

## **Testimony to Metrics and Scoring Committee**

August 22<sup>nd</sup>, 2014

Helen Bellanca, MD, MPH

Dear Dr. Dannenhoffer, members of the committee and staff of OHA,

Thank you for the opportunity to provide testimony today. I am here to advocate for a new metric to be added to the list of incentive metrics in 2015:

### **Effective contraception use among women at risk of unintended pregnancy**

While I am aware that this metric is already under consideration by this committee, I would like to add additional information that I hope will persuade you to adopt it.

I am a family physician, and have worked in the primary care safety net system for many years in Oregon. I have worked with the Oregon Foundation for Reproductive Health for the past 5 years to create and develop the One Key Question® Initiative, which encourages primary care providers to screen women for their pregnancy intentions. I currently work for Health Share of Oregon as the Maternal Child Family Program Manager, I serve on the Technical Advisory Group for this committee, and I am a member of the newly appointed Child and Family Wellbeing Metrics subcommittee of the OHPB/ELC.

Of note, I also chair a national workgroup on contraception metrics, and I work with staff of the Association of Reproductive Health Professionals, the CDC and the Office of Population Affairs on the development of contraception metrics which would be viable for national endorsement. Currently, there are no nationally endorsed metrics on contraception or unintended pregnancy, but Oregon is seen as a leader on this issue because one of our CCO demonstration metrics is “Effective contraception use among women at risk of unintended pregnancy”.

### **I am proposing that we move this metric from the demonstration set to the incentive set for 3 reasons:**

1. **CCOs need a new women’s health metric.** This committee has already decided to retire the “Elective Delivery before 39 weeks” metric, and it is important to replace it with another women’s health metric as women and children comprise more than half of the Medicaid population, and Medicaid pays for nearly half of the deliveries in our state.
2. **CCOs need to reduce unintended pregnancies to improve outcomes.** Unintended pregnancies result in poorer health for families and worse social outcomes (poverty, derailment of jobs and education, foster home placement). An initiative to promote pregnancy planning in primary care will improve those outcomes. While families from all income levels experience unintended pregnancy, low-income women have 5.5 times the risk of unintended pregnancy as middle-income women. This is a critical issue in the Medicaid population.

3. **CCOs need to reduce costs.** While Medicaid pays for about 43% of all births in our state, Medicaid pays for 61% of the births that result from unintended pregnancies. That amounts to more than 10,000 births per year. If we conservatively spend \$8500 per birth, those unintended births result in \$85 million in Medicaid spending per year for prenatal and delivery costs alone. Reducing unintended pregnancies by just 10% would produce \$8-10 million in cost savings, and it would help families meet their own goals for the number and spacing of their children.
  
4. **It is feasible to measure in meaningful ways.** There are claims and clinical data sources for this, as well as public health survey data (which is why it is a current CCO demonstration metric). We have national and state data on the use of various methods to develop targets and benchmarks. We have technical support for clinicians to implement this work through the Oregon Foundation for Reproductive Health and the One Key Question initiative. All primary care provider organizations in Oregon (OMA, OAFP, Oregon chapter of ACOG, and 19 other organizations) support pregnancy intention screening in primary care, so providers are more likely to be engaged.

I think it would be most effective for CCOs to move this metric from the core demonstration set to the incentive set: **“Effective contraception use among women at risk of unintended pregnancy”**

I have worked with my colleagues here in Oregon and nationally to develop specifications of this metric and have attached some draft specifications. While it is possible to use only administrative data for this metric, it will be more meaningful and accurate with clinical data.

However, there is another metric being proposed by the CDC and OPA for national endorsement which is based entirely on administrative data and is also worthy of consideration:

**“The proportion of women who received contraceptive services in the past 12 months who adopt or continue to use the most effective forms of contraception”**

National specifications for this metric are still under development, but the draft specifications from that national work group are included in the attachment as well.

Of note, CMS released a bulletin in July 2014 announcing an initiative to reduce unintended pregnancies which includes promoting use of that metric. The bulletin states “To facilitate reporting of [this] measure, **CMCS will make available an incentive payment** to states that choose to participate in this initiative”. See the bulletin attached.

Thank you for your time and consideration.

