Continuity of Care for Pregnant Women and Children in an Uncertain Environment

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Dania Palanker, J.D., M.P.P.

Uncertain Policy Environment

Image Credit: "Weather Forecast (Improving!)", by David Spender is licensed under CC BY 2.0
Federal Health Funding is Unknown - CHIP

- Children’s Health Insurance Program (CHIP)
  - Funded through September 2017
  - Federal Legislation Needed to Extend Funding
Federal Health Funding is Unknown - Medicaid

- Federal funding reduced by $800 billion in American Health Care Act (AHCA)
- Medicaid expansion funding could be reduced or eliminated
- Per capita caps would fundamentally change federal/state partnership shifting risk to states
- Block grant option could allow for significant restructuring and elimination of programs at state level

Private Insurance Options Unknown – Marketplaces

- Future of Health Insurance Marketplaces at Risk
  - Premium subsidies may be reduced
  - Premium subsidies may shift away from marketplaces
  - Payments to insurers to reimburse for lower cost-sharing plans for low income enrollees may end
  - Insurer participation is declining in some areas
Private Insurance Options Unknown – Protections

- Insurance Protections May Change
  - Continuous coverage requirement could mean increased premiums if a woman or child has a coverage gap
  - Elimination of Essential Health Benefit requirement could mean individual market plans no longer coverage maternity care and other services
  - Health status rating could mean women and children charged more for pre-existing conditions

Moving Forward through Uncertainty

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Help Women and Parents Make Choices

Rhetoric vs Reality
- Lots of information and misinformation about health reform
- Challenge to make people aware there are no changes now
- If federal policy changes, need to differentiate between current and future eligibility

Enrollment Timing
- Individual market special enrollment opportunities
  - 60 days from end of coverage
  - 60 days from birth of child
- When coverage terminates
- When eligibility redetermination

Providing Access and Information
- Navigators and enrollment assisters need to understand where gaps may occur
- Providers should be prepared to help women and parents be aware of options and resources

Plan Contracting & Insurance Requirements

Managed Care Organization (MCO) Contracting
- Transition plans
- Readiness reviews
- Health information sharing

Network Adequacy
- Align provider networks between Medicaid, CHIP and private market
- Adequate network of ob/gyn, pediatricians, hospitals

Care Transition when Change Plans
- Coverage of ongoing course of treatment, including keeping provider (through postnatal for pregnant women)
- Acceptance of prior authorization
Reduce Churn: Keep Women and Children Enrolled

Eligibility Policies
- 12 month continuous eligibility
- Presumptive eligibility

Enrollment Procedures
- No wrong door – don’t lose woman or parent once they contact the state
- Close any existing backlogs delaying enrollment

Notice
- Multiple avenues of notification when coverage terminating
- Clear options for other coverage
- Clear whose coverage terminating

Know Your Gaps in Coverage

Image Credit: “Mind The Gap” by Allen Brewer is licensed under CC BY 2.0
When is care disrupted?

• Newly eligible
• Transitioning off Medicaid after postnatal period
• Changing eligibility between programs
• Shifting to private insurance
• Eligibility redetermination
• Incarceration or post-incarceration
• More...

When are women and children in your state having coverage disruption?

Thank you!

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Maryland Medicaid Enrollment and MCOs

- Total Enrollment: about 1.2 million
  - Over 20% of Marylanders receive health coverage via Medicaid.
  - 85% are currently enrolled in a HealthChoice managed care organization (MCO)

- Beneficiaries choose from 8 Medicaid MCOs
ACA’s Impact on Medicaid/ Maryland Children’s Health Program (MCHP) Eligibility

Maryland leveraged the policy and financial levers under the Affordable Care Act to expand its program and provide health coverage to a greater number of residents, including children and pregnant women.

