

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



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Introduction

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

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



FAST FACTS ABOUT MEDICAID AND BIRTH OUTCOMES

- Medicaid alone pays for 45 percent of all births nationally and more than half of births in 14 states.³
- Health disparities and inequities exist: women of color and low-income women are more likely to experience unintended pregnancy and poor birth outcomes.⁴
- Unintended pregnancy and closely spaced births are correlated with adverse outcomes.⁵
- Preterm or low-weight births carry higher costs, including for services provided in neonatal intensive care units.⁶
- Low birth-weight and preterm babies also are more likely to experience developmental and physical problems throughout their lives, including chronic health conditions in adulthood.⁷
- Medicaid finances most births to teen mothers,⁸ another population more likely to experience poor birth outcomes.⁹
- Teen pregnancy affects educational attainment and employment, and can contribute to a cycle of poverty across generations.¹⁰

THE IMPORTANCE OF EFFECTIVE CONTRACEPTIVE USE AND POSTPARTUM VISITS

Providers can support women in improving their preconception health and assist in pregnancy planning by asking whether they would like to become pregnant in the next year.ⁱ To support healthy, planned births, providers can educate women who are not interested in becoming pregnant about **effective methods of contraception.**ⁱⁱ

The **postpartum follow up visit** (typically within six weeks after delivery) is also an opportunity to support healthy women and babies. Postpartum, many women experience conditions that affect their physical and emotional health and influence their infants' health.ⁱⁱⁱ During the postpartum follow up visit the provider assesses a woman's physical and emotional health to address any acute needs or chronic conditions, and can address family planning to ensure adequate birth spacing.^{iv} Pregnancies that begin less than 18 months after a live birth are associated with increased risk for adverse birth outcomes.^v

ⁱOregon Foundation for Reproductive Health Care. [The One Key Question Initiative](#). ⁱⁱCenters for Disease Control and Prevention. [Effectiveness of Family Planning Methods](#). ⁱⁱⁱCheng, C., Fowles, E. and Walker, L. Postpartum Maternal Health Care in the United States: A Critical Review. [J Perinat Educ](#). 2006 Summer; 15(3): 34–42. ^{iv}Ohio Department of Health. [The Postpartum Visit](#). ^vMarch of Dimes. [Birth Spacing Fact Sheet](#). November, 2015.

Context For Contraceptive Use and Postpartum Care Measurement and Incentives

States and federal partners are focused on performance-based measurement and payment to help drive improvement in health care and outcomes, including birth outcomes. The U.S. Department of Health and Human Services' Secretary's Advisory Committee on Infant Mortality (SACIM) outlined a national framework and policy strategy recommendations reflecting the body of research about the importance of quality care before, during and after pregnancy.¹¹ SACIM underscored the value of the Health Resources and Services Administration (HRSA)'s Collaborative Improvement & Innovation Network to Reduce Infant Mortality (IM CollIN), which supports efforts in all states. Additionally, as a result of expert panel recommendations,¹² The Centers for Medicare and Medicaid Services (CMS) launched a Maternal and Infant Health Initiative¹³ focusing explicitly on effective contraceptive use and postpartum visits (see text box) among women enrolled in Medicaid and the Children's Health Insurance Program (CHIP). CMS supports improvement in outcomes through the inclusion of maternity measures (e.g., postpartum care rate) in the Children's and Adult Core Set of Medicaid and CHIP measures voluntarily reported by states. The postpartum visit is also a metric of HRSA's IM CollIN.

Overview of Medicaid Delivery System Transformation Trends

There are a number of coverage, benefit and delivery system changes Medicaid agencies can implement to support women's health and improved birth outcomes.¹⁴ One strategy is holding Medicaid providers or managed care entities accountable for tracking or reporting their performance on quality measures that support planned births and healthy birth outcomes, and linking provider performance to additional payment.

