WEBVTT

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00:02:23.940 --> 00:02:31.139
Elisabeth W Burak - GCCF: Hi, everyone. We still have a few people trickling. And I'm gonna give it just about 30 more seconds and we will get started.

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00:02:53.030 --> 00:03:05.449
Elisabeth W Burak - GCCF: Okay, well, we will get going. Thank you so much. Welcome to everyone. To our webinar on Medicaid managed care organizations and maternal health.

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00:03:05.820 --> 00:03:11.729
Elisabeth W Burak - GCCF: My name is Elizabeth Wright Burak. I'm a senior fellow at the Georgetown Center for children and families.

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00:03:11.840 --> 00:03:16.939
Elisabeth W Burak - GCCF: We are really grateful. You all can join us for this timely, timely discussion.

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00:03:17.100 --> 00:03:34.800
Elisabeth W Burak - GCCF: This is the second webinar we've held on. Medicaid managed care, maternal health. So the first was back in July with our colleagues at George Washington University and Johnson policy consulting on their review of Medicaid-managed care contracts around maternal health.

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00:03:35.390 --> 00:03:45.380
Elisabeth W Burak - GCCF: And today we're gonna learn about our Ccf's new study on sort of what we know about performance at the managed care, level and maternal health.

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00:03:46.850 --> 00:03:52.939
Elisabeth W Burak - GCCF: So it's no secret, of course, that we're in the midst of an ongoing and worsening maternal health crisis.

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00:03:53.000 --> 00:04:04.999
Elisabeth W Burak - GCCF: And recently, just yesterday, actually, we learned from new Cdc data that we've seen the first increase in 2 decades. In the Us. Infant mortality rate.

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00:04:05.400 --> 00:04:17.790
Elisabeth W Burak - GCCF: So it is important to really underscore what and understand what kind of healthcare, pregnant and postpartum people and expected parents are getting.

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00:04:18.360 --> 00:04:26.570
Elisabeth W Burak - GCCF: Why is Medicaid important? We know Medicaid's the primary pair of births in the United States, well, over 40%

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00:04:26.860 --> 00:04:51.330
Elisabeth W Burak - GCCF: and most in most states, most people are covered in Medicaid through their experience with managed care organizations or plans that contract with State medica organizations, and we really don't know a lot. And we haven't been able to unpack a lot of about performance of those managed care organizations and maternal and child health care. And that's where our team has come in

12
00:04:51.580 --> 00:05:01.360
Elisabeth W Burak - GCCF: and why we're here to discuss it. So in terms of housekeeping, we will post the recording in the slides on our website and send those out after today's webinar

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00:05:02.130 --> 00:05:25.970
Elisabeth W Burak - GCCF: in terms of language. We use the terms maternal health and pregnant women throughout the report in this conversation, because that is what the term that's coming up in a lot of the State reports and pregnant women is often referred to in statute as an eligibility category. But we mean to be inclusive of all expectant parents, prenatal to postpartum, regardless of how they identify

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00:05:26.850 --> 00:05:36.630
Elisabeth W Burak - GCCF: and we will have time for questions at the end of our presentation. So please use the Q&A function in the Webinar chat to ask those questions as we go.

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00:05:38.260 --> 00:05:52.660
Elisabeth W Burak - GCCF: Okay? So first, we're going to hear from our 3 of our 4 report co-authors from the Center for Children and families. Andy Schneider, who has been doing a lot of this work on managed care transparency at Ccf.

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00:05:52.820 --> 00:05:59.620
Elisabeth W Burak - GCCF: As well as Tanisha Mandestin and Ella Matthews, research associates here at the Center for Children and families.

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00:05:59.630 --> 00:06:13.120
Elisabeth W Burak - GCCF: But we also want to acknowledge the fourth co-author co-author. On this report Annie Akinigi, as well as the significant contributions of our former project. Director here at Ccf. Maggie Clark.

18
00:06:13.970 --> 00:06:34.999
Elisabeth W Burak - GCCF:  finally, just so, you all know, as you're going through the many detailed findings, we have 2 versions of this report. The first is sort of a digital version, and thanks to Hannah Green and our Comms team to help put that together, a lot of interactive tools on the digital report. And we also have a Pdf. Version of the report that Nancy Mcgill put together for us.

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00:06:36.000 --> 00:06:42.280
Elisabeth W Burak - GCCF: So we'll hear from my colleagues here at Ccf. And then, after we hear from the report co-authors.

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00:06:42.290 --> 00:06:51.560
Elisabeth W Burak - GCCF: We've got 2 excellent expert respondents. The first is Sarah Rosenbaum, who's Professor Emerita at George Washington University School of Public Health.

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00:06:51.650 --> 00:07:12.569
Elisabeth W Burak - GCCF: She is a long time, and widely known, expert in health, care and health justice, particularly in Medicaid, and has been working on this for many, many decades, and was one of the lead authors of the Commonwealth Fund report we featured in our last Webinar called the road to maternal Health, run through Medicaid, managed care.

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00:07:13.270 --> 00:07:23.639
Elisabeth W Burak - GCCF: and our second respondent will be Jc. Montoya Price, who is the senior director for advocacy and issue campaigns at the Alliance for early success, which is one of our funders.

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00:07:23.820 --> 00:07:46.010

Elisabeth W Burak - GCCF: And she currently supports maternal and state child advocates around the country and health but before that led and developed coalitions around Latina, reproductive and maternal health justice in Colorado as well as early childhood advocacy. So we are so thrilled to have the 2 of them to weigh in on, on what we found.

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00:07:46.320 --> 00:07:53.049
Elisabeth W Burak - GCCF: So thank you all for being here. And with that I'm going to turn it over to Andy Schneider to dig into our findings. Thanks, Andy.

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00:07:54.150 --> 00:07:55.570
Andy Schneider: Thanks, Elizabeth.

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00:07:56.260 --> 00:08:05.859
Andy Schneider: Okay, so as Elizabeth mentioned for pregnant women how the Mcos they're enrolled in.

27
00:08:06.110 --> 00:08:09.879
Andy Schneider: how those Mcos perform matters a lot.

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00:08:11.530 --> 00:08:19.879
Andy Schneider: Among other things, the Mcos organize the provider networks, and they are paid to manage the care of all their enrollees, including pregnant

29
00:08:20.090 --> 00:08:26.510
Andy Schneider: women. So so that is the basic purpose of

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00:08:26.540 --> 00:08:30.890
Andy Schneider: the report we asked the question,

31
00:08:31.600 --> 00:08:42.510
Andy Schneider: what kind of information about the performance of individual Mcos on maternal health is possible is publicly available.