Sincerely,

Helen K. Bellanca, MD, MPH  
[helen@healthshareoregon.org](mailto:helen@healthshareoregon.org)  
503-416-4983

## Draft specifications of contraception metrics

### **Effective contraception use among women at risk of unintended pregnancy**

#### Admin data only

Denominator: Women age 15-50, exclude hysterectomy or current pregnancy

Numerator: In the past 12 months has there been:

-a claim for prescription contraceptive methods

-a claim for IUD insertion, implant insertion or diaphragm fitting

-a claim for surveillance of ongoing use of a long acting method (V25.42) or sterilization (v25.2)

Shortcomings: No way to exclude women seeking pregnancy from the denominator, no way to account for male sterilization in the numerator, and difficult to account for female sterilization and long acting methods in the numerator

#### Admin+clinical data

Denominator: Women age 15-50, exclude hysterectomy, current pregnancy, intent to become pregnant, women who do not partner with men

Numerator: In the past 12 months is there documentation of use of sterilization, IUD, implant, prescription pills, patch or ring or diaphragm use

Shortcomings: Requires new workflows in EHR for accurate documentation and extraction of clinical data. However, Kaiser is currently piloting inclusion of this data in EPIC charting, and OCHIN has expressed interest in taking this on, so it may be feasible soon.

### **The proportion of women who received contraceptive services in the past 12 months who adopt or continue to use the most effective forms of contraception**

#### Admin data only

Denominator: Women with a family planning visit in the past 12 months

Numerator: In the past 12 months has there been:

-a claim for prescription contraceptive methods

-a claim for IUD insertion, implant insertion or diaphragm fitting

-a claim for surveillance of ongoing use of a long acting method (V25.42) or sterilization (v25.2)

Shortcomings: The denominator is women who make a visit for contraception services. This represents only a small fraction of the women at risk of unintended pregnancy, and most of these visits occur in family planning clinics. In primary care, most contraception happens as part of another type of visit, so this metric would be less focused on the primary care population.



---

## CMCS Informational Bulletin

**DATE:** July 17, 2014

**FROM:** Cindy Mann  
Director  
Center for Medicaid and CHIP Services (CMCS)

**SUBJECT: CMCS Maternal and Infant Health Initiative**

This informational bulletin describes opportunities for states to collaborate with CMCS on a new national initiative to improve maternal and infant health outcomes in Medicaid and CHIP. Based on consultation with stakeholders, over the next several years, CMCS will focus improvement efforts in two areas: 1) increasing the rate and content of postpartum visits; and 2) increasing the rate of pregnancies that are intended.

### Background

Recognizing the urgency presented by our nation's poor birth outcomes, CMCS is experiencing a unique time in this nation's history in which the federal and state governments, maternal and infant health advocacy groups and provider groups are working in tandem to improve perinatal outcomes and reduce disparities. As the payer for at least half of all births in the U.S.,<sup>1</sup> Medicaid and CHIP have an important role to play. Adverse birth outcomes such as preterm birth and low birth weight, with their associated economic and social costs, are far reaching; furthermore, their impacts can be long-lasting, particularly among the most vulnerable populations. Medicaid is an important source of health insurance coverage for vulnerable individuals and families; and while considerable progress has been made in improving birth outcomes in the last decade among public and private payers, the rate of births reported as preterm or low birth weight remains higher in Medicaid than private insurance (10.4% vs. 9.1%).<sup>2</sup>

In 2012, the Department of Health and Human Services' launched *Strong Start for Mothers and Newborns*, which is funding 27 grantees over the next four years to test the effectiveness of three models of enhanced prenatal care for reducing preterm births in Medicaid and/or CHIP.<sup>3</sup> In an effort to identify strategies that could be adopted in the short term, an Expert Panel on Improving

---

<sup>1</sup> Markus A. R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." *Women's Health Issues*, vol. 23, no. 5, 2013, pp. e273–e280.

<sup>2</sup> Barradas D.T., et. al. "Hospital Utilization and Costs among Preterm Infants by Payer: Nationwide Inpatient Sample, 2009." Unpublished manuscript 2014.