Alabama, Colorado, Ohio and Oregon are all transforming the way they pay for and deliver health care across their Medicaid programs to improve the quality and cost of care, often in alignment with changes among commercial payers. Specifically, these state Medicaid agencies have or are in the process of implementing new payment models that increase provider accountability, often through accountable care initiatives and or patient-centered medical home (PCMH) initiatives (see text box). These Medicaid initiatives include performance measurement, reporting and performance-based payment for a variety of health care services, including for family planning or postpartum care. Colorado, Ohio and Oregon are leveraging federal State Innovation Model (SIM) grants¹⁵ to support these Medicaid transformation efforts. The important role of Medicaid agencies in financing pregnancy and delivery has been an impetus for implementing provider incentives for planned or healthy births. Table I highlights incentives and broader initiatives in the four states.



DEFINING ACCOUNTABLE CARE, ACOs AND PCMHs

- Accountable care: Health care provider payment linked to improved care quality and lowered costs for a population of patients.ⁱ
- Accountable care organization (ACO): No consensus definition. Three distinguishing features: provider-led collaborations that include primary care; accountability for improving health outcomes and care quality while slowing overall cost growth for a set population of patients; and payments that increase with measurable improvement in quality, health outcomes and cost trends.ⁱⁱ Nine states have active Medicaid ACO programs.ⁱⁱ
- Patient-centered medical home (PCMH): An enhanced model of primary medical care grounded in seven jointly endorsed principles: continuity of care; team-based care; whole-person orientation; care coordination and integration; quality and safety; enhanced access (e.g., extended hours, open scheduling); and a payment structure that recognizes the investments needed to provide care in a PCMH.ⁱⁱⁱ There are 24 states with active Medicaid payments to PCMHs.^{iv}

ⁱKakoot, et al. [Early Experiences with Accountable Care in Medicaid](#): Special Challenges, Big Opportunity. Population Health Management. Vol 16, Suppl 1, 2013. ⁱⁱCenter for Health Care Strategies, Inc. [Medicaid Accountable Care Organizations: State Update](#). March 2016. ⁱⁱⁱAmerican Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, [Joint Principles of the Patient-Centered Medical Home](#). ^{iv}National Academy for State Health Policy. [State Delivery System and Payment Reform Map](#)

Table I: Overview of Four State Incentive Measures

State	Alabama	Colorado	Ohio	Oregon
Measure	Prenatal and Postpartum Care (postpartum visit on or between 21 and 56 days after delivery) ¹⁶	Postpartum Follow Up Care (on or between 21 and 56 days of delivery)	Postpartum Follow Up Visit (within 60 days of birth)	Effective Contraceptive Use (percent of women ages 18-50 using most or moderately effective contraceptives)
Medicaid Initiative (federal authority)	Regional Care Organizations * (1115 waiver) ¹⁷ *Implementation on hold due to state budget constraints ¹⁸	Accountable Care Collaborative (State Plan Amendment) ¹⁹	Perinatal Episode of Care in Ohio's Episode-Based Payment Model (State Innovation Model Grants) ²⁰	Coordinated Care Organizations (1115 waiver)
Accountable Entity (# in state as of July 2016)	Regional Care Organization (11 with preliminary certification, none yet in place)	Regional Care Collaborative Organization (7)	Principal Accountable Provider (PAP) (375 estimated for perinatal episode)	Coordinated Care Organization (16)
Incentive Strategy	Withholding money that can be earned back	Withholding money that can be earned back	Highest performers can earn incentive payment; lowest performers can incur a payment	Withholding money that can be earned back
Performance Threshold	State target: ²¹ postpartum care visit rate of 69.7%	Tier one: Increase visits above expected baseline by 1% Tier two: Increase visits above expected baseline by 5% or more	State threshold: ²² postpartum visit rate of 50%* *Must also have average risk-adjusted perinatal episode cost below \$3210 for positive incentives. ²³ PAPs with average episode cost above \$4473 incur negative incentive.	State benchmark: 50% of women ages 18 to 50 continuously enrolled with evidence of effective contraceptive method
Incentive		Percentage of full amount (\$0.30-\$0.40 per member per month) for this indicator: ²⁴ Tier 1: 66%, Tier 2: 100%	Difference between PAP's average risk-adjusted episode reimbursement and commendable cost threshold (for a positive incentive) or acceptable cost threshold (negative incentive) ²⁵	Percentage of overall capitation payments: in 2015, 4% ²⁶
Measurement and Payment Status	Not yet active. Timeline to be determined.	Active	Measurement active. First payment will occur after performance is reported to PAPs in 2017.	Active
Results	Not yet available	4 RCCOs met threshold based on October 2015-April 2016 data	Not yet available	9 CCOs met state benchmark or improvement target based on 2015 data