32
00:08:43.200 --> 00:08:52.189
Andy Schneider: and and the focus here is on the performance of individual Mcos. Not all the Mcos as a class in a particular State.

33
00:08:52.720 --> 00:09:01.979
Andy Schneider: Not not state level data aggregating all the Mco performance. But how individual Mcos are performing?

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00:09:02.240 --> 00:09:07.869
Andy Schneider:  in order to distinguish high performers.

35
00:09:08.330 --> 00:09:11.200
Andy Schneider: average performers and low performers.

36
00:09:11.850 --> 00:09:16.049
Andy Schneider: And to do this. We pick 12 States

37
00:09:16.210 --> 00:09:20.740
Andy Schneider: you can see them here. Georgia, Illinois, Iowa.

38
00:09:20.920 --> 00:09:27.550
Andy Schneider: Kansas, Kentucky, Michigan, Mississippi. Nevada, New Jersey.

39
00:09:27.740 --> 00:09:34.139
Andy Schneider: New Mexico, Tennessee, and Washington. and you can see there, there is a geographic mix.

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00:09:35.380 --> 00:09:40.789
Andy Schneider: There is a expansion. Non-expansion. Mix there.

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00:09:41.340 --> 00:09:50.620
Andy Schneider: And on the maternal issue front there's a there's a range of

42
00:09:51.200 --> 00:10:01.819
Andy Schneider: State level data. For example. in New Jersey, about 29 of the births for the most recent year

43
00:10:01.920 --> 00:10:08.199
Andy Schneider: we're financed by Medicaid and in Mississippi. It's it's 59.

44
00:10:09.190 --> 00:10:11.509
The maternal death rates

45
00:10:12.240 --> 00:10:18.960
Andy Schneider: 17 per 100,000 in Illinois to 42 to 43 per 100,000 in Tennessee in Mississippi.

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00:10:19.220 --> 00:10:24.150
Andy Schneider: So again, a range of State level experiences.

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00:10:25.760 --> 00:10:47.179
Andy Schneider: Th, this isn't a statistically representative sample of states, and some some of our findings might not be generalizable. But II would say they're not necessarily unrepresentative either. You've got. You've got quite a mix. So here's what we did in East States. We looked at the State Medicaid Agency websites.

48
00:10:47.470 --> 00:10:49.490
Andy Schneider: I use the Royal. We, of course.

49
00:10:49.830 --> 00:11:01.669
Andy Schneider: most of the work here was done by by Ella and and any. But we scanned the the State Medicated Agency websites. Also took a look at the

50
00:11:01.820 --> 00:11:07.540
Andy Schneider: Medicaid Medical Care Advisory committee websites where State agencies had those up.

51
00:11:08.140 --> 00:11:09.700
Andy Schneider: The

52
00:11:09.750 --> 00:11:15.110
Andy Schneider: Public Health Agency websites, particularly looking for the Maternal Mortality Review.

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00:11:15.830 --> 00:11:18.850
Committee information.

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00:11:18.880 --> 00:11:32.710
Andy Schneider: We scanned all 52 of the websites of the Mcos contracting with the different States plus their parent companies. We did all this work, basically from May until August

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00:11:33.100 --> 00:11:38.680
Andy Schneider: and and why don't we go to the next slide and talk about

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00:11:39.340 --> 00:11:42.760
Andy Schneider: our findings? So this is the bottom line.

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00:11:43.310 --> 00:11:51.609
Andy Schneider: There were a lot of findings, but this is the bottom line, and the short of it is that there's not a lot of transparency

58
00:11:51.790 --> 00:11:53.339
Andy Schneider: in most states.

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00:11:53.570 --> 00:12:02.800
Andy Schneider: and at least in the States we looked at. We didn't feel that we could get enough information about how individual plans were performing on maternal health

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00:12:02.870 --> 00:12:07.929
Andy Schneider: to decide who was doing well and who was not doing well.

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00:12:09.520 --> 00:12:12.839
Andy Schneider: we had some of the individual findings, so

62
00:12:12.970 --> 00:12:27.070
Andy Schneider: I guess the first question is, how many pregnant women do you have enrolled in any particular plan. and only 3 of the States. We looked at Could we find that information, and that was Illinois and New Mexico and

63
00:12:27.710 --> 00:12:36.170
Andy Schneider: and Washington? And your next question would be, Well, how about a breakdown by race and ethnicity? And

64
00:12:36.230 --> 00:12:41.890
Andy Schneider: only New Mexico and Washington? We'd be able to find that on an individual Mcco basis.

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00:12:42.020 --> 00:12:48.970
Andy Schneider: The next session would be, what kind of an investment is Medicaid making in?

66
00:12:49.170 --> 00:12:52.270
Care for pregnant women enrolled in particular.

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00:12:52.440 --> 00:12:53.840
Andy Schneider: Mcos.

68
00:12:54.530 --> 00:12:56.580
And we weren't able to find that

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00:12:57.030 --> 00:12:59.670
Andy Schneider: information for any of the

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00:13:00.010 --> 00:13:15.550
Andy Schneider: States or individual. 52 websites that we looked at Kansas did provide a total of all capitation payments. It was making date Mcos for pregnant women, but that was it.

71
00:13:17.500 --> 00:13:34.069
Andy Schneider: Standardized performance metrics either out there in the in the Cms maternity care core set and I was gonna expand on this in a little while. In our discussion around Appendix B, but

72
00:13:34.180 --> 00:13:44.860
Andy Schneider: only 2 of the only 2 of the metrics, timeliness of prenatal care and timely, that is, a postpartum care were available in all the States. and

73
00:13:45.130 --> 00:14:04.130
Andy Schneider: finally, all the all the States had Mmrcs medicinal mortality review committees. They all issued reports. some were more dated than others. But we could not find in any of them. Mmrc reports we looked in

74
00:14:04.720 --> 00:14:10.090
Andy Schneider: information specific to individual Mcos and how they were performing

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00:14:10.480 --> 00:14:16.060
Andy Schneider: and Tanisha's gonna elaborate on that next slide, please.

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00:14:17.350 --> 00:14:24.459
Andy Schneider: So the underlying premise here is that transparency matters

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00:14:24.840 --> 00:14:37.929
Andy Schneider: transparency, as as I'm using the term as as it's using the report is the public availability of data about individual Medicaid Mcos, and what their performance is on maternal health.

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00:14:38.380 --> 00:14:46.939
Andy Schneider:  my, my argument here is it's an effective way of holding.

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00:14:46.950 --> 00:14:56.009
Andy Schneider: not just Mcos, but state Medicaid agencies and Cms. The folks paying for all this accountable for the performance of the plans

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00:14:56.130 --> 00:14:58.159
Andy Schneider: on maternal health.