<sup>3</sup> The models of enhanced prenatal care are centering/group care, birthing centers, and medical homes. For additional information see [Strong Start](#). CMS will also evaluate HRSA's Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) as a fourth model of enhanced prenatal care.

Maternal and Infant Health Outcomes in Medicaid and CHIP (the Expert Panel) was convened by a CMCS contractor to explore program, policy and reimbursement opportunities that could be adopted to provide better care, improve birth outcomes and reduce the cost of care for mothers and infants (additional information about our [Expert Panel](#) is available on Medicaid.gov). This stakeholder convening served to inform opportunities for Medicaid to address birth outcomes and complemented existing Departmental investments in improving maternal and infant health.

### **Initiative Goals**

After considering the advice of the Expert Panel and partnership opportunities, CMCS has identified two distinct yet interrelated goals for its [Maternal and Infant Health Initiative](#). The initiative leverages existing partnerships and activities to:

- Increase by 10 percentage points the rate of postpartum visits among pregnant women in Medicaid and CHIP in at least twenty states over a 3-year period; and
- Increase by 15 percentage points the use of effective methods of contraception in Medicaid and CHIP in at least twenty states over a 3-year period.

These goals consider the critical benefits that can be realized when women receive appropriate and timely postpartum care. Regular postpartum visits have positive implications for the woman's health, infant care and health, and also subsequent pregnancies. In addition, reproductive planning which includes access to contraception, either during the immediate postpartum period or during any other time in the reproductive continuum, allows for appropriate birth spacing and improved access to services that can, in turn, improve perinatal outcomes.

### **Action Steps**

One of the key themes that emerged from the Expert Panel is that current public and private reimbursement mechanisms do not align well with achieving good perinatal outcomes. Through the Maternal and Infant Health Initiative, CMCS will provide technical assistance to support Medicaid agencies in implementing reimbursement and related policy changes to achieve these goals. CMCS will also provide technical assistance to states that seek to improve health coverage for women before and after pregnancy utilizing existing coverage options, expansion opportunities and new delivery models. Through this initiative, CMCS will promote payment, program and coverage policies that enhance provider service delivery for use of effective contraception and timely postpartum care and enhance the accessibility of these services to women.

### **Assessing Progress**

To determine a baseline and to assess progress toward the goals, states will be invited to voluntarily report on 2 quality measures:

- 1) The measure for Postpartum Care from the Medicaid Adult Core Set; and
- 2) A developmental measure on Contraception Service Utilization.

The specifications for reporting the Postpartum Care measure are contained in the Technical Specifications and Resource Manual for the Adult Core Set.<sup>4</sup> The measure assesses the rate of postpartum visits occurring on or between 21 and 56 days after delivery. The developmental Contraception Service measure<sup>5</sup> is claims based and consists of two rates to assess the proportion of women who received contraceptive services in the past 12 months that adopt or continue use of:

- a) The most effective (i.e., male or female sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception;
- b) An FDA-approved, long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS)).

To report on these measures, states will use the CARTS<sup>6</sup> web-based data submission tool that is used for the Medicaid Adult Core Set measures. Baseline data for the initiative will be reportable with 2013 submissions, due by January 31, 2015. To facilitate reporting of these measures, CMCS will make available an incentive payment to states that choose to participate in this initiative. Details about the process for qualifying for the reporting incentive payment will be announced when the specifications for the Contraceptive measure are released.

### **Next Steps**

Over the next several months, CMCS will host a series of webinars to provide more information about the Initiative and review the performance measures that will be used to track our collective progress toward improving outcomes.

CMCS welcomes the opportunity to work more closely with states in advancing improvements in perinatal outcomes. For additional information on the Maternal and Infant Health Initiative, please contact Lekisha Daniel-Robinson, Coordinator, Maternal and Infant Health Initiative at [Lekisha.Daniel-Robinson@cms.hhs.gov](mailto:Lekisha.Daniel-Robinson@cms.hhs.gov).

We hope this information will be helpful. Thank you for your commitment to improving maternal and infant health through these critical programs.

---

<sup>4</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html>

<sup>5</sup> CMCS, in collaboration with Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA) will release detailed specifications and resources for the developmental contraception measure by mid fall.

<sup>6</sup> Guidelines for submitting to CARTS can be found at : <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html>