Incentivizing Effective Contraceptive Use

Oregon has transformed its Medicaid delivery system by establishing a network of Coordinated Care Organizations (CCOs) across the state that are responsible for providing integrated and coordinated health care for Medicaid enrollees. CCOs are community-based health entities representing a partnership of physical, mental, and oral health and other providers and health systems stakeholders; they have local flexibility to determine the payment and care delivery strategies of need in their communities to achieve performance goals set by the state. The state has 18 CCO incentive measures that cover a range of services (e.g., preventive and acute care) and populations (e.g., children, adults).²⁷ For the incentive metrics, CCOs are eligible to earn annual bonus payments. Two current incentive metrics address perinatal care: timeliness of prenatal care and effective contraceptive use.²⁸

CCOs have financial responsibility and risk, and are paid through a global budget. The global budget includes a per member per month payment for provision of health care services along with annual incentive payments that support performance improvement. A set percent of the global budget is withheld from CCOs to create a quality pool for bonus payments.²⁹ To receive the bonus payment, a CCO must meet the performance threshold for any 12 of the incentive metrics and have at least 60 percent of their members enrolled in a PCMH

(known as patient-centered primary care home in Oregon).³⁰ CCOs meet the performance threshold by reaching a statewide benchmark or meeting an improvement target established by the Oregon Metrics and Scoring Committee, which advises the Oregon Health Authority.

CCO incentive measures have been in place since 2013, however Oregon introduced an Effective Contraceptive Use (ECU) incentive metric beginning in 2015. The ECU metric tracks the percentage of women ages 18 to 50 who were not pregnant during the measurement period and who have adopted or continued the use of a “most effective” or “moderately effective” contraceptive method.^{31,32,33} These contraceptive methods include: intrauterine device (IUD), implant and sterilization (most effective with a failure rate of less than one percent); and contraception injection, contraceptive pills, patch, ring or diaphragm (moderately effective with a failure rate of six to 12 percent).³⁴

Results to Date in Oregon

The first quality pool payments to include the ECU metric were provided in June 2016. Performance data from 2015 show that most CCOs improved effective contraceptive use compared to 2014, and the statewide rate “increased slightly”.³⁵ Final 2015 CCO data also show improvement in ECU rates for all racial and ethnic groups except Hawaiian/Pacific Islander.³⁶

Oregon, along with other states, has collaborated with the federal government (CMS and the Centers for Disease Control and Prevention (CDC)) on ECU measurement.³⁷ Oregon’s ECU incentive measure was based on national specifications under review with CDC and CMS with some modifications (e.g., Oregon incentivizes ECU for women ages 18-50, draft national specifications look at women ages 15-44). Guidance and technical assistance in measuring ECU is available to state Medicaid agencies through CMS’ Maternal and Infant Health Initiative.³⁸ For example, CMS has compiled frequently asked questions about measuring contraceptive use.³⁹ As of 2015, Oregon was the only known Medicaid program to have implemented ongoing ECU performance-based incentives.

Partnerships in Oregon

In Oregon the Title X and Medicaid family planning program (Oregon Contraceptive Care) are in the Public Health Division of the Oregon Health Authority, which houses public health and Medicaid. The structure has resulted in a history of collaboration across programs, which helped with the ECU metric. Public health division and reproductive health program staff played a critical role in developing and reviewing the CCO ECU measure specifications and CCO guidance, which includes suggested improvement strategies.⁴⁰ Medicaid staff also benefitted from Behavioral Risk Factor Surveillance System (BRFSS) data provided by the public health division. BRFSS data offered insights on state-level activity, along with racial and ethnic disparities, and variation in ECU by county and payer.