<table>
<thead>
<tr>
<th>Coverage Group</th>
<th>Pre-ACA</th>
<th>Post-ACA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (varies across age brackets and household income)</td>
<td>300%</td>
<td>322%</td>
</tr>
<tr>
<td>Former Foster Care (under 26 years old)</td>
<td>N/A</td>
<td>No income limit</td>
</tr>
<tr>
<td>Parents and Caretakers</td>
<td>116%</td>
<td>123%</td>
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<tr>
<td>Pregnant Women</td>
<td>250%</td>
<td>264%</td>
</tr>
<tr>
<td>Childless Adults (only primary care)</td>
<td>116%</td>
<td>138%</td>
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</table>

*Income level based on the Federal Poverty Level (FPL)

Coverage for Maryland Children

- In Maryland, eligible children are covered under Medicaid, MCHP, and MCHP Premium.
- Over 600,000 children served
- MCHP is a Medicaid expansion CHIP program, so...
  - Children in Medicaid and MCHP receive similar benefit packages
  - MCHP enrollees also enroll in and have their care managed by a HealthChoice MCO
  - MCHP is not subject to capped funding allotments set under CHIP
- MCHP Premium is an extension of MCHP
  - Offers coverage for children in households with incomes between 211% - 322% FPL for a nominal premium; no premium for families under 211% FPL
MCHP Household Income Guidelines

### 2017 MCHP Income Guidelines

<table>
<thead>
<tr>
<th>Household Size</th>
<th>MCHP 211% FPL</th>
<th>MCHP 264% FPL</th>
<th>MCHP 322% FPL</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$25,447</td>
<td>$31,838</td>
<td>$38,833</td>
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<tr>
<td>2</td>
<td>$34,266</td>
<td>$42,874</td>
<td>$52,293</td>
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<td>3</td>
<td>$43,086</td>
<td>$53,909</td>
<td>$65,752</td>
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<tr>
<td>4</td>
<td>$51,906</td>
<td>$64,944</td>
<td>$79,212</td>
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</table>

### MCHP Benefits

- Similar to children in Medicaid, MCHP enrollees have access to a robust benefit package including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).
- Benefits include, but are not limited to:
  - doctor visits, including well and sick care;
  - hospitalization;
  - lab work and tests;
  - dental care;
  - vision exams and corrective lenses;
  - hearing exams and hearing aids;
  - immunizations;
  - prescription drugs;
  - transportation to medical appointments;
  - mental health services; inpatient and outpatient behavioral health services;
  - physical and occupational therapy;
  - services for speech, hearing and language disorders; and
  - durable medical equipment.
## EPSDT in Maryland

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is Medicaid’s comprehensive and preventative health benefit program for children under 21.
  - The program was federally authorized in 1967
  - All medically necessary health care services must be made available for treatment of all physical or mental health or conditions discovered by any screening and diagnostic procedure.
- Maryland has the Healthy Kids Program, the preventative care arm of the overall EPSDT program
- Standards for Healthy Kids program were developed through collaboration with key stakeholders, including:
  - Dept. of Health & Mental Hygiene Prevention and Health Promotion Administration
  - Maryland Chapter of the American Academy of Pediatrics
  - University of Maryland Dental School
  - Maryland Department of the Environment

## Maryland Healthy Kids Program

- The Maryland Healthy Kids Preventative Health Schedule closely correlates to the American Academy of Pediatrics’ periodicity schedule. It covers six areas:
  - Health history and development;
  - Physical examination;
  - Risk assessments by questionnaire;
  - Laboratory tests;
  - Immunization; and
  - Health education.
- The program provides practice-based performance improvement assessments and targeted interventions to enhance quality of services.
Continuity of Coverage / Choice of Coverage for Pregnant Women

• Pregnant women are eligible for Medicaid up to 250% of FPL
• Maryland allows women to stay in Qualified Health Plan (QHP) coverage if they affirmatively choose to do so
• 12,000 individuals switched from QHP to Medicaid during the most recent open enrollment and 4,000 individuals switched from Medicaid to QHP during open enrollment.
  – Compared to our total QHP related determinations during open enrollment, that was almost 10%.
  – If we compare that to total enrollment of Medicaid and QHP, it is about 2% - small, but not insignificant.