81
00:14:58.210 --> 00:15:02.139
Andy Schneider: And it's low cost.

82
00:15:02.290 --> 00:15:04.020
Andy Schneider: The data being collected

83
00:15:04.230 --> 00:15:16.939
Andy Schneider: the plans have the data. The States have the data Cms can get the data if it wants. But the issue is getting it out into the public domain in a way that's accessible.

84
00:15:17.460 --> 00:15:36.179
Andy Schneider: We did not take the additional step beyond going to websites and other accessible forms of at of submitting public records, act, request, or freedom of Information Act request. That doesn't meet our definition of publicly available.

85
00:15:36.420 --> 00:15:38.210
So

86
00:15:39.310 --> 00:15:50.870
Andy Schneider: it just doesn't cost that much to add a page to your website and maintain it and keep it up to date. That provides information about how individual plans are doing.

87
00:15:51.880 --> 00:16:06.989
Andy Schneider:  the data is essentially you cannot. You cannot distinguish the the highly performing plans from the low performing plans, and that really makes it difficult to work with the low performing plans to

88
00:16:07.010 --> 00:16:08.199
Andy Schneider: up their game.

89
00:16:08.930 --> 00:16:29.220
Andy Schneider: And we're not arguing. The transparency is gonna solve the maternal health crisis that obviously can't do that in and of itself. But it it is certainly not gonna make it worse, and it is going to give everybody involved. an incentive. Knowing that the results will be public.

90
00:16:29.480 --> 00:16:32.319
Andy Schneider: it will give them an incentive to do better.

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00:16:33.140 --> 00:16:35.949
So with that, let me turn it over to Tanisha.

92
00:16:39.300 --> 00:16:40.700
Tanesha Mondestin: Thanks, Andy.

93

00:16:40.710 --> 00:17:01.390
Tanesha Mondestin: Now some of you may already be familiar with the term Internal Mortality Review Committees or Mmrcs, and you may be wondering, why do they matter? Why are they a part of this topic in conversation? So Medicaid itself covers over 40% of birth, and is the single largest payer or birth in the United States.

94
00:17:01.390 --> 00:17:13.490
Tanesha Mondestin: and since most States have an Mmrc. We seek to explore how Mmrcs can work with State Medicaid agencies and stakeholders, such as Mcos to advance maternal health outcomes.

95
00:17:13.520 --> 00:17:26.199
Tanesha Mondestin: So Andrcs themselves are state level committees that consist of multidisciplinary representatives that are typically appointed to review deaths that occur during or within a year of pregnancy.

96
00:17:26.200 --> 00:17:48.189
Tanesha Mondestin: So the scope of Mmrc. Review processes. They differ by state, and there is a great deal of variation in composition and operation. But currently there are 49 States plus the District of Columbia that haven't been Mrc. Unfortunately, Idaho is only State. That doesn't have an Mmrc. Because they disbanded theirs. This past summer.

97
00:17:48.190 --> 00:18:10.770
Tanesha Mondestin: So Mmrc's generally their goal is to review all maternal death, identify the root causes and contributing factors to these deaths, make recommendations to improve care at an individual in systemic level, and to disseminate findings to the public. The way that Mmrcs are able to do this is that they're provided access to clinical records

98
00:18:10.770 --> 00:18:24.640
Tanesha Mondestin: and demographic information to enable them to understand the circumstances that led to the maternal death and to help identify systemic changes that can occur within the State to avoid maternal death in the future.

99
00:18:24.970 --> 00:18:53.069
Tanesha Mondestin: While there is no uniform analytical protocol, many Mmrcs follow guidelines created by the Cdc. The Cdc currently supports Mmrcs and 44 States and 2 Us. Territories. Other funding sources may

come from State funding grants or donations from private organizations, and the committees themselves. They are differ by state, but typically they consist of public health, professionals.

100
00:18:53.190 --> 00:19:17.649
Tanesha Mondestin: birth workers, such as obis, maternal fetal specialists, Doulas, Midwives, Medicaid agency representatives, community based organizations, individuals with lived experience, behavioral health experts, social workers, law enforcement representatives, American Indian and Alaska, native travel members, advocacy groups, and more. Next slide, please.

101
00:19:19.910 --> 00:19:38.120
Tanesha Mondestin: Now, generally, you can find these Mmrc reports on the websites of State public health agencies, and that's where we found these for the 12 State scans that we performed. So out of the 12 States that we reviewed, all of them had an active Mmrc. But what you could tell was that the report

102
00:19:38.470 --> 00:20:03.670
Tanesha Mondestin: had data that was often not up to date. The table on the right table 6 shows the most recent year of maternal mortality data that was measured. And, as you can see, the most recent data ha! That we had found was from Michigan and Nevada that had data from 2021. But you can see that New Mexico and New Jersey had data, the latest data from 38, which is about 5 years behind on where we are.

103
00:20:03.670 --> 00:20:30.790
Tanesha Mondestin: and most of the Mmrc. Reports identified the source of insurance coverage at the time of death, so whether the birthing person was covered by private Medicaid or uninsured, or whether they had insurance at all. And the State Medicaid Agency did not participate in Mr's. In Iowa, Mississippi, Nevada, and New Mexico. But all the Mmrc. Reports include a Medicaid related finding or policy recommendations.

104
00:20:30.880 --> 00:20:44.220
Tanesha Mondestin: No. Mmrc report that we reviewed included data that was specific to enrollment in individual Medicaid and Mcos among women who died during pregnancy or within a year after birth.

105
00:20:44.530 --> 00:20:45.880
Tanesha Mondestin: Next slide, please.

106
00:20:49.190 --> 00:20:52.809
Tanesha Mondestin: So the data that we collected from the 12 State scan

107
00:20:52.930 --> 00:21:18.930
Tanesha Mondestin: was from updated from July 2023, and most recently, this past month. That passed in October, Illinois updated their Mmrc. Report. So the report that they released analyze data from 2018 to 2020 and the last report, that they had reported data from 2015 to 2017, and what they noticed where that was that pregnancy related death increased by 40%

108
00:21:18.930 --> 00:21:37.680
Tanesha Mondestin: from those time periods. The report did not make recommendations about the transparency of the performance of Mcos, but they did know a very important point, and that was, they recommended that both private and public insurance plans like medicaid that they are integral and promoting maternal health.

109
00:21:37.680 --> 00:21:57.410
Tanesha Mondestin: and can contribute to improve maternal health outcomes. So that, being said, Mcos have to be part of the solution to the maternal health crisis that we are facing and what they do or what Mcco's don't do matter for enrolled, pregnant women and birthing persons. Now I will pass it off to my colleague. Ella.