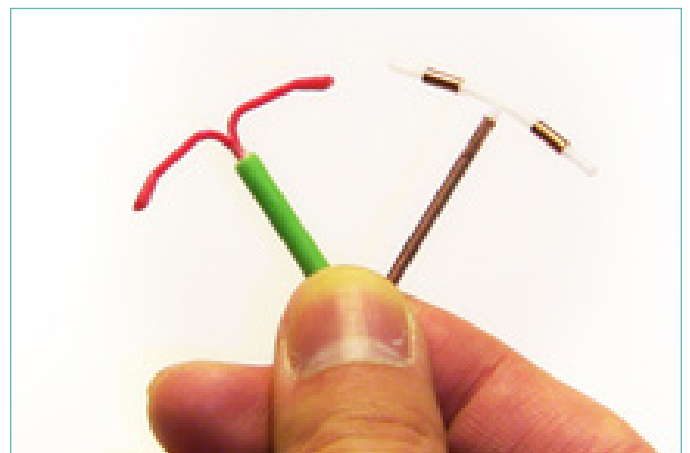
Incentivizing Postpartum Care

Another key factor of maternal health and birth outcomes is postpartum care. Colorado, Ohio and Alabama each have a strategy for incentivizing postpartum care as part of statewide Medicaid delivery system transformation.

Colorado Postpartum Care Incentive Measure

Colorado has transitioned its Medicaid program into an Accountable Care Collaborative made up of Regional Care Collaborative Organizations (RCCOs) that coordinate care for members, link members to non-medical services, support providers through coaching, and contract with primary care medical providers (PCMPs) who serve as PCMHs.⁴¹ Each PCMP is associated with one or more RCCOs, and both PCMPs and RCCOs are accountable for health care costs and quality. Colorado holds entities responsible for quality through incentive payments. RCCOs and PCMPs each receive a per member per month payment from the Medicaid agency for the services they provide, however, Medicaid withholds a small portion (\$1 per member per month) from each entity. The entities can earn back the withheld money by performing well on incentive measures, known as Key Performance Indicators (KPIs). To support regional improvement, a RCCO must perform well enough to qualify for the incentive in order for a PCMP to receive an incentive payment. Incentive payments currently are available for three measures, one of which is postpartum follow up care use.⁴²

Colorado introduced the incentive measure for postpartum follow up care in 2014; overall, it measures the percentage of eligible members who had an outpatient postpartum visit following a live birth.⁴³ The Medicaid agency sets improvement targets based on baseline/historical performance and offers two incentive levels.⁴⁴





Results to Date in Colorado

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

Colorado is embarking on a second phase of its Accountable Care Collaborative to improve health and control costs through further emphasis on whole-person care, care integration, care coordination and accountability.⁴⁹ The implications of

Phase II for women’s health are to be determined; however, Colorado already has examples of promising partnerships (see below) and is committed to value-based payment.

Partnerships in Colorado

An innovative example of cross-agency partnership and alignment is the Colorado Opportunity Project (Project).⁵⁰ Through the Project, multiple Colorado agencies—including the Departments of Health Care Policy and Financing (Medicaid), Public Health and Environment (Title V), and Human Services—are aligning efforts to efficiently and collaboratively deliver evidence-based programs along the entire life continuum, from preconception to mature adulthood to facilitate upward economic mobility for Coloradans. At the core of the Project are themes of prevention, leveraging existing resources and community partnerships, and integration of the social determinants that drive health care costs. Family formation—including an intended pregnancy, good birth outcomes, number of caregivers and the family income—is one life stage of focus. The Project aims to create shared performance measures and identify both evidence-based programs and promising practices at the community level. One area of strong collaboration is with the Nurse-Family Partnership home visiting program for low-income, first-time mothers. As part of their contracts in 2015, RCCOs received money to determine the feasibility of care coordination of a number of evidence based programs that drive positive outcomes during the family formation stage, which clearly aligns with and reinforces the RCCO incentive measure.

Alabama’s Prenatal and Postpartum Care Incentive Measure

Alabama is establishing Regional Care Organizations (RCOs) in a Medicaid transformation model somewhat similar to Colorado that includes prenatal and postpartum care as one of 10 incentive measures. RCOs are “locally-led managed care systems” that will provide healthcare services

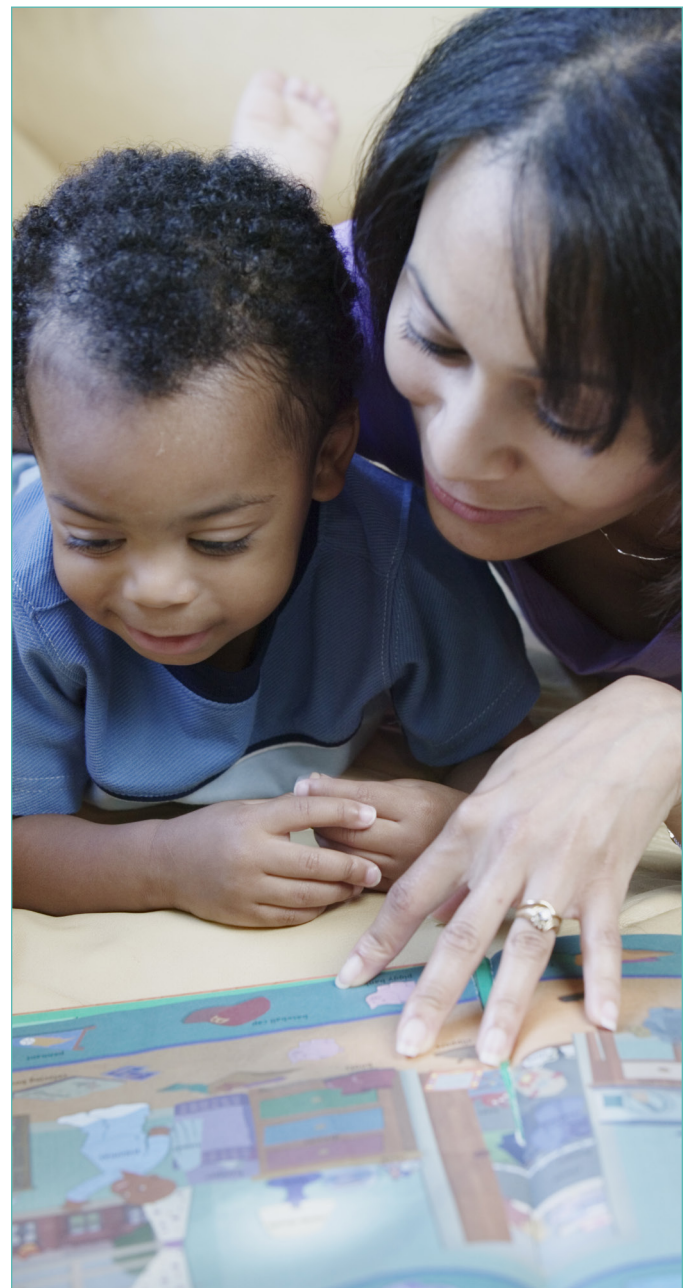
to eligible beneficiaries.⁵¹ The initiative is newer, with RCO networks in place as of April 2015, and capitated payments from Medicaid to RCOs originally scheduled to begin in October 2016. Alabama plans to withhold a portion of payment to create a quality of care incentive pool, but phase it in. The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

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

Ohio Perinatal Episode of Care

One part of Ohio's multi-payer payment and delivery system transformation is a type of pay-for-performance known as episodes of care. Episodes of care include all the care related to a defined medical event, such as a procedure or an acute exacerbation of a chronic condition, including care of the event itself, any pre-cursors to the event as well as follow up care. For a given episode type, a principal accountable provider, or PAP, is the clinician, practice or institution most responsible for the quality and cost of care delivered to the patient for the duration of the episode. Depending on how high

or low a PAP's average episode costs and whether or not they meet specific quality metrics for the episodes, they may be eligible to receive a positive incentive payment or be subject to paying money back to the state (negative incentive payment). The goal is to encourage improvement in value and patient outcomes by redistributing a share of cost savings back to those who perform best in quality and cost. Currently Ohio has implemented 13 episodes of care, including a "perinatal episode" encompassing prenatal care, most delivery-related services and postpartum care.⁵²



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

Like other states Ohio has phased in implementation by beginning with a “reporting only” period, during which PAPs receive information about their cost and quality performance relative to other PAPs, but are not held accountable for their performance. Reporting for the perinatal episode began in March 2015, and the official performance period began January 2016. Episodes ending during the 12-month performance period will be used to determine positive and negative incentive payments.

Key Considerations and Early Lessons for Medicaid and Title V Collaboration

States identified a range of strategies for implementing measures and incentives in collaboration with other agencies. There are common themes and action steps across Alabama, Colorado, Ohio and Oregon in developing Medicaid performance-based incentives (see text box), and Medicaid officials in each state identified opportunities for cross-agency collaboration between Title V and Medicaid for Medicaid performance-based measurement or payment. Collaboration on contraceptive or postpartum care measures and incentives is a natural fit; the agencies share responsibility for serving vulnerable women and children and have a mutual commitment to improving health outcomes for women, infants and children in need. Certainly where Title V agencies or family planning programs are housed in a state can facilitate or hinder cross-agency collaboration, but aligning agency efforts is a way to maximize resources for greatest impact. Strategies for cross-agency collaboration include:

- **Align maternal and infant health measures and incentives** in state Medicaid programs and Title V block grants. State Medicaid 1115 waivers and SIM grants may include population health performance measures related to women's health. Many Title V National Performance Measures and Outcome Measures⁵⁵ relate to birth outcomes and infant health, which can be supported by Medicaid initiatives or measures to improve maternal health and birth spacing, e.g., through postpartum care and effective contraceptive use. Additionally, state Title V agencies conduct needs assessments to



identify priority MCH needs, which may overlap with Medicaid priorities. Alabama’s public health department seeks to leverage Medicaid’s maternity measures in its Title V block grant.

- **Leverage complementary data.** As exemplified by Oregon, public health departments have population data from BRFSS or vital statistics that likely can inform Medicaid measure development through identification of trends or benchmark setting. Similarly in Alabama and Ohio, biostatistics from the public health department supplement administrative claims data for maternity measures.
- **Include Title V agency staff in Medicaid measure development and implementation.** Public health or family planning program staff can provide in-depth programmatic and subject matter expertise to inform Medicaid measure specifications or guidance documents and to collaborate on provider training. Program staff also may have helpful insights about promising interventions or existing initiatives in the state (see next bullet), as well as materials and effective messaging.
- **Foster partnership at the local level** between regional ACO-like entities or health care providers and local public health departments. Local health departments often have or provide community resources, services and programs key to healthcare provider referral or outreach regarding Medicaid services during the inter-conception or postpartum period. Oregon’s reproductive health program has encouraged local health departments to partner or contract with Medicaid health plans.



ACTION STEPS IN MEDICAID PERFORMANCE MEASURE AND INCENTIVE DEVELOPMENT

- Engage medical providers and sister agencies or programs (Title V, family planning) early and often.
- Consider incremental implementation, particularly for incentives, by beginning with reporting data only before phasing in accountability
- Understand limitations and challenges associated with measures:
 - Different measures have different definitions for days in the postpartum period, which affects the data that are collected.
 - For the ECU measure, some providers or patients may be uncomfortable discussing contraceptive options due to the nation’s history of forced sterilization of women of color and the poor.
- Identify and leverage complementary program policies that facilitate improvement. For example, Oregon’s Legislature enacted policies allowing pharmacists to prescribe contraceptives and dispense a 12-month supply, which support ECU.



Conclusion

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

Author's Note:

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¹ Mann, C. CMCS Maternal and Infant Health Initiative. CMCS Informational Bulletin. July 17, 2014. <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-18-2014.pdf>

² Sonfield A and Kost K, Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010, New York: Guttmacher Institute, 2015. https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf

³ Markus, AR, et al. Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform. Women's Health Issues. Sept-Oct 2013; 23(5):e273-e280; and Erratum, Nov 2013; 23(6): e411, as cited by <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/>

⁴ Unintended Pregnancy in the United States. New York: Guttmacher Institute, 2016. https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf

⁵ Johnson, KA. Addressing Women's Health Needs and Improving Birth Outcomes: Results from a Peer-to-Peer State Medicaid Learning Project. New York: The Commonwealth Fund, 2012, 2. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Aug/1620_Johnson_addressing_womens_hl_needs_improving_birth_ib.pdf

⁶ Markus et al, Medicaid Covered Births, 2008 Through 2010.

⁷ See for example <http://www.marchofdimes.org/complications/low-birthweight.aspx>

⁸ Curtin, SC, et al. Source of Payment for the Delivery: Births in a 33-state and District of Columbia Reporting Area, 2010. National Vital Statistics Reports, Vol. 62, No. 5, Hyattsville, MD: National Center for Health Statistics, 2013. http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_05.pdf

⁹ Kavanaugh, ML and Anderson, RM. Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers. New York: Guttmacher Institute, 2013.

<https://www.guttmacher.org/sites/default/files/pdfs/pubs/health-benefits.pdf>

¹⁰ See for example <https://thenationalcampaign.org/sites/default/files/resource-primary-download/childbearing-education-economicwellbeing.pdf>

¹¹ See the January 2013 Report of the Secretary's Advisory Committee on Infant Mortality (SACIM): Recommendations for Department of Health and Human Services (HHS) Action and Framework for a National Strategy available at <http://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/About/natlstrategyrecommendations.pdf>

¹² Improving Maternal and Infant Health Outcomes CMCS Crosswalk of Current Activities and Identified Potential Strategies. December 2013. Accessed July 8, 2016. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Crosswalk-of-Activities.pdf>

¹³ Centers for Medicaid and CHIP Services. Overview of the CMCS Maternal and Infant Health Initiative. Fact Sheet. December 2014. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/mih-initiative-fact-sheet.pdf>

¹⁴ Johnson, Addressing Women's Health Needs and Improving Birth Outcomes.

¹⁵ Centers for Medicare and Medicaid Services. "State Innovation Models Initiative: General Information." Accessed July 8, 2016. <https://innovation.cms.gov/initiatives/state-innovations>

- ¹⁶ This is a hybrid measure that includes two components—timeliness of prenatal care and the postpartum visit. To learn more about this measure, please see: <http://www.ncqa.org/portals/0/prenatal%20postpartum%20care.pdf>
- ¹⁷ Section 1115 waivers are a mechanism through which states request to waive certain federal regulations to try new benefit packages or new ways of paying for or delivering Medicaid services. To learn more see: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>
- ¹⁸ RCOs were initially expected to be implemented October 2016 but due to budget issues, the implementation date has been postponed, with no start date identified as of July 19, 2016.
- ¹⁹ See <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html> to learn more about Medicaid State Plan Amendments and view them by state.
- ²⁰ To learn more about the federal SIM Initiative, including Ohio's two SIM grants, see <https://innovation.cms.gov/initiatives/state-innovations>.
- ²¹ Alabama set the postpartum care rate target at a percentile of performance on the Healthcare Effectiveness Data and Information Set measure. To learn more about HEDIS, see <http://www.ncqa.org/hedis-quality-measurement>.
- ²² To be eligible for a positive incentive payment, perinatal PAPs must meet the postpartum visit rate benchmark, have costs below the commendable threshold (\$3210), and meet benchmarks for three other clinical quality metrics: HIV screening rate (50%), prenatal Group B Strep screening rate (50%), C-section rate (45%). See: Ohio Governor's Office of Health Transformation. Threshold Methodology, I. Accessed July 8, 2016. <http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Threshold/ThresholdMethodology.pdf>
- ²³ Ibid, 5.
- ²⁴ Colorado Department of Health Care Policy and Financing. ACC Incentive Payments Fact Sheet. <https://www.colorado.gov/pacific/sites/default/files/KPI%20Incentive%20Fact%20Sheet.pdf>
- ²⁵ Ohio Administrative Code 5160-1-70
- ²⁶ The 4% is the total for all incentive metrics. Oregon does not pay per measure, so an ECU-specific total is not available. To learn more about the quality pool methodology, see <http://www.oregon.gov/oha/analytics/CCODData/2015%20Quality%20Pool%20Methodology.pdf>
- ²⁷ Oregon Health Authority. Oregon Health Authority Measure Sets. September 2015. <http://www.oregon.gov/oha/analytics/CCODData/2016%20Measures.pdf>
- ²⁸ Oregon Health Authority. CCO Incentive Measures Since 2013. <http://www.oregon.gov/oha/analytics/CCODData/CCO%20Incentive%20Measures%20since%202013.pdf>
- ²⁹ Oregon Health Authority. Quality Pool Methodology. <https://www.oregon.gov/oha/analytics/CCODData/2015%20Quality%20Pool%20Methodology.pdf>
- ³⁰ Oregon Health Authority. 2015 Quality Pool Reference Instructions. September 2015. <https://www.oregon.gov/oha/analytics/CCODData/2015%20Quality%20Pool%20Methodology.pdf>
- ³¹ For ECU measure details and technical specifications, please see: <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>
- ³² The Oregon Health Authority also measures and reports on ECU by women ages 15-17, but those data are not included in the incentive metric.
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- ³⁴ Ibid.
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- ³⁷ See, for example, the November 5, 2014 webinar on Measuring Contraception Use in Medicaid and CHIP. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/contraception-use-webinar.pdf>
- ³⁸ Centers for Medicaid and CHIP Services. Overview of the CMCS Maternal and Infant Health Initiative. Fact Sheet. December 2014. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/mih-initiative-fact-sheet.pdf>
- ³⁹ Centers for Medicare and Medicaid Services Maternal and Infant Health Initiative. Frequently Asked Questions about the Contraceptive Use Performance Measures (Developmental). February 2015. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/contraceptive-measure-faqs.pdf>
- ⁴⁰ Oregon Health Authority. Effective Contraceptive Use Among Women at Risk of Unintended Pregnancy Guidance Document.
- ⁴¹ Colorado Department of Health Care Policy and Financing. Supporting a Culture of Coverage: Accountable Care Collaborative 2015 Annual Report. <https://www.colorado.gov/pacific/sites/default/files/Supporting%20a%20Culture%20of%20Coverage%20Accountable%20Care%20Collaborative%202014-15%20Annual%20Report.pdf>
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- ⁴³ Colorado Department of Health Care Policy and Financing. ACC Incentive Payments Fact Sheet.
- ⁴⁴ Ibid.
- ⁴⁵ Colorado Department of Health Care Policy and Financing. Supporting a Culture of Coverage, 7.
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- ⁴⁹ Colorado Department of Health Care Policy and Financing. "Accountable Care Collaborative Phase II." Accessed July 8, 2016. <https://www.colorado.gov/pacific/hcpf/acphase2>
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- ⁵³ <http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/Perinatal.pdf> (same as endnote 30)
- ⁵⁴ The three other quality metrics linked to gain-sharing are prenatal HIV screening rate, prenatal Group B Strep Infection screening rate, and C-section rate. For more information, see: <http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/Perinatal.pdf>
- ⁵⁵ For a list of Title V National Performance and National Outcome Measures, see: <http://mchb.hrsa.gov/programs/titlevgrants/blockgrantguidanceappendix.pdf>