New Initiatives
Reduce Lead Poisoning and Improve Asthma

• Dept. of Health & Mental Hygiene (DHMH), in partnership with the Department of the Environment and the Department of Housing and Community Development applied to the Centers for Medicare and Medicaid Services to develop an initiative to reduce lead poisoning and to improve asthma.

• The program will be funded with CHIP administrative dollars to eliminate sources of lead poisoning in housing, to build capacity in local health departments to reduce lead poisoning and asthma related to housing conditions, and to address lead and asthma health disparities.

Reduce Lead Poisoning and Improve Asthma (cont’d)

• The new program would have two parts: lead abatement and eliminating sources of lead exposures and asthma triggers in homes.

• If approved, up to $3.7 million dollars in CHIP federal matching funds could be available to the State, to supplement $500,000 in Medicaid general funds for lead abatement purposes.

• An additional $2.6 million could potentially be available to the State in fiscal year 2018 to build training capacity for community health workers stationed in local health departments’ programs that serve families with children affected by lead or asthma.
Home Visiting

- Effective July 1, 2017, Maryland will provide Medicaid reimbursement through an evidence-based home visiting services pilot program.

- The pilot program is aligned with two evidence-based models focused on the health of pregnant women: Nurse Family Partnership and Healthy Families America.
  
  - Home visiting services are provided by licensed practitioners OR certified home visitors to promote health outcomes, whole person care, and community integration for high-risk pregnant women and children up to two years old.

- Services provided under the pilot include prenatal, postpartum and infant home visits.

Thank you!
Extraordinary Challenges in Arkansas

- 48th in terms of overall health, according to United Health Foundation
- One in three (31%) of households have incomes less than $25,000 per year
- 62 of 75 counties (82%) are classified as rural
- State saw a 13% increase in infant mortality rate from 2006 to 2014 (infant mortality rate is 22% higher than national average)
- 39% of K-12 students had BMI in overweight or obese category (2013-2014 data)
- Highest teen birth rate in nation (60% higher than average)
- 49th nationally for average life expectancy
Medicaid Picture

- In 2013, Medicaid coverage was expanded to cover those with income up to 138% Federal Poverty Line, FPL, (up from 17%) by using 100% federal Medicaid money to purchase individual insurance coverage from the market for qualifying individuals.
- Program became known as the Private Option, now is Arkansas Works
- Approximately 300K Arkansans (2.95 million total population) are covered by Medicaid expansion
- 67% of births are paid by Medicaid
- Arkansas uninsured rate decreased by more than half, down to 9.1% from 2013-15
- ARKids A and ARKids B cover 400,000 children in Arkansas

Financial Considerations

- Pregnant women up to 209% FPL covered through traditional Medicaid
- Child receives traditional Medicaid for 12 months if Mom was eligible
- No look back on Medicaid beneficiaries through 60 days postpartum
- Private Option/Arkansas Works increased access to care because of high reimbursement rate

“Those we are able to touch with a program are showing progress.”
Brad Planey, ADH
Federal Grants, Programs Used in Arkansas

- MCH Federal Block Grant to Arkansas Department of Health (ADH)
  - 32% goes to DHS for children with special healthcare needs
  - ADH provides maternity clinics through birth and further
  - ADH using home visiting grants through Nurse Family Partnership
- Federal “Follow Baby Back Home” started in 2009
  - Home visiting by nurse for referrals from neonatal intensive care unit (NICU) only
  - Visit approximately 180 babies per year
- Federal “Parents as Teachers” grant formed over 20 years ago
  - One-on-one personal visits
  - Group connections
  - Health and developmental screenings for children

The Commonwealth of Virginia

Blue Ridge
Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health

Baltimore, Maryland
May 22, 2017

Continuity of Coverage and Care for Pregnant Women and Children

Cornelia Ramsey Deagle, PhD, MSPH
MCH/Title V Director
Director, Division of Child and Family Health
Office of Family Health Services

Virginia ...

Population 8,260,405
Square Miles 39,490

State Insect Tiger Swallowtail Butterfly

State Fish Brook Trout

... and famous...
11 Native Tribes
Arthur Ashe
Warren Beatty
Pat Benatar
Sandra Bullock
Dave Matthews
Pocahontas
Wanda Sykes
Maggie Walker
George Washington
Elliot Yamin
Virginia...

A major cash crop & industry is tobacco
Norfolk is home base for US Naval Atlantic Fleet
Rich Diversity
  • Largest Salvadoran population in the US
  • Other communities include Vietnamese, Filipino, Mexican and Puerto Rican
2010 Census
  • 68.6% White
  • 19.4% Black
  • 5.5% Asian
  • <1% Native American

MCH Data Facts

Births
Over 100,000 births each year
57 birth hospitals

Access and Quality
102 HRSA Medically Underserved areas
13 HRSA Medically Underserved populations

Health Professionals Shortage Areas (HPSAs)-HRSA designated
  • 108 Primary Medical Care
  • 88 Dental
  • 75 Mental Health
MCH Data Snapshot

<table>
<thead>
<tr>
<th>Issue</th>
<th>VA</th>
<th>US</th>
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<tbody>
<tr>
<td>Maternal Mortality</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>Infant Mortality*</td>
<td>6.0</td>
<td>5.9</td>
</tr>
<tr>
<td>LBW*</td>
<td>8.0</td>
<td>8.1</td>
</tr>
<tr>
<td>Preterm births*</td>
<td>9.2</td>
<td>9.6</td>
</tr>
<tr>
<td>Cesarean births</td>
<td>33.1</td>
<td>32.2</td>
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</table>

*very large racial disparities make these issues priorities in Virginia

Areas of Disparities

**The darker areas have a higher infant mortality disparity (Black vs. White Ratio)
Success 1: Virginia’s Title V Transformation

1. Fully Embracing MCHB Transformation
2. Formalization of MCH/Title V Executive Committee
3. Comprehensive Complex Coordination of Care - Systems Building Approach
   - Medical Neighborhood
   - Full Family Involvement - at all stages
4. Emphasize Continuous Quality Improvement (CQI) or informal assessment

Virginia MCH Life Course Model for Health

Legend

Title V Health Domains
Population and Program Focus
Gap categories
Growth Areas

Health Domain 1
Women/Maternal Health

Health Domain 2 & 3
Infant & Child Health

Health Domain 4
Adolescent Health

Health Domain 5
Maternal and Infant Health

Health Domain 6
Cross Cutting (division, home visiting)

Universal Early Developmental Screening
ZIKA and Birth Defects Registry
Healthy Start, Resource Mothers
School Nursing
Abstinence Education Program
Healthy Young Men Initiative

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Success 2: Virginia’s Partnerships for MCH

Inter-agency partnerships improve MCH!

- Department of Behavioral Health and Developmental Services & Department of Social Services - *Handle with Care* - Opioid Use an “Emerging Issue” in Virginia (maternal and infant health)
- Department of Medical Assistance Services - Increased access to Quality Family Planning - *Presumptive Eligibility, unbundling reimbursement*
- Department of Education - Virginia Preschool Initiative (VPI) & Virginia Preschool Initiative Plus (VPI +) - (early childhood health and development, screening)

Success 2: Virginia’s Partnerships for MCH

Medical Neighborhood (Transition and Medical Home)
Strong Home Visiting Network linking to Maternal and Child Health systems of care In Virginia - Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), Healthy Start, Early Impact Virginia
Challenges to MCH in Virginia

Changes in Funding, Priorities, and Leadership
- Federal and State budgets over grant period
- Complimentary Programmatic Categorical and Block grants over Title V grant period
- Executive Branch changes every 4 years

Virginia did not expand Medicaid
Aging of public health workforce

Need to adapt programs to meet needs of diverse populations (i.e., geographically, economically, demographics etc.)

Questions