110
00:22:00.210 --> 00:22:06.590
Ella Mathews: Thanks, Tanisha. Okay, so I'm going to talk to you all about Appendix B,

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00:22:06.830 --> 00:22:08.990
Ella Mathews: so on the left, and this is

112
00:22:09.400 --> 00:22:20.179
Ella Mathews: a comprehensive collection of all the metrics that we and results we found from our all 52 Mcco. So on the left. Starting there, we have the States,

113
00:22:20.190 --> 00:22:31.129
Ella Mathews: followed by the Mcos, the parent firms, the most recent reporting year for the External Quality Review report, and then we start with our metrics

114
00:22:31.230 --> 00:22:46.000
Ella Mathews: from the Cms core set. So you'll see that the State Medicaid averages those are in dark gray, and then the Mcco level performance is in the lighter colors below. So starting as we move to the right, here we have

115
00:22:46.390 --> 00:22:49.039
Ella Mathews: performance on births.

116
00:22:49.110 --> 00:23:04.120
Ella Mathews: Lot of births. Below 2,500 grams. Cesarean's delivery moving on to postpartum contraceptive care performance on timeline is a prenatal and post natal or and postpartum care

117
00:23:04.320 --> 00:23:13.229
Ella Mathews: as well as we get to our hetus metrics, which prenatal immunization, and then both prenatal and postpartum, just pressure and screening and follow up.

118
00:23:15.640 --> 00:23:33.250
Ella Mathews: Okay, so as we mentioned, and Andy said before, there are only 2 metrics that all 12 of our States reported on on an Mcco level, and that was prenatal and postpartum timeliness of care, and we put those in blue, and they're in a bit of a heat map as we'll talk a little bit more about for you to look at. And then

119
00:23:33.260 --> 00:23:45.839
Ella Mathews: for 8 States. That was the only Mcco level data that was available. And then for 4 other States. We also had additional metrics. One example of that would be in New Jersey. We had

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00:23:46.540 --> 00:23:55.200
Ella Mathews: there it is access to contraceceptive care at 3 and 60 days postpartum for 2 different age groups, which is great.

121
00:23:55.430 --> 00:24:22.680
Ella Mathews: So the usefulness of this chart, unlike our others, is that it's sortable, searchable, and you can compare data within it. So if we select performance of 10 min of prenatal care, you can compare the plan that you're in, or a plan versus how it is with other plans in the country or across States. Here, you can see our top line is a

Miss 17 plan Magnolia, held from Mississippi, and all the way at the bottom

122
00:24:22.940 --> 00:24:36.779
Ella Mathews: performance on this lowest ranking plan would be. and New Mexico, the Western Skyhouse plan, which also happens to be a canteen plan. You can also search within your State. So I'm from Tennessee. Let's do Washington.

123
00:24:37.830 --> 00:24:45.539
Ella Mathews: and here you can see which state or which plans are performing above and below the State average again. That is, in that gray line.

124
00:24:45.780 --> 00:24:47.459
Ella Mathews: Right there.

125
00:24:47.600 --> 00:24:55.090
Ella Mathews: great. And then I'm gonna show you all. If we go back to the slideshow, what you all can do with this data

126
00:24:56.600 --> 00:25:08.039
Ella Mathews: great. So I want to show you all what appendix we could do, because this is where everything that we put together is. And I want you all to make the most of this data. So I used it to all the data and

127
00:25:08.200 --> 00:25:10.610
Ella Mathews: Compare Timeliness of

128
00:25:10.610 --> 00:25:24.380
Ella Mathews: Postpartum care by parent firm, which you can also do on the table. But I just wanted to pull it out and show you guys. So to use an example, we have elevons, which was in 7 of our 12 states with Mcos

129
00:25:24.380 --> 00:25:42.170
Ella Mathews: level data for 6 of those, including the regional performance results. In Tennessee. There had a range of performance from 71% to 79% with an average of 75%, which is above the average for all of them at 72, and then also above the average for those

130
00:25:42.170 --> 00:26:09.150
Ella Mathews: plans that did not have a publicly traded national parent firm. Alternatively. You could look at Malina here, which isn't operating in 6 States, and they reported for 5 plans. I think they have a new plan coming in Nevada that was not available at the time of our search, and their range, though, was the lowest at 64 and a high of 80. Then again, though average still above the rest. So of course, this

131
00:26:09.510 --> 00:26:30.620
Ella Mathews: is just to reflect. The subsidiary of the fall states that we looked at. So take it with a grant of salt in some states this was just one plan that we were getting data for but I do think this is a great starting place, for if you wanted to compare parent firms A to B and see which one might be performing better for others, for their pregnant enrollees.

132
00:26:30.620 --> 00:26:43.250
Ella Mathews: Also it would be great, as you also on Appendix B, that we had more metrics to compare. Besides these 2, between all of them, and from there I'm gonna send it over to Andy to talk about recommendations for our advocates.

133
00:26:45.290 --> 00:26:46.460
Andy Schneider: Thanks, Ella.

134
00:26:47.100 --> 00:26:48.210
So

135
00:26:48.230 --> 00:27:06.289
Andy Schneider: in the report you'll see we've made recommendations to State Medicaid agencies to state public health agencies around. Mrc reports to Cms, I just wanna focus here. Briefly, before turning this over to Sarah

136
00:27:06.390 --> 00:27:11.080
on on the recommendations for advocates. And I know that Jc's gonna have

137
00:27:11.350 --> 00:27:14.450
Andy Schneider: some some thoughts about these as well.

138
00:27:14.560 --> 00:27:15.940
Andy Schneider: So

139
00:27:17.550 --> 00:27:24.599
Andy Schneider: so we we think it'd be a good place to start in your state if your state is not one of the 12. We've already looked at

140
00:27:25.230 --> 00:27:30.049
to do a little research and see if you can find

141
00:27:30.490 --> 00:27:36.520
Andy Schneider: information about how individual Mcos are performing. And

142
00:27:36.700 --> 00:27:46.210
Andy Schneider: in a way, our our report methodology could be a playbook for this. I'm sure. There are other ways to to get information

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00:27:46.480 --> 00:27:58.320
but looking at the Medicaid agencies performance dashboard. Some of them have them. or the consumer facing report, card or scorecard. Again, some agencies

144
00:27:58.390 --> 00:27:59.560
Andy Schneider: have those.

145
00:28:00.590 --> 00:28:06.259
Andy Schneider: All of the agencies have to post the annual technical reports that the Qur's

146
00:28:06.380 --> 00:28:12.430
Andy Schneider: prepare for them each year, and those do have to have some findings

147
00:28:12.450 --> 00:28:20.890
Andy Schneider: with respect to individual Mcos. So if you can find those and dig through them, which is easier said than done.

148

00:28:21.170 --> 00:28:30.520
Andy Schneider: There should be some information there. That's where we found most of the data that that Hela was just discussing

149
00:28:30.890 --> 00:28:37.669
then, of course, on the Public Health Agency websites you should be able to find the Mmrc. Reports.

150
00:28:38.230 --> 00:28:54.960
Andy Schneider: In some states the agencies make detailed and useful presentations to their medical care advisory committees that they then post on either the advisory committees website or the State's website, so that that could be a good source as well.

151
00:28:55.490 --> 00:29:00.540
Andy Schneider: So if you're not from that search able to identify

152
00:29:00.860 --> 00:29:09.609
Andy Schneider: which Mcos are high performing, and which are low performing on maternal health, that I think you've got to go to the State Medicaid Agency. You know. They're the ones contracting

153
00:29:09.770 --> 00:29:15.420
Andy Schneider: they're the ones to whom the Mcos are accountable, and you have to

154
00:29:15.690 --> 00:29:24.079
Andy Schneider: talk with them about transparency of results and improving performance reporting requirements.

155
00:29:24.410 --> 00:29:44.439
Andy Schneider: of course, Sarah and her colleagues at at Gw. Did a lot of work on this that was discussed in the in the last webinar, and I think the the as an accountability mechanism, the con, the combination of the contracts and transparency, could work very well here to advancing better care for

156
00:29:45.490 --> 00:29:48.379
Andy Schneider: for pregnant women enrolled in Mcos

157
00:29:48.770 --> 00:29:52.760

Andy Schneider: and then, on the other hand, if you're actually able to figure out

158
00:29:53.010 --> 00:29:56.749
who the low performers are, if there are low performers.

159
00:29:56.850 --> 00:30:00.780
Andy Schneider: then again, you engage directly with them Medicaid Agency.

160
00:30:00.800 --> 00:30:08.149
Andy Schneider: I'd go talk to the Mmrc. Committee and directly to the Mcos to figure out a way of improving their performance.

161
00:30:09.780 --> 00:30:12.970
Andy Schneider: So with that I am going to turn it over to Sarah.

162
00:30:16.010 --> 00:30:27.129
Sara Rosenbaum: Thank thank you, Andy. So I will make. I'm going to make a few brief remarks, and then I turn it back over to. Does it go to Elizabeth next?

163
00:30:28.160 --> 00:30:29.270
Sara Rosenbaum: Mundan?

164
00:30:29.580 --> 00:30:43.890
Sara Rosenbaum: Okay. I knew I was passing the baton somewhere somewhere. Good. So this is a great report. Of course it adds another incredibly important

165
00:30:44.290 --> 00:30:49.529
Sara Rosenbaum: set of information to what I have always

166
00:30:49.690 --> 00:30:53.890
Sara Rosenbaum: thought is one of the most complicated issues in Medicaid and managed care.

167
00:30:53.970 --> 00:30:58.120
Sara Rosenbaum:  Because.

168
00:30:58.280 --> 00:31:04.550
Sara Rosenbaum: on the one hand. since the mid 1980 s.

169
00:31:04.640 --> 00:31:20.790
Sara Rosenbaum:  the Federal laws governing Medicaid eligibility thanks in great part to to Andy and his colleagues, and and to force mostly to Henry Waxman. Had

170
00:31:21.000 --> 00:31:23.950
Sara Rosenbaum: the structure of eligibility for pregnant women

171
00:31:24.460 --> 00:31:25.520
as

172
00:31:25.800 --> 00:31:32.479
Sara Rosenbaum: Contained a safeguard that is absolutely essential. If you're talking about

173
00:31:32.890 --> 00:31:52.180
Sara Rosenbaum: pregnancy care, I don't care if it's in managed care outside of managed care, which is continuity over time, sustained enrollment over time. And now, of course, that that period of postpartum care has been has been extended, which is a crucial

174
00:31:52.280 --> 00:32:00.130
Sara Rosenbaum: improvement building on the longstanding continuity rules for

175
00:32:00.770 --> 00:32:08.009
Sara Rosenbaum: pregnant people and their babies. With the babies, of course, enrolled for the first year of life.

176
00:32:08.080 --> 00:32:24.700
Sara Rosenbaum:  on the other hand, we're talking about a really really complicated set of issues, and I would say, very complicated for managed care plans not just complicated for advocates, and certainly for families and for providers.

177
00:32:25.030 --> 00:32:32.019
Sara Rosenbaum: But it's complicated for managed care entities

themselves and for state Medicaid

178
00:32:32.480 --> 00:32:34.969
Sara Rosenbaum: programs trying to oversee

179
00:32:35.060 --> 00:32:48.060
Sara Rosenbaum: the quality and accessibility of maternal and infant care services. And that's because there are really 2 basic pathways into

180
00:32:48.070 --> 00:32:53.629
Sara Rosenbaum: Medicaid managed care, and I don't think we understand enough

181
00:32:53.650 --> 00:33:16.650
Sara Rosenbaum: about how who populates, which pathways, what their risks are. And how these different populations may relate to the work of maternal mortality. Review committees, which Georgetown's, you know, greatest contribution is pointing out that these findings are just are just totally crucial

182
00:33:16.650 --> 00:33:28.319
Sara Rosenbaum: for for managed care, advocacy, and maternal health improvement. And the 2 groups are people who are enrolled in Medicaid

183
00:33:28.330 --> 00:33:38.990
Sara Rosenbaum: who are members of plans who become pregnant as plan members. They might be low-income adults

184
00:33:39.030 --> 00:33:50.610
Sara Rosenbaum: or or adolescents. They might be Very poor parents. They might be adults with disabilities, but they're already

185
00:33:50.880 --> 00:33:55.770
Sara Rosenbaum: in a plan. They're already receiving care. They become pregnant.

186
00:33:55.870 --> 00:34:00.499
Sara Rosenbaum: The other group is the group of beneficiaries who

187

00:34:00.980 --> 00:34:28.770
Sara Rosenbaum: become eligible, based on pregnancy. There was an event. The event is a pregnancy, confirmation that pregnancy, confirmation triggers your eligibility. It triggers your selection of a plan, or your assignment to a plan, and I think States differ tremendously on how they connect people to manage care when the eligibility is based on pregnancy.

188
00:34:28.810 --> 00:34:57.319
Sara Rosenbaum: and if you stop and think about it, the populations are hugely different. They may be different in their pre prior access to health care. They may be different in various demographic factors. They just are very different people, and I think it's really important for us as advocates around Medicaid and maternal health. To understand. And to do a lot of work educating maternal mortality review committees

189
00:34:57.320 --> 00:35:08.590
Sara Rosenbaum: about some of the nuances of the Medicaid population. I'm just not sure how attuned the committees are to thinking this through and thinking through what kinds

190
00:35:08.610 --> 00:35:09.800
Sara Rosenbaum: of

191
00:35:10.130 --> 00:35:31.279
Sara Rosenbaum: issues they want to look at. as they are doing reviews of these terrible sentinel events. You know, there, there! The rates are terrible in the Us. It's still a relatively small number of people, but of course, every case is a sentinel event.

192
00:35:31.410 --> 00:35:55.329
Sara Rosenbaum: and so I think the characteristics of the beneficiaries, and when they entered, and how they entered, and what, when their connection to managed care happened. Is important, and it's very important for plans. My sense is that there's just not enough. Give and take between the plans and the work of the review committees, for example, how many State Medicaid programs require?

193
00:35:55.330 --> 00:36:06.189
Sara Rosenbaum: Their health plans as part of their ongoing operations to read and understand the Mmrc. Reports

194

00:36:06.210 --> 00:36:24.969
Sara Rosenbaum: and then make clear what they are going to do in the way of maternal health innovations which this is theory why, a lot of agencies buy managed care for for it's it's it's innovative approach to certain key population health issues.

195
00:36:25.000 --> 00:36:40.840
Sara Rosenbaum:  you know how they're gonna respond. It's one thing to sort of in the abstract. Say, well, we're gonna have really good maternal health services. It's another thing to really expect the Mcos to internalize the results of the Mmrcs.

196
00:36:40.870 --> 00:36:49.590
Sara Rosenbaum: And you know whether it's always a Medicaid beneficiary, which is most certainly is not. But every maternal death

197
00:36:50.050 --> 00:36:58.630
Sara Rosenbaum: tells us important things about how the system is working. Another really important aspect to all of this, and this is.

198
00:36:59.210 --> 00:37:06.049
Sara Rosenbaum: goes back to the work we did in our study is the

199
00:37:06.650 --> 00:37:12.990
Sara Rosenbaum: kind of the continuity of care. In other words, this is not about prenatal and delivery care.

200
00:37:13.020 --> 00:37:18.709
Sara Rosenbaum: and a couple of postpartum checkups. This is about the health of people going into a pregnancy.

201
00:37:18.830 --> 00:37:25.989
Sara Rosenbaum:  how the pregnancy was identified when the pregnancy was identified.

202
00:37:26.000 --> 00:37:35.690
Sara Rosenbaum: the bundle of services that go into what we call pregnancy-related care, which can vary from state to State.

203
00:37:35.730 --> 00:38:05.779
Sara Rosenbaum:  in terms of what the State is emphasizing. How much

the status sort of tried to push the boundaries, how much it expects the plans to push the boundaries which services, according to experts, which is what we did. In in addition to our study, we did a huge literature review that's indispensable. That gives you all the evidence in one place of exactly what we know about various components of maternal health services and and what matters

204
00:38:05.780 --> 00:38:15.290
Sara Rosenbaum: and and so really understanding the continuum of care and expecting that the contract.

205
00:38:15.630 --> 00:38:16.960
Sara Rosenbaum: while

206
00:38:17.050 --> 00:38:34.439
Sara Rosenbaum: certainly giving plans, running room to assemble, care teams to try strategies for enrolling, you know, attracting providers for linking to social services all the things that managed care in theory is doing.

207
00:38:34.480 --> 00:38:49.589
Sara Rosenbaum: I think it's important to have specificity in the contracts to not just say in a contract. We expect the prenatal care is a covered benefit. Of course we all expect the prenatal care is a covered benefit that really doesn't tell the plan anything.

208
00:38:49.800 --> 00:39:11.029
Sara Rosenbaum: And we were actually quite taken aback by how limited the directives were. Even assuming you don't wanna micromanage the plan, which is a a big issue for States, and it's a big issue for plans. But enough directives so that you have the expectations that then turn into

209
00:39:11.220 --> 00:39:30.140
Sara Rosenbaum: performance. Metrics? you know, it's great that there's early entry. It's great that there's a postpartum visit. But there are probably 5 or 6 other bellwether issues that most experts in maternal health would say, You wanna look at along the way. The content of the care.

210
00:39:30.140 --> 00:39:42.649
Sara Rosenbaum: the setting and structure of care, the other services that people got while they were enrolled in in, in maternal health

care of, and of course, the all important postpartum period. Not just the 2 week checkup

211
00:39:42.660 --> 00:39:59.550
Sara Rosenbaum: But now in States with 12 months, what's going on over that 12 month period? And I just I think that my biggest takeaway from this terrific study is is is certainly

212
00:39:59.860 --> 00:40:10.410
Sara Rosenbaum: the findings on limited transparency. But equally importantly, is this unexplored relationship

213
00:40:10.540 --> 00:40:16.860
Sara Rosenbaum: of what the maternal Mortality review committees are doing. and how Medicaid agencies

214
00:40:16.880 --> 00:40:19.340
Sara Rosenbaum: translate their work

215
00:40:19.360 --> 00:40:34.529
Sara Rosenbaum: into their contract, expectations into their performance measures, and how much they expect their their managed care plans to internalize these essential studies as well. So why don't I pass it off to Jc, now.

216
00:40:37.630 --> 00:41:02.670
Jacy Montoya Price: Hi, and thank you for including me in this presentation that's so important to understanding how managed care organizations perform in maternal health? As you learned, I'm Jc. Montoya Price, and I'm with the alliance for early success for those who aren't familiar. The alliance for early success works with child advocates in all 50 States, plus DC. To make legislative and administrative changes

217
00:41:02.670 --> 00:41:08.379
Jacy Montoya Price: to ensure that young children and their families have what they need to thrive. Maternal health is

218
00:41:08.390 --> 00:41:21.899
Jacy Montoya Price: integral to ensuring that young children and families can thrive, and we're fortunate to work with the Georgetown Center for children and families as one of our responsive support

providers. To our State grantees.

219
00:41:22.090 --> 00:41:44.120
Jacy Montoya Price: As an advocate. There was so much in this report. That was eye opening and shocking. To be frank, the fact that the way that the managed care organizations are compensated actually creates a perverse incentive for them to minimize their costs.

220
00:41:44.130 --> 00:41:45.330
Jacy Montoya Price: It was

221
00:41:45.460 --> 00:42:13.830
Jacy Montoya Price: shocking and something new for me as a non medicaid expert. We know, I think that what gets measured gets changed. And what was really striking to me is that these factors, these measures, are being tracked by the managed care organizations, but that data is not necessarily being shared with the folks who need that information in order to advocate for change.

222
00:42:13.960 --> 00:42:18.799
Jacy Montoya Price: And so, as we look at the recommendations and the report and the takeaways.

223
00:42:18.970 --> 00:42:36.070
Jacy Montoya Price: It feels like there's an opportunity for a low-cost bill or administrative change simply to make that data that's being collected available publicly. I know it can sometimes be a little bit sensitive for the Medicaid agencies to share that themselves.

224
00:42:36.070 --> 00:42:51.480
Jacy Montoya Price: But I believe in every State there is at least one organization that is on the forefront of advocating for maternal health, and would be thankful to have that data to inform their work and their advocacy with legislators and others.

225
00:42:51.940 --> 00:43:14.790
Jacy Montoya Price: I appreciated what Andy said about you know, transparency is necessary, but not sufficient to address maternal health disparities. And that is absolutely true. But that data transparency is what will give advocates the fuel they need to push for change

226
00:43:16.270 --> 00:43:31.239
Jacy Montoya Price: in addition to having the data available by Mco. Which seems very important for the contracts and assessing performance, and also for individuals to decide which plan may be most opportune for them.

227
00:43:32.070 --> 00:43:40.059
Jacy Montoya Price: disaggregating the data by race and ethnicity is essential. We know that the racism and

228
00:43:40.060 --> 00:44:07.900
Jacy Montoya Price: discrimination that has been impressed upon people of color, black women in indigenous women in particular, in our country is what is maintaining the disparities that we've seen over time, and without that disaggregated data, advocates will not have the information they need to call for the changes that will help to narrow that disparity and ensure that all people have the care that they need

229
00:44:09.120 --> 00:44:18.439
Jacy Montoya Price: I appreciate the recommendations in the report about advocates going to look for what might be available in their States?

230
00:44:18.640 --> 00:44:37.689
Jacy Montoya Price: My takeaway from this report is that there's probably not a whole lot. And so, in addition to doing that research on their their own being able to have something like this that can be fueled to talk with the Health Department, to talk with a Medicaid agency, to talk with legislators, and say.

231
00:44:37.760 --> 00:44:45.269
Jacy Montoya Price: Hey, here's a low-cost way for us to understand what's happening for pregnant people on Medicaid in our State.

232
00:44:45.310 --> 00:45:04.719
Jacy Montoya Price: Could be a great first step in bringing around the understanding that is needed to have stronger contracts and to measure outcomes for pregnant people, and not just the processes like access to prenatal and postnatal appointments.

233
00:45:05.260 --> 00:45:21.149
Jacy Montoya Price: thank you. I think that's all I have for now. But

again, the disaggregated data is so clear, so clearly needed for an issue that is impacted by race and ethnicity, and can't be fixed without acknowledging that.

234
00:45:21.750 --> 00:45:22.420
Yes.

235
00:45:25.360 --> 00:45:42.869
Elisabeth W Burak - GCCF: thank you so much. Jc, I really appreciate your pulling together. How to think about an advocacy opportunity for better transparency and indeed! There's a lot of money and a lot of lack of information which we all where I think

236
00:45:43.370 --> 00:45:44.550
Elisabeth W Burak - GCCF: amazed 5.

237
00:45:45.460 --> 00:46:03.369
Elisabeth W Burak - GCCF: So I wanna start with some of the questions in the chat. I have many questions myself, but I want to start with some of the folks who've asked this. So one of the first questions, this is really Ellen Andy was about, is there a state that has a dashboard that you would point to as a model

238
00:46:03.380 --> 00:46:06.839
Elisabeth W Burak - GCCF: for transparency and data. In this work

239
00:46:38.750 --> 00:47:05.360
Ella Mathews: I would probably say that one of the best was New Jersey's. Unfortunately, though, it has not been updated since 2,019. So that takes them out of the running, though I do think it's a good example. If you were able to keep it updated. And then also Georgia. They had a good one that, you know, gave you Mcco level breakdowns and performance of timeliness and postpartum care. I want to say there was another third metric, but it's all an appendix. So encourage you to look there.

240
00:47:08.600 --> 00:47:23.949
Elisabeth W Burak - GCCF: Thank you, and I think I know the answer to this, but I wanted to flag it, because I know there are a lot of folks looking at intersections, dream Medicaid and wic for food nutrition programs. And, in fact, I know we have a project coming out soon with the center on budget on this. But

241
00:47:23.990 --> 00:47:36.400
Elisabeth W Burak - GCCF: was there any consideration around Wic participation as you were looking at this, or I guess but I would ask more, I think, to you, Alice, did you see anything in some of these reports around Wic participation.

242
00:47:36.470 --> 00:47:39.620
Elisabeth W Burak - GCCF: As you were reviewing what was publicly available.

243
00:47:40.810 --> 00:48:04.800
Ella Mathews: you know, not to mine out specifically. And then again, we had laser focused on our metrics. But you know, I think some of the results we found did cross over a bit, but again was not included in our study as much. Nothing really comes to mind. But I'll also leave that to Tanisha and Andy, if they have any thoughts. If I could just note that in the contract study

244
00:48:04.800 --> 00:48:17.099
Sara Rosenbaum: in the tables. There are, and Caitlin Murphy is probably listening in. She's our lead Guru on the contract study. There are states that

245
00:48:17.130 --> 00:48:33.499
Sara Rosenbaum: dove more deeply into nutrition assistance during pregnancy as an expectation. But as I recall, and we can send, you know, a note to the chat box, or whatever afterwards, for everybody who's listening.

246
00:48:33.500 --> 00:48:49.979
Sara Rosenbaum: a a lot of states where there was no mention whatsoever. And that's a perfect example. I mean, the question is a great question, because it's a perfect example of where you'd want to specify some level of nutrition assistance during pregnancy, whether it's wic

247
00:48:49.980 --> 00:49:11.160
Sara Rosenbaum: whether it's wic and more broadly, nutrition services. And then have a performance measure related to you know, how well are you getting health supportive services? And of course, one example would be wic so you sort of want the front end expectation. And then a performance measure.

248
00:49:12.910 --> 00:49:15.620
Andy Schneider: Yeah, I agree. That's a great question

249
00:49:15.820 --> 00:49:23.039
Andy Schneider: we did not look at that, because, as Ella mentioned, we were focused on the Cms maternity core set metrics.

250
00:49:23.160 --> 00:49:26.900
Andy Schneider: And and it does raise the question

251
00:49:26.940 --> 00:49:34.759
Andy Schneider: for future policy, development and regulatory development about how metrics might be adjusted

252
00:49:35.190 --> 00:49:43.240
Andy Schneider: or new metrics created that would reflect with participation and nutritional support that that was.

253
00:49:43.490 --> 00:49:47.479
Andy Schneider: as we like to say, in the biz, beyond the scope of our report.

254
00:49:50.760 --> 00:50:07.300
Elisabeth W Burak - GCCF: Well, this kind of gets into another question. We had around performance improvement projects. So it seems like that would be an opportunity for States to look at, for example, with participation in Medicaid, and I should note that for those of you asking about Wic, there's really low participation in it as compared to what it could be.

255
00:50:07.500 --> 00:50:19.490
Elisabeth W Burak - GCCF: So there is a role to play here. But what did you all find in terms of the performance? Improvement plans in states, and what they might be looking at? And then, Andy, I know you had some recommendations around this for State agencies, too.

256
00:50:24.860 --> 00:50:27.500
Ella Mathews: Oh, you're on mute, Andy. Oh, you're muted, Andy.

257
00:50:27.570 --> 00:50:32.680

Andy Schneider: Sorry, Ellie Rartanishi. You want to start with that no got the recommendations.

258
00:50:33.450 --> 00:50:35.230
Ella Mathews: Yeah. So

259
00:50:35.890 --> 00:50:46.190
Ella Mathews: we looked in the 12 plans, I wouldn't say. And I there's an exact table of how many pips were covered. We did see. Usually, you know, a State would have

260
00:50:46.860 --> 00:50:51.369
Ella Mathews: all of them doing a pip. I think that was the case in Michigan or a number of States. I am

261
00:50:52.270 --> 00:51:20.739
Ella Mathews: trying to remind myself, postpartum care which were the most common, and in some cases they all 3 of them

262
00:51:20.740 --> 00:51:39.740
Ella Mathews: where they were plans. Altered a different pip. I would say that in our reviews of the Eqr. Reports there was a lot left to be desired on what that looked like for those participating in those pips. And what the follow up was year to year, and what the actual improvements were from those plans. But into your thoughts.

263
00:51:41.050 --> 00:51:50.129
Andy Schneider: So we didn't. We didn't make 2 recommendations on this one was that the States that haven't been requiring performance improvement plans

264
00:51:50.250 --> 00:51:57.569
Andy Schneider: of Mcos relating to maternal health should do that. They have the option to do it. They should do it.

265
00:51:57.930 --> 00:52:11.829
Andy Schneider: The! And there's Federal match, of course, on what they're paying the Mcos to to conduct the pips. And there's several match on what they're paying the Eqrs. To review the plans performance on the pips.

266

00:52:12.080 --> 00:52:18.810
Andy Schneider: The other recommendation we made was to Cms. Cms. Under its own regulations.

267
00:52:18.900 --> 00:52:32.020
Andy Schneider: gives itself the option to require pips that address certain issues and require all States to to require them intern of manage care organizations. And

268
00:52:32.140 --> 00:52:47.110
Andy Schneider: you know, this is a national issue. We think Css. Tell the States they need to develop some pips and and require them. Of all all the plans until we can get a handle on the problem.

269
00:52:48.650 --> 00:53:01.179
Elisabeth W Burak - GCCF: Yes, it's great to see the pips, the performance, improvement plans and states on timeliness of prenatal and post hard. I don't care, but it seems like we've already heard about potential Wic participation pips. There are all kinds of other outcomes we could look at so

270
00:53:01.800 --> 00:53:08.100
Ella Mathews: great opportunity. I will say, on that note. We were always interested in the ones that kind of chose their own very specific

271
00:53:08.190 --> 00:53:17.619
Ella Mathews: topic for their pip. That seems they had a little more thought of. It was geographically located or based on improving. You know what those pregnancy outcomes were. But

272
00:53:17.750 --> 00:53:18.990
Ella Mathews: we can move on to the next.

273
00:53:22.090 --> 00:53:26.540
Elisabeth W Burak - GCCF: I just wanted to note in our Q. And a. That Virginia

274
00:53:26.770 --> 00:53:34.760
Elisabeth W Burak - GCCF: breaks their heat as outcome measures by C. By Mco. So we'll try to put that in the chat. That's thank you for that heads up

275
00:53:35.000 --> 00:53:37.100
Andy Schneider: the folks in Virginia.

276
00:53:37.260 --> 00:53:41.550
Elisabeth W Burak - GCCF:  and

277
00:53:41.720 --> 00:53:49.340
Elisabeth W Burak - GCCF:  We have a few other questions, and I want to think about how best to answer them.

278
00:53:49.670 --> 00:53:58.809
Elisabeth W Burak - GCCF: So. One was about the importance of stratifying by race and ethnicity, which, of course, we know is important to understand the challenges.

279
00:53:59.070 --> 00:54:14.519
Elisabeth W Burak - GCCF: But Sharon cards asking in more homogeneous states, would it also be important to look at rural versus urban data or other breakouts? And had did you see any other types of stratification or look at sort of rural versus urban areas.

280
00:54:17.870 --> 00:54:20.579
Andy Schneider: We did not look at rural versus urban

281
00:54:23.370 --> 00:54:33.330
Andy Schneider: then the the metrics that we were looking for were standardized across both urban and rural and across the country. So but it's a fair question.

282
00:54:33.580 --> 00:54:42.420
Andy Schneider: It's definitely a fair question as we dig down further. but it we did not. We did not look at that

283
00:54:43.090 --> 00:55:05.679
Jacy Montoya Price: from an advocacy advocacy, perspective. I would say that that data could be really valuable. You know, race and ethnicity data, even in seemingly homogeneous states, is important. And at the same time I've seen some of our Allies be able to make a stronger case for policy shift in maternal care when they can show that contrast between urban and rural

284
00:55:05.680 --> 00:55:19.669
Jacy Montoya Price: so that legislators and other policy makers understand. This isn't just a quote unquote inner city problem or something that impacts. You know, a group that they don't identify with that. This impacts all pregnant and parenting people.

285
00:55:19.840 --> 00:55:34.040
Sara Rosenbaum: I would also say that what we know about maternity desert, I'm sure, has an impact on this as well. And so yeah, well, II do think again, going back to the earlier discussion.

286
00:55:34.100 --> 00:55:39.489
Sara Rosenbaum: it's very important that that people begin to focus on how

287
00:55:40.290 --> 00:55:51.890
Sara Rosenbaum: folks entered Medicaid. And when did they enter, already pregnant with a confirmed pregnancy that, had that was not confirmed for months.

288
00:55:52.070 --> 00:56:01.140
Sara Rosenbaum: there might have been a long delay in a pregnancy, confirmation, and so the plan is starting late. Did they, in fact.

289
00:56:01.560 --> 00:56:07.669
Sara Rