delivered a baby on Medicaid, she retains coverage for 60 days and then is evaluated for eligibility as an adult with a dependent child. Most states set lower income limits for non-pregnant adults often at or below the federal poverty level.⁴³ The federal poverty level for a couple with a child was \$15,260 in 2003 (in the 48 contiguous states).⁴⁴ Therefore a pregnant woman with an income of 133% of poverty will be eligible for Medicaid in every state but once her baby is born, will often lose that eligibility after 60 days due to the different, lower, income standard applied to non-pregnant parents.

Theoretically women with incomes above the Medicaid limits can receive family planning services funded with Title X Family Planning Block grants funds. However, Title X funds have not kept pace with the costs and demands for service over the last two decades. For example, the \$254 million allotted to Title X for FFY 2000 was worth 58% less than the \$162 million appropriated in 1980. If funding had kept pace with inflation, over \$564 million would be appropriated today.⁴⁵

Many states have supplemented Title X with MCH Title V block grant funds, Social Services block grant funds, state health funds, TANF dollars or others sources of funding, but nonetheless many eligible women are unable to access Title X programs or must pay relatively high co-pays to receive the most effective methods of birth control. Under-funding by Title X, the number of uninsured women needing help, and the advent of Medicaid managed care are all challenging the family planning clinic system. Expanding Medicaid coverage for family planning via Medicaid can be done in a way that supports the Title X clinics while increasing access to services. The

⁴⁰ Smith GC, Pell JP, Dobbie R, Interpregnancy interval and the risk of preterm birth and neonatal death: a retrospective cohort study , *British Medical Journal*, 2003 August 9; 327(7410):313

⁴¹ The Institute of Medicine, *The Best of Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Editors: Brown S. Eisenberg, National Academy Press, 1995

⁴² National Governor's Association, MCH Update 2002 State Health Coverage of Low-Income Pregnant Women, Children, and Parents, June 9, 2003, page 20 accessed at www.nga.org/cda/files/MCHUPDATE02.pdf April 30 2004

⁴³ *Ibid*, page 22

⁴⁴ Federal Poverty Level Chart and explanation <http://aspe.hhs.gov/poverty/03poverty.htm> accessed May 21, 2004

⁴⁵ Dailard, C. Challenges Facing Family Planning Clinics and Title X, *The Guttmacher Report on Public Policy*, April 2001. The Alan Guttmacher Institute, 2001.

new Medicaid coverage funding can free-up other health and social services funds to serve additional women above the Medicaid income limits or to meet other MCH needs.

Program Model:

Rhode Island implemented the family planning expansion as one element of a waiver which expanded coverage and improved access through a managed care model for Medicaid enrollees. The managed care program, known as RItE Care, included many features designed to improve access to care for uninsured pregnant women and children, including outreach campaigns, free pregnancy testing, streamlined application processes, expanded access to OB providers and changes to reimbursement. The family planning waiver itself covered primary care outpatient services and the following family planning services:⁴⁶

- An annual gynecological exam including a Pap test and breast exam
- STD and HIV tests
- Education and counseling about a method of birth control
- Birth control prescriptions/ supplies for pills, IUD, Norplant, condoms, etc.
- Treatment of STDs
- Pregnancy testing

Women can receive services from any provider under contract with the Health Plan including primary care physicians, gynecologists and nurse practitioners in private practices, health centers, or hospital clinics. Women had a choice of paying a small monthly premium or nominal co-payments at the time of service.

During the first five years of the program 5,400 women participated in the family planning component of the waiver program, including 1,300 enrolled in the post- partum family planning component at any one time. In 1998, RItE Care was expanded to provide full Medicaid coverage to parents with incomes up to 185% of poverty. Thus, mothers between the cash assistance income level and 185% of poverty no longer needed the limited family planning eligibility, as they were now eligible for the full scope of Medicaid services, which includes family planning. Mothers between 185% and 250% of poverty continued to be eligible for the family planning component of the waiver for two years postpartum. In 2003, this permitted a family of two to qualify for Medicaid with an income of up to \$30,300.

Eligibility/Benefits Waiver: Financing Family Planning Expansions

Family Planning services occupy a special status in the Medicaid program. All states receive 90% federal reimbursement for Medicaid expenditures on family planning, a much higher rate than for other medical services which are reimbursed at between 50% and 83%, depending on the state's level of poverty.

⁴⁶ Federal funds cannot be used to pay for most pregnancy terminations (due to the Hyde Amendment); pursuant to court order, RItE Care covers abortions only when the pregnancy endangers the woman's life or is the result of rape or incest.

It is widely accepted that family planning is a cost-efficient service. Each public dollar spent to provide family planning services saves an estimated \$3.00 that would otherwise be spent in Medicaid costs for pregnancy-related care and medical care for newborns.⁴⁷ Another study measured the cost of contraceptive methods compared to the cost of unintended pregnancies when no contraception was used. It found the net savings to the health care system were between \$9,000 and \$14,000 for each woman who used contraception over five years.⁴⁸

RIte Care spent \$5.7million on Medicaid family planning services during the first three years of the waiver from 1994 to 1997⁴⁹. The state share was 10% or \$570,000. The federal share was \$5.1 million (90%). Rhode Island calculates that the family planning expansion program resulted in 1,443 fewer Medicaid deliveries between 1994 and 1997. Since each Medicaid delivery would have cost \$5,000, and each month of coverage for a newborn \$400, Medicaid avoided expenditures of \$14.3 million. Thus RIte Care's investment of \$5.7m in family planning yielded immediate savings worth 250% of that amount to the federal/state Medicaid program.⁵⁰

The return on investment is even more dramatic when only the state share of expenditures is considered. Rhode Island spent \$570,000 of state funds for family planning in three years but saved \$6.43 million in medical care costs.⁵¹ The return on investment for the State of Rhode Island was over 11 times its outlay or 1,130%. Even though it paid for 90% of the new family planning services, the federal government also saved more than it invested: savings were \$7.86m vs. expenditures of \$5.1million.⁵² These favorable cost benefit numbers are higher than most other government investments and yet they don't include lifetime cost savings for education, health care, and other services needed by babies born prematurely or with other health needs.

Waivers typically are used to test innovative approaches in the Medicaid program for a limited time period, usually five years, though they are often extended. They include evaluation requirements and extensive reporting; successful approaches may become part of the regular Medicaid program. CMS requires that a waiver be "budget neutral," namely, increased federal costs for new eligibles or new services will be offset by savings in federal expenditures as a result of the change. In other words, net federal expenditures will not increase as a result of the waiver though money will be spent on different things. The Rhode Island waiver clearly met and exceeded the qualifications to be budget neutral.

⁴⁷ Forrest, Jacqueline & Renée Samara. (1996). "Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures." *Family Planning Perspectives*, 28(4), 188-195.

⁴⁸ Trussell, et al (1995). "The Economic Value of Contraception: A Comparison of 15 Methods." *American Journal of Public Health*, 85, 494-503.

⁴⁹ Gold, R. State Efforts to Expand Medicaid-funded Family Planning Show Promise, *Guttmacher Report* Vol. 2, No.2, April 1999

⁵⁰ Gold, R. *Ibid*

⁵¹ The federal government pays 55% and RI pays 45% of expenditures for Medicaid medical services. 45% of the \$14.3 million savings in Medicaid expenditures equals \$6.43million.

⁵² The federal government pays 55% and RI pays 45% of expenditures. 55% of the \$14.3m saved is \$7.865m

Program Outcomes:

The RIte Care program focused on lengthening inter-birth intervals and was strikingly successful. In 1993, (pre-waiver) 41 % of women who had a Medicaid-funded birth became pregnant within 18 months of their previous delivery. By 1996, the number of Medicaid mothers who became pregnant again within 18 months had been dramatically reduced to 29%, and has remained between 29% and 31% each year since. This change essentially ended the disparity in short inter-birth intervals between women with public coverage and women with commercial coverage.⁵³ Rhode Island determined that the greatest reduction in short interval pregnancies occurred in repeat pregnancies occurring in less than nine months. There was a 54% reduction in those very short interval pregnancies, which are associated with the highest risks for preterm birth and other infant health problems.⁵⁴

Rhode Island has measured maternal and infant health indicators for women delivering with Medicaid coverage since before the waiver was implemented and compared these indicators to women delivering with private coverage. For women delivering with Medicaid coverage, not only has short inter-birth intervals decreased but adequacy of prenatal care improved dramatically, and smoking during pregnancy has reduced significantly. These improvements in access and health status are statistically significant, even when controlling for changing demographics of the population as income limits were expanded, including age, race, and mother's education level.⁵⁵

While there has not been a corresponding impact on traditional *indicators* of infant health outcomes (including prematurity and low birth weight) there has been a dramatic improvement in actual infant health outcomes. Infant mortality for infants born to Rhode Island Medicaid-enrolled mothers during 1990's dropped a full 36% from 10.7 to 6.8 deaths per 1,000 births. The infant mortality rate for privately insured infants dropped 17% to 5.3 per 1,000. Thus, in 2000 Rhode Island Medicaid insured infants had a better survival rate than the national rate for all infants: 6.8 vs. 6.9. While there is still a gap between the low income and privately insured population in Rhode Island, the gap was cut in half in the 1990's. The decline in infant mortality is seen in both the neonatal and post-neonatal period.⁵⁶

The Centers for Medicare and Medicaid Services recently commissioned a study of state family planning waivers to determine if they were truly budget neutral, if they increased access to family planning services, if they decreased unintended pregnancy and if states reduced their spending on family planning after receiving the waiver. The study, conducted by CNA Corporation with assistance from Emory University and the University of Alabama, was released January 2004 and is summarized on the Alan Guttmacher Institute web site.⁵⁷

⁵³ RIte Care Program shows Marked Reduction in Births with a Short Interval, research materials from the RIte Care program

⁵⁴ Ibid

⁵⁵ Griffin et al, The Effects of Medicaid Managed Care on Prenatal Care Utilization in Rhode Island . The Am J of PH, 1999 89:497-501

⁵⁶ "Rhode Island's Infant Mortality Rate Drops Significantly in 1990's. RI Medicaid Research and Evaluation Reports, Issue Brief #3-December 2002 at <http://www.dhs.state.ri.us/dhs/dreports.htm>

⁵⁷ CMS study of Medicaid family planning waiver programs. Memo, January 26, 2004 WWW URL: www.guttmacher.org/pubs/memo012604.pdf accessed Feb. 1,2004

The study defines a standard methodology for calculating the financial impact of family planning waivers and calculating budget neutrality. Applying that methodology to six selected states, the study concludes that all are exceeding the cost neutrality standard and are generating savings for both the state and federal governments. The study summary shows a total of approximately \$230 million of savings in the six states reviewed. It also concludes that access is increasing in most programs, although use of the waiver by eligible women varies greatly from state to state. Unintended pregnancy is decreasing in some but not all states with program design and ease of access being factors.

Challenges, Room for Improvement:

The Rhode Island waiver made additional services available only for women who had already delivered a baby on Medicaid and who lost financial eligibility. This is not the largest population that could be reached. As the next section reports, ten states have secured waivers to provide services to men and women based on their income alone. In these states Medicaid financed family planning services can be provided under the waiver before a pregnancy occurs and can thus be used prevent a first unintended pregnancy and to improve pre-conceptual health prior to a first birth. Rhode Island could increase the scope of the program by permitting access to family planning services based on income alone and could serve men as well as women.

Other States Using this Intervention:

Rhode Island and South Carolina pioneered the 1115 Family Planning Waiver program and other states quickly followed. By December 1, 2003, 18 states had received family planning waivers and four states had waivers pending.⁵⁸ The nature of the existing family planning waivers varies substantially. The majority of states (10) provide services to a woman based on her income alone; no prior pregnancy is required. In Arkansas, for example, the regular Medicaid program covers non-pregnant adults with incomes up to only 15% of poverty. With this waiver, Arkansas is able to provide family planning coverage for women with incomes up to 133% of poverty. During the first three months of operation, the Arkansas program served 12,000 enrollees.

Oregon took the waivers one step further and received approval to cover both men and women up to 185% of poverty. Oregon initially used the existing Title X providers as the base for delivering services. Clients are certified as eligible by the clinic provider each time they come in for services. This has reduced administrative enrollment costs and made access easier for clients. Using the eligibility determination methodology specified in Title X programs, nearly all teens in Oregon are eligible to receive coverage based on their own incomes. (Not all family planning waivers cover teens.) Washington, New York and California cover men and women up to 200% of poverty. At last report, approximately 12% of the California enrollees were men.

⁵⁸ States with waivers include: Alabama, Arizona, Arkansas, California, Delaware, Florida, Illinois, Maryland, Mississippi, Missouri, New Mexico, New York, Oregon, Rhode Island, South Carolina, Virginia, Washington, and Wisconsin. States with waivers pending (as of Dec. 2003) included Colorado, Minnesota, North Carolina and Oklahoma. For more information on each state's program see: <http://www.gutmacher.org/pubs/ib2004no1.html>

Taking the Next Steps in your State:

Securing a waiver of federal Medicaid regulations is not a project that should be undertaken lightly. Waiver applications require extensive documentation and analysis and often take months, or even years of negotiation before CMS and the state reach an agreement. The new CMS-commissioned study should standardize the process for determining budget neutrality and may ease the negotiation process. Depending on the state's requirements, the Medicaid Director, the Secretary of Health (or Health and Human Services), the Governor, or even the Legislature must approve the waiver request. In Wisconsin, the legislature passed a bill requiring the Health Agency to submit and implement a family planning waiver request. In Oregon, the Medicaid Director already had legislative authority to seek additional matching funds for any state expenditures.

Regardless of the legal specifics, broad-based support for a waiver is necessary. Ideally, the legislature, governor, health director, congressional delegation, private practice leaders, family planning providers and the advocacy community will all support a waiver request. Although getting a waiver takes sustained effort, the results are positive on many levels (financial, maternal and child health, family independence). Not only can states improve birth outcomes but they can improve family independence and reduce the rate of teen pregnancy. If more states ask for waivers, it will help educate Congress and the executive branch about their importance and may lead to "waiving the waiver" so that states, at their own option, could expand family planning services.

If you are interested in improving infant health by improving access to family planning in your state, here are some ways to begin:

If your state does not have a waiver:

- Consider whether Medicaid beneficiaries have a high unintended pregnancy rate and/or a short interval between births (under 18 months) that negatively impacts birth outcomes. States participating in PRAMS (Pregnancy Risk Assessment Monitoring System) have access to data on unintended and intended pregnancy by insurance type. Other states may need a special study of Medicaid and birth certificate data.
- Is the state concerned about other costs (for welfare, special education and child protective services for example) that might be reduced if unintended pregnancies and preterm births were reduced?
- Learn whether your state has ever considered a family planning waiver before. Find out if state policy makers and program officials interested in discussing this option with MCH advocates and professionals.
- Is the state spending its own funds to provide family planning services to any populations that might be covered under a Medicaid expansion? Some states have been able to fund waivers by shifting existing appropriations from one department to another.
- Consider expert consultation with design and data analysis to enable your state to move ahead more rapidly.

If your state already has a waiver:

- Does it cover postpartum women only, women based on income alone, or men and women based on income? If coverage is postpartum only, for what period of time is coverage extended? What are the income limits for coverage?
- How many eligible individuals are receiving services under the waiver? Consider increasing utilization through simplified enrollment, more publicity, a larger network of providers, or automatic extension of coverage after a birth or by other means.
- Does the program require (and are the payment rates high enough to support) outreach to hard-to-serve individuals? Is the program reaching rural women, women involved with the criminal justice system, women with mental health, drug and alcohol, domestic violence or child abuse issues? Or is the program only serving the most motivated individuals who need little assistance to access services?
- When does the waiver expire and will your state request a renewal? Will it request any changes or expansions? Can MCH professionals and community advocates participate in discussions of renewal options?

Don't forget to plan for evaluation of new programs or changes to existing programs. Evaluation results can be used to improve and refine the intervention. They can also document the program's value, thus preserving it during times of budget pressure.

Additional Resources

Tricia Leddy, Center for Child and Family Health, Department of Human Services
401-462-6346, Email: Tricial@DHS.RI.gov

Murray Brown, Rhode Island Department of Human Services
401-462-1585

Rachel Gold, Researcher, Alan Guttmacher Institute
202-296-4012, Email: rgold@guttmacher.org

More information:

Summary, Analysis of Family Planning Waiver Evaluation Study by CAN:
www.guttmacher.org/pubs/memo012604.pdf

The impact of birth intervals on maternal and infant health:
http://www.rhcatalyst.org/site/PageServer?pagename=Programs_Birth_Spacing

Medicaid Support for High-Risk Perinatal Care

Case Study: Arizona's High-Risk Perinatal Program

Overview:

During the 1970's, the Arizona medical community and state health department began developing a system of services to respond to high-risk pregnancies and deliveries. The goal of the system is to reduce maternal and infant mortality (deaths) and morbidities (abnormalities that may impact a child's growth and development.) The program provides a statewide system of services that are available to all families regardless of their health insurance, provider network, where they live or the language they speak. Known as the High-Risk Perinatal/Newborn Intensive Care (HRPP) Programs, the services include the following:

- Maternal and neonatal transport services to a higher level of care and back again to their community of residence;
- Access to consultation with neonatologists and perinatologists for community-based obstetricians and health care providers;
- Hospital and inpatient physician services that provide comprehensive, developmentally and risk appropriate care to critically ill infants;
- Certification systems for hospitals and transportation providers that care for at risk pregnant women and neonates;
- Community nursing services that facilitate the transition of the child and family from the NICU (neonatal intensive care unit) to their home and educate and support the family and provide referral to other early intervention programs; and
- Developmental follow-up system support provides access to developmental assessments and evaluations for babies at risk of developmental delays and referrals to services for children with special needs.

The program is achieving many goals related to quality of care. In 2001, 98.7% of all infants weighing less than 3 pounds, 5 ounces were delivered at HRPP Centers (Level III or IIEQ).⁵⁹ Standards of practice have been developed for Perinatal Social Work, Neonatal Community Health Nurses and developmental evaluation. Discharge Planning Guidelines and Guidelines for Developmental Care in a NICU have been published and are utilized. Standards for various levels of acute hospital care have been developed and are monitored and enforced.

The Arizona Medicaid program, known as AHCCCS, (Arizona Health Care Cost Containment System) supports this program through its structure of health care reimbursement. Additional support options are available and could be pursued by Arizona and/or other states.

⁵⁹ Arizona Health Services web site: www.hs.state.az.us/phs.owch/hiriskper.htm accessed May 21, 2004

The Problem of Providing Optimal Medical Care to High-Risk Pregnancies and Preterm Infants:

Research has shown that very low birth weight (VLBW) infants have lower death rates when they are delivered at Level III hospitals, which are appropriately staffed and equipped to care for them and that have a high volume of these admissions.⁶⁰ Almost all babies in the category of very low birth weight, that is less than 3 pounds 5 ounces, are babies born prematurely. The Healthy People 2010 Objective 16-8 (and the Core Performance Measure 17 for Title V), is that 90% of VBLW infants will be born in tertiary care hospitals or specialized facilities. In 1996-97 approximately 73% of VLBW babies nationwide were delivered in these types of facilities.⁶¹

Transporting a mother in premature labor before the baby is born is safer and provides better results, but this can be logistically complicated. Getting premature infants born in the right facility takes systems development. For example, a FIMR (Fetal and Infant Mortality Review Program) review in the Pee Dee Health District in South Carolina found that it took 6 or 7 hours and 6 phone calls to transport a pregnant woman to the closest Level III hospital. However, once the woman delivered, one phone call activated the system to transport a very high-risk baby.

Developing a “one call transport system” is highly desirable, but not always sufficient. Helping hospitals to bear the cost of expensive preterm births is usually a necessary aspect of assuring open access regardless of insurance coverage.

Making the decision to transport a pregnant patient in preterm labor or to manage her pregnancy locally can be complicated. Factors affecting this decision include a host of clinical, logistic and facility-related factors: the health status of the pregnant patient, the gestational age and health status of the fetus, availability and methods of transportation and length of time in transport, capabilities of the originating and potential receiving hospitals as well as the capabilities of the health care providers involved. Providing easily accessible consultation to a high-risk obstetrics specialist (also known as a perinatologist) for a community physician who is responsible for the high-risk pregnancy can be critical to arriving at the best decision for all involved.

Once a preterm infant is discharged from the hospital, continuity of care can be a problem. Many infants go home to environments where the parents have little support in caring for their babies who may have multiple health problems. Entry into early intervention services or receipt of early treatment helps to reduce disabilities but many babies are lost to follow-up until they are school age. This is particularly a problem for low-income families or families with language and cultural barriers.

⁶⁰ Powell, S.L.; Holt, V.L.; Hickok, D.E.; et al. Recent changes in delivery site of low-birth-weight infants in Washington: Impact on birth weight-specific mortality. *American Journal of Obstetrics and Gynecology* 173(5):1585-1592, 1995

Kirby, R.S. Perinatal mortality: The role of hospital of birth. *Journal of Perinatology* 16(1):43-49, 1996 Paneth, N.; Kiely, J.L.; Wallenstein, S.; et al. The choice of place of delivery: Effect of hospital level on mortality in all singleton births in New York City. *American Journal of Disabilities in Children* 141(1):60-64, 1987

⁶¹ Healthy People 2010 Objective 16-8, available at

www.healthypeople.gov/Document/HTML/Volume2/16MICH.htm accessed May 18, 2004

The Program Model:

In the mid-1960's, the Arizona State Health Department received a federal grant to evaluate maternal and infant health outcomes, especially those attributable to premature birth. This effort revealed that infant mortality was excessively high, and that bringing premature infants to centers with well-developed neonatal care facilities improved outcomes for premature infants.

The Arizona legislature, while not an early adopter of Medicaid, agreed to support the development and operation of a high-risk perinatal system with state funds. Specifically, funds were allocated for the development of regional NICUs and transport services. The state designed a "single level of quality of care with varying levels of complexity,"⁶² including the ability to assess individual infants expeditiously and transport those in need to the nearest appropriate facility. The legislature set aside limited dollars for transport and hospital costs for families without a source of health coverage with the High Risk Program serving as the payer of last resort.

Hospital and inpatient physician services are at the heart of the Arizona program. The Arizona Perinatal Trust, a private non-profit organization made up of MCH specialists, sets standards for the different levels of inpatient care (including Neonatal Intensive Care Unit coverage by contracted physician groups) and for specialty transport services. The Trust sets the standards for hospitals and inspects and monitors them to be sure the standards are met.

Cooperation and communication among primary-care obstetric providers, neonatologists and high-risk obstetric specialists is essential. The State Health Department contracts with three regional teams of perinatologists and neonatologists to be available 24 hours a day, seven days a week. Community obstetrical care providers can call a toll free number for their region and get immediate access to this specialty consultation. If the woman, or less desirably the infant, needs to be transported, the consultant makes the arrangement and prepares the facility to receive the patient. This process insures the receiving hospital is ready to get the patient and relieves the community physician of having to make transportation arrangements.

Perinatal transport services for the system are provided under a contract with the State Health Department and are reimbursed by Medicaid. Standards for perinatal transport have been developed but have not yet been implemented. Once a preterm infant is stabilized and growing, he or she may be able to return to a community hospital closer to the family. This can reduce the tremendous stress of having a fragile infant cared for in a distant facility. The High Risk Program supports back transport, or return to a lower level of care in the family's home community.

HRPP provides payment for hospital, physician and transport services as the payer of last resort for patients who do not qualify for any other type of insurance. The hospitals accept the discounted reimbursement and write-off the rest of their charges. This helps uninsured families experiencing a high risk pregnancy to avoid financial catastrophe. The availability of a payer of "last resort" also helps insure that hospitals and physicians will accept women into the system, whether their insurance has been fully confirmed or not.

⁶² Meyer B. personal communication 2/5/2004

HRPP provides case management services for women who are transported and their infants. Community nursing services provide home visits to assist in the transition of the premature infant and the family from inpatient hospitalization to home, and periodic evaluation of the infant's medical and developmental needs to identify referrals that may be needed to other early intervention programs. The community nurses typically work for the county health departments but receive training and support from the High-Risk Perinatal system. The tertiary care case managers make referrals to the community nursing services and help insure that the family is connected to a source of medical care and support.

Developmental Follow-up is available to infants at-risk of developmental delay due to a variety of factors including preterm birth. All states are required to provide early intervention services to infants but in fact, many infants are lost to follow-up once they are discharged from a specialty hospital into the community. Developmental Follow-up provides regular developmental assessments and evaluations of infants at-risk of ongoing disability and assists them in receiving services.

Program Outcomes:

HRPP reports substantial decreases in neonatal deaths (i.e. deaths within the first 28 days of life) and infant deaths (i.e. deaths within the first 29 to 365 days of life). Neonatal deaths have dropped from 6.9 per 1000 in 1985 to 4.3 per 1000 in 2000, with infant deaths declining from 10.6 per 1000 to 6.7 per 1000 in the same timeframe.⁶³ In 2001, 94.6% of all Arizona births occurred in hospitals that participate in the Arizona Perinatal Trust certification program. In addition, 98.7% of "Very Low Birth Weight" infants, those weighing less than 3 lbs 5 oz, were delivered in level III (or equivalent) specialized regional centers. This high rate of appropriate delivery location confirms the success of the HRPP consultation and transport system.

Reasons for maternal transport in 1999 were evaluated at the request of the Arizona Perinatal Trust.⁶⁴ Approximately 1100 pregnant women were transported for pregnancy-related conditions that year, with approximately half of the transfers due to preterm labor (prior to 37 weeks gestation). Nearly 60% of maternal transports occurred by air. Sixty-four percent of pregnant women transported delivered a live born infant after transport, with most deliveries occurring within one day of transport. Of 411 maternal transports with estimated gestational age less than 32 weeks, 53% were transferred due to preterm labor; nearly half of deliveries in this group resulted in live births.

This study also points out the importance of maternal transports that occur without imminent delivery: about 21% of pregnant women transported do not deliver during that hospital stay. In addition, the length of stay after transport and before delivery is important as well: for preterm pregnancies, longer time before delivery can result in substantial infant health gains. For pregnancies transferred at 28 weeks gestation, for example, the average length of stay before delivery was 12 days. And for the 50 mother-infant pairs with complete data, where the pregnant patients were transported at 32 weeks gestation or less and the infants were born at least 10 days

⁶³ High Risk Perinatal Program web site available at www.hs.state.az.us/phs/owch/hiriskper.htm

⁶⁴ Clement, M.S. Perinatal Transport in Arizona. February 2002.

after transport, the study estimates cost savings of \$5.6 million and no deaths compared to 12-15 deaths and costs of \$10.74 million if delivery had occurred at the time of transport.

In this evaluation the importance of delivery at a facility able to provide the appropriate level of care is clear: infants weighing less than 750 g at birth and then transported had a 90-100% mortality rate compared to similar infants delivered at a level III facility who had a 50% mortality rate. For infants weighing more than 750 g but less than 2500g at birth, higher rates of morbidity (disability) were seen for those transported as compared to those delivered at level III facilities.⁶⁵

The Role of Medicaid in Financing a System of High-Risk Services

In 2002, 48.6% of Arizona births were covered by AHCCCS (Medicaid), compared to 26.5% in 1989. Medicaid supports HRPP by reimbursing specialty facilities at higher rates for the full range of perinatal services they provide. Medicaid also reimburses for emergency transport of the pregnant woman based upon the approval of the consulting perinatologist. This reduces financial uncertainty about whether a transport will qualify for reimbursement by Medicaid. Medicaid also pays for the community nurses who follow up with high-risk babies and families once they return to their communities.

Challenges, Room for Improvement

Arizona is working to achieve follow-up with a higher percentage of the infants discharged from the HRPP system. Only 54% of eligible infants received follow-up home visits in 2002. The use of “back transport” (transport of the infant back home to a community hospital) could be utilized more frequently. Medicaid does not pay for that service, which limits its use. The impact of managed care systems on where patients are transported needs to be monitored.

From a financial standpoint, it appears that Arizona could structure its Medicaid program to provide additional support to HRPP. For example, the State Health Department activities and the Arizona Perinatal Trust Activities involved with administering the system could be viewed as Medicaid Administration (program planning and development). This would permit the state to claim federal financial participation for a portion of those costs. The contract with physician specialists to provide telephone consultation to community physicians might be considered an element of administering the Medicaid program. Skilled medical professionals working for the state who make decisions about the appropriate level of care for Medicaid beneficiaries are reimbursed at an enhanced 75% rate by the federal government; the standard federal matching rate for administration is 50%.

Other States Using this Intervention

Following the 1971 endorsement by the American Medical Association (AMA) of the importance of regionalized perinatal care, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the AMA and the March of Dimes formed

⁶⁵ High Risk Perinatal Program available at <http://www.hs.state.az.us/phs/owch/hiriskper.htm>, accessed May 18, 2004

a Committee on Perinatal Health. Their work culminated in "Toward Improving the Outcome of Pregnancy: Recommendations for the Regional Development of Maternal and Perinatal Health Services" which was published by the March of Dimes in 1976. Responding to the need for further development, the Robert Wood Johnson Foundation (RWJ) funded eight sites between 1975 and 1979. Arizona was one of the eight sites. A key feature and accomplishment of the RWJ effort was the Problem Oriented Perinatal Risk Assessment System, which consisted of a common set of forms and reporting documents for all of the facilities involved in these projects.⁶⁶ Not only was maternal transport added to the system of infant transport, but educational activities and data collection and evaluation occurred as well. At the conclusion of the project, RWJ permitted Arizona to use remaining funds to establish the Arizona Perinatal Trust.

Many states have a system of regionalizing Perinatal Services for high risk women. The role of the state varies tremendously. About half have legislation or state guidelines; the remainder utilize more informal systems. Many states rely on self-declarations by health care facilities in regard to meeting criteria for designation. AHA data shows that the rates of neonatal special care and intensive care beds per 10,000 births varied dramatically from region to region. The highest rates were in the West South Central part of the US with 62 beds per 10,000, followed by East South Central region at 58 beds per 10,000. The lowest region was the Pacific with 36 beds per 10,000. The National Perinatal Information Center (a private organization of Centers) surveyed 1,208 hospitals that indicated involvement in high-risk perinatal care in the American Hospital Association annual survey. The base year for data collection was 1997. Some 790 hospitals responded with detailed information on maternity units, the level of obstetrical high-risk services, neonatal specialty and subspecialty services, and staffing levels of these perinatal services. Thirty-five percent of the centers were staffed by one or more neonatologists on a 24-hour basis. Over half had a maternal fetal medicine specialist on staff or on consultant status, but only 120 hospitals had an organized maternal transport team. In contrast, some 354 hospitals had an organized neonatal transport team. Survey results for perinatal centers are posted by state clusters (by hospital).⁶⁷

Another interesting reference on state perinatal system organization is available from the Women's and Children's Health Policy Center at the Johns Hopkins School of Public Health. Sponsored by HRSA it includes profiles of Arkansas, Colorado, Georgia, Indiana, Missouri, New Jersey, Oregon, Virginia, Washington and Wisconsin.⁶⁸

Taking the next steps in your state:

If you are interested in improving preterm birth outcomes through optimal medical care services in your state, here are some places to begin:

⁶⁶ Holloway M. "Chapter 8: The regionalized perinatal care program" in To Improve Health and Health Care 2001: The Robert Wood Johnson Anthology, Isaacs SL and Knickman JR, eds. Jossey-Bass San Francisco 2001: 175-193

⁶⁷ National Perinatal Information Center, Survey available at www.npic.org accessed May 1, 2004

⁶⁸ Strobino DM, Grason HA, Koontz AM, Silver GB, 2000. Reexamining the Organization of Perinatal Services Systems: A Preliminary Report. Baltimore, MD: Women's and Children's Health Policy Center, Johns Hopkins School of Public Health. Available at www.jhsph.edu/WCHPC/Projects/orgperinatal.html

- Determine if your state currently has a regionalized perinatal network. If so, who administers it, what are the components and what are the outcomes and issues?
- Do obstetric health care providers throughout the state have ready access to consultation for high-risk pregnancies?
- Find out how transfers of high-risk pregnant patients are approved and by whom. In some facilities, maternal transports are accepted by the obstetric physician on-call for labor and delivery, in others the transfer must be approved by the hospital perinatologist.
- Do patients remain the responsibility of the sending or receiving facility during transfer? While either system is workable, both the sending and receiving hospitals must have clear policies and procedures about responsibility and liability during transport.
- Are transport capabilities adequate? Are all forms of transport (ground and air) readily available, or do factors (such as weather, or multiple demands on limited transportation forms) affect availability?
- Is there reliable information about outcomes for infants and mothers who are transported, and for those who are not? If not, what data collection and verification systems need to be developed so that outcomes can be determined and tracked over time?
- Does your state have a certification system for hospitals and for transportation providers? What is required to achieve and maintain certification? Does Medicaid financially support the higher standards in Level II and III facilities?
- Community nursing services help the preterm infant, mother and family transition from the hospital to home. Do those services exist and are they well-coordinated?
- Does home visiting continue after the acute phase of transition home? Is there a system to identify and refer at-risk infants with developmental delay and/or other special needs?
- If your state does not have a regionalized perinatal network, then in addition to the questions above, what are the patterns of referral in your state?
- Do referrals include hospitals outside of your state?

Additional Resources:

Deb Christian, Executive Director of the Arizona Perinatal Trust
480-814-0323, Email Deb@azperinatal.org

Jeanette Shea-Ramirez, Chief of the Office of Women and Children's Health, AZ Department of Health Services
602-364-1419, Email: jsheara@hs.state.az.us

Barbara J. Hess
Program Manager, Community Nursing Services and Developmental Follow-up
(602) 364-1430, Email: bhess@hs.state.az.us

Christine Parayno, HRPP Unit Manager
(602) 364-1453 Email: paraync@hs.state.az.us

Program web site: <http://www.hs.state.az.us/phs/owch/hiriskper.htm>

**Using Medicaid/ SCHIP to
Support Preterm Birth Prevention:
Five Case Studies**

**By Elinor Hall, MPH
Michelle Berlin, MD, MPH**

Appendices Table of Contents

Appendix A:	Evaluation Results from Dr. Olds and colleagues
Appendix B:	CMS Letter on Targeted Case Management
Appendix C:	CMS Letter to Medicaid Directors on coverage of cessation
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Appendix A: Evaluation Results from Olds and Colleagues

Olds and colleagues have conducted three major implementations and evaluations of their nurse home visiting model. Programs were implemented in Elmira, N.Y (1978), Memphis, Tennessee (1991) and Denver, Colorado (1994-99). Each study randomized high-risk first time pregnant women into groups that received home visiting and a control group who did not. The Elmira women were predominately white, aged 19 or under at the start of the study, unmarried and from low socio-economic backgrounds. The Memphis women were African American (92%), unmarried (98%) and young (64% were aged 18 or under at the start of the program). The Denver women were predominantly Hispanic (45%), unmarried (84%) and averaged 19 years old. The outcomes of each intervention and control group were compared over time.

This research, and an independent evaluation of the studies by the Rand Corporation, documented numerous positive effects on “maternal life course” and the maternal-infant relationship for women who received home visiting compared to women in control groups.² Women who received home visiting demonstrated a:

- 25% reduction in cigarette smoking during pregnancy among women who smoked cigarettes at registration
- 56% fewer hospital emergency room visits where injuries were detected
- 79% reduction in rates of child maltreatment among at-risk families from birth through the child’s 15th year
- 43% reduction in subsequent pregnancy among low-income, unmarried women by first child’s fourth birthday (31% reduction through age 15, with two years’ greater interval between birth of first and second children)
- 83% increase in the rates of labor force participation by first child’s fourth birthday
- 30 month reduction in AFDC (now TANF) utilization among low-income, unmarried women by first child’s 15th birthday
- 44% reduction in low-income, unmarried mothers’ behavioral problems due to alcohol and drug abuse over the 15 years following program enrollment
- 69% fewer arrests among low-income, unmarried mothers over the 15 years following program enrollment
- 54% fewer arrests and 69% fewer convictions among the 15 yr. old children of mothers enrolled in the program
- 58% fewer sexual partners among the 15 yr. old children of mothers enrolled in the program
- 28% fewer cigarettes smoked and 51% fewer days consuming alcohol among the 15 yr. old children of mothers enrolled in the program

² Olds, D.L., Eckenrode, J., Henderson, Jr. C.R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L.M. & Luckey, D. (1997). Long term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial. The Journal of the American Medical Association, 278, 637-643. Kitzman, H., Olds, D.L., Henderson, Jr. C.R., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K.M., Sidora, K., Luckey, D.W., Shaver, D., Engelhardt, K., James, D. & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. The Journal of the American Medical Association, 278, 644-652.

In the Elmira study the positive impacts of the program on preterm births were demonstrated most strongly in women who smoked thirty or more cigarettes at intake. The fact that they stopped or reduced tobacco use helped to account for the reduction in pre-term births. In Memphis, where fewer women smoked heavily, this effect was not shown.

The effectiveness of the Nurse-Family Partnership model may be due to the fact that it provides intensive services beginning during early pregnancy and continuing for two years of new motherhood. The “dose” of support provided by the program is high. Nurse home visitors are carefully selected, systematically trained and supervised. They address specific health needs and issues using standardized guidelines. Therefore the quality of the program is uniform. Women who are enrolled in the program are first-time mothers; who may indeed be more receptive to intervention and help at this point in their lives than are women with previous births. The program design and the intensity and duration of the interventions permit multiple health and social issues present in high-risk clients to be addressed.

Appendix B: Letter to State Medicaid Directors on Targeted Case Management

This letter defines case management and provides other useful information about the service. Interfacing TCM with Title IV-E services may or may not be relevant in program design for your population. The letter was accessed on the internet February 8, 2004 at www.cms.hhs.gov/states/letters/smd119c1.asp.

January 19, 2001

Dear State Child Welfare and State Medicaid Director:

The Department of Health and Human Services (HHS) is dedicated to providing support to children and other populations who receive case management services. We want to take this opportunity to clarify HHS policy on targeted case management services under the Medicaid program as it relates to an individual's participation in other social, educational, or other programs.

When social programs or other programs are also the providers of Medicaid case management services, a number of complex issues may arise. This letter clarifies existing HHS policy regarding State plan case management and Title IV-E foster care programs. Specifically, this letter discusses: (1) the Medicaid definition of case management services, (2) whether services provided to individuals not eligible for Medicaid, or eligible but not part of the target population, can be covered, and (3) application of third party liability rules.

Please note that we anticipate issuing additional guidance for State plan case management, as it relates to all programs through notice and comment rulemaking in the future.

I. Definition of Case Management Services

Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define case management as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services are referred to as Target Case Management (TCM) services when the services are not furnished in accordance with Medicaid statewide or comparability requirements. This flexibility enables States to target case management services to specific classes of individuals and/or to individuals who reside in specified areas.

Because the statute permits states flexibility to target Medicaid case management services based on any characteristic or combination of characteristics, States may use eligibility for, or participation in, a state social welfare program or other programs as the basis for defining the target population among Medicaid eligible individuals. Foster care programs employ their own case workers who, in addition to facilitating the delivery of foster care benefits and services, help individuals access and coordinate the delivery of other services. When foster case workers are also enrolled in Medicaid as providers of case management services, States must undertake a careful review to ensure the activities to be claimed under Medicaid meet the definition of case management and are not directly connected to the delivery of foster care benefits and services.

While HCFA has not further defined case management services in regulations, activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up. When consistent with Medicaid requirements discussed below, Medicaid can be used to supplement these activities for Medicaid eligible individuals when they are embedded in another social or other program. We discuss below activities that are allowable case management as well as activities that would be unallowable as case management. In general, allowable activities are those that include assistance in accessing a medical or other service, but do not include the direct delivery of the underlying service.

Assessment: This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the Medicaid eligible individual.

Care Planning: This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the Medicaid-eligible individual and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medicaid eligible individual.

Referral & Linkage: This component includes activities that help link Medicaid eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

Monitoring/Follow-up: This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid eligible individual. The activities and contacts may be with the Medicaid eligible individual, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid eligible individual's care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

Unallowable services: Medicaid case management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred. For example, if a child has been referred to a state foster care program, any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as case management. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as case management. In the case of foster care programs, we view the following activities as part of the direct delivery of foster care services and therefore may not be billed to Medicaid as a case management activity.

The following list is intended to be illustrative and not all-inclusive: research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements. During the State plan approval process, HCFA will provide guidance to determine Medicaid billable activities.

II. Contacts with Non-eligible or Non-targeted Individuals

There is confusion involving contact with individuals who are not eligible for Medicaid or, in the case of targeted services, individuals who are Medicaid eligible but not part of the target population specified in the State plan. HCFA policy permits contacts with non-eligible or non-targeted individuals to be considered a Medicaid case management activity, and to be billed to Medicaid, when the purpose of the contact is directly related to the management of the eligible individual's care. It may be appropriate to have family members involved in all components related to the eligible individual's case management because they may be able to help identify needs and supports, assist the eligible individual to obtain services, provide case workers with useful feedback, and alert them to changes.

On the other hand, contacts with non-eligibles or non-targeted individuals that relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care cannot be billed to Medicaid. While the nature of the contacts may squarely fall into one of the components of case management (i.e., assessments, care planning, referral and follow-up), Medicaid cannot be used to pay for them due to the fact that the individual is not Medicaid eligible or is eligible but does not meet the targeting criteria set by a State in its State plan amendment.

III. Third Party Liability

In accordance with Medicaid third party liability policy, Medicaid would only be liable for the cost of these services if they fall within the definition of case management and there are no other third parties liable to pay.

The Administration for Children and Families has clarified that the Title IV-E program does not authorize reimbursement for the assessment, care planning, and monitoring of medical care and services. Since the Title IV-E program is not liable for the assessment, care planning, and monitoring of medical care needs, the cost for such activities could be billed to the State Medicaid program if the activities are furnished to a Medicaid eligible individual who is a member of a target group defined in the State plan. This also assumes that there is not another third party payer available to cover the costs of medical case management services provided to a Medicaid eligible individual.

In contrast, referrals to medical care providers are Title IV-E reimbursable. This means that referrals are not billable to Medicaid. Because Title IV-E is liable for covering case management for a range of other services (including referrals to medical care), States, which offer Medicaid case management services to foster care populations, must properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program.

Page 4 - State Child Welfare and State Medicaid Director

If you have any questions, please contact Mary Jean Duckett, Director, Division of Benefits, Coverage and Payment, Disabled and Elderly Health Programs Group at 410-786-3294.

Sincerely,

/s/

Olivia A. Golden
Assistant Secretary for Children and Families

/s/

Timothy M. Westmoreland
Director
Center for Medicaid and State Operations
Health Care Financing Administration

cc:

ACF Regional Administrators
HCFA Regional Administrators

last Modified on Friday, April 26, 2002

Appendix C: Letter to State Medicaid Directors on Cessation Coverage

January 5, 2001

Dear State Medicaid Director:

I am writing to make you aware of the most recently published Public Health Service (PHS) Clinical Practice Guideline related to tobacco usage and the implications this Guideline may have for Medicaid coverage of smoking cessation drug therapy and counseling programs. The Guideline, *Treating Tobacco Use and Dependence*, released June 27, 2000, reflects the latest research on treating tobacco use and addiction and recommends tools to help individuals stop the use of tobacco. It was developed by a public and private consortium convened by the U.S. Public Health Service. The Guideline is an update to the 1996 Smoking Cessation, Clinical Practice Guideline No. 18, which was sponsored by the Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ)(formerly the Agency for Health Care Policy and Research).

Research has shown that physicians and health care plans have an important role in improving tobacco cessation success rates. Health care plans which have increased smoking cessation rates have demonstrated ways in which the health delivery system can support program changes and staff training necessary for implementing the evidence-based protocols. Unfortunately, models that research has proven to be successful have not yet been widely adopted and implemented. The updated Guideline describes scientifically validated treatments and offers clear guidance to clinicians, employers, insurers, health benefits managers, and others on how such treatments can be consistently and effectively integrated into health care delivery. The Guideline illustrates programs and therapies that been proven effective, and proven to help prevent tobacco-related illnesses and deaths. It also can be a valuable resource for evaluating and improving existing State and Federal smoking cessation programs. With this new information, the challenge to all clinicians, Medicaid and other insurance plans, purchasers, and medical school officials is to promote the use of the Guideline and to make treating tobacco dependence a top priority.

At their option, States can cover prescription and certain non-prescription smoking cessation drugs for Medicaid beneficiaries. Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) component of Medicaid, States are required to cover smoking cessation drug therapy when it is determined medically necessary for eligible individuals under age 21. States also are required as part of the EPSDT screening component to discuss tobacco use and provide counseling for smoking cessation to children and adolescents at appropriate ages. The Guideline indicates that there is no evidence that certain drug therapies are harmful for children and adolescents, and use of smoking cessation drug therapies should be considered when tobacco dependence is obvious. The Guideline cautions that because many adolescents who smoke do not intend or are not motivated to quit, providers should give considerable thought before recommending smoking cessation drug therapy.

In addition, State Medicaid programs are required to provide pregnancy-related services that are necessary for the health of the pregnant woman and the fetus. States also may provide enhanced pregnancy services that are not otherwise specified in the State plan (CFR 42, section 44.250).

The Guideline provides evidence that smoking during pregnancy can cause adverse fetal outcomes, including stillbirths, spontaneous abortions, decreased fetal growth, premature births, low birth weight, placental abruption, sudden infant death syndrome (SIDS), cleft palates and cleft lips, and childhood cancers. The Guideline also points out that relapse from smoking cessation during the postpartum period (i.e., second-hand smoke) can produce poor health outcomes in infants and children such as SIDS, respiratory infections, asthma, and middle ear disease. States should encourage health care providers to screen all pregnant women for tobacco use and provide smoking cessation counseling and appropriate treatment as needed.

Currently, about half of the State Medicaid programs cover some type of smoking cessation drug therapy, and about a fifth of the States cover smoking cessation counseling. In light of the updated findings and recommendations, we strongly encourage State Medicaid agencies to consider the benefits of promoting smoking cessation, and recommend that you provide coverage for smoking cessation drug therapy and counseling. Moreover, State Medicaid agencies must ensure that such services are available to pregnant women and children as appropriate under EPSDT. States should encourage providers to screen for tobacco use and make recommendations for smoking cessation treatments. States should also make sure that Medicaid managed care contracts specifically reflect coverage for these services. Under the terms of the Drug Rebate Program, States that do cover smoking cessation drugs would receive a full statutory rebate for these drugs from the manufacturer.

Enclosed is a copy of the Executive Summary that outlines the key findings and recommendations of the Guideline. You can access a copy of the full report from AHRQ's website: <http://www.ahrq.gov>, or call 1-800-358-9295 to obtain a free copy of Treating Tobacco Use and Dependence: A Public Health Service Clinical Practice Guideline, and a companion consumer guide You Can Quit Smoking. You also may write to AHRQ Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD, 20907-8547 to order these publications.

If you would like additional information about the PHS Guideline and how your State can work with the Public Health Service to implement smoking cessation programs in your State, you may contact Harriett Bennet, AHRQ, at (301) 594-6119 or email her at hbennett@ahrq.gov. For any Medicaid related questions, you may contact Marlene Jones, HCFA, at (410) 786-3290 or email her at mjones3@hcfa.gov.

Sincerely,

/s/

Timothy M. Westmoreland
Director

Appendix D: Oregon Smoke-Free Mothers and Babies Project: Five A's Intervention Record (FAIR)



Client name: _____ Date of birth: _____

On each visit (one column per visit) → Enter **Date/Initials**

ASK all new clients about their smoking status. Complete all that apply for clients who currently smoke or who have smoked in the past 6 months.

If client quit smoking **LESS** than 6 months ago, → enter most recent quit **date** (or approximate date).

Is client currently smoking? **YES** → Enter # cig/day.

NO → Go to Arrange.

ADVISE smoking client to quit. Client was advised →

ASSESS willingness to make a quit attempt within 30 days.

Is client ready to try to quit? **YES** →

NO, motivational counseling provided. →

▲ Go to Arrange.

ASSIST client with quitting. Check all that apply.

Information and referrals provided? **YES** →

Accepted referral to the Quit Line? **YES** → Planned

NO →

ARRANGE follow-up visit. **Check** if next visit planned.

-

-

-

-

Sent to provider?

YES → Check

NO → Check

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Initials _____ Signature _____ Printed Name _____
Agency _____

Initials _____ Signature _____ Printed Name _____
Agency _____

Appendix E: Medicaid Administration Activities

By Elinor Hall

The federal Medicaid program reimburses states 50% of the cost of performing administrative activities that are necessary for the effective, efficient administration of their Medicaid programs. States may contract with other entities, including counties and local education agencies (and subcontractors to these entities), to perform administrative activities that assist Medicaid eligible individuals and families to access health care services. The administrative activities that are reimbursable as Medicaid Administration may include the following:

- ***Marketing/Outreach***
 - Outreach about available Medicaid funded programs and referral of Medicaid enrollees to Medicaid covered services (local Medicaid participating clinics, physicians, dentists, etc.)
 - Information and referral to Medicaid eligibility offices and/or assistance with completing applications
 - Referral to entities in the community providing Medicaid services

- ***Assisting with Access***
 - Assisting with the Medicaid program enrollment process
 - Translation in order to enroll or access health programs
 - Assisting with transportation to Medicaid services

- ***Health Program Planning***
 - Analysis and planning of Medicaid/health services
 - Collaboration with others to fill gaps in Medicaid/health services

The amount of money a state can be reimbursed for administering Medicaid is not capped and states have broad discretion to contract with entities that can assist them. Administrative services rendered, and the associated costs of those services, are documented most typically by the use of a time survey conducted one to four times per year. Contractors submit their invoices for administrative activities to the state and the state submits an overall Medicaid administration cost to the feds. Thus a state can draw down 50% federal reimbursement for Medicaid administrative activities conducted by local entities under contract to the state.

Typically the federal government pays half of the allowable administrative costs and the state pays the other half, which is known as the “local share”. The federal government allows states to accept funds from other government entities, or certification that the funds have been spent, in order meet the state’s 50% “local share”. This permits a local government entity that is currently conducting Medicaid administrative activities (or sub-contracting for those activities), to be reimbursed for 50% of allowable costs with federal funds using its existing expenditures as the “local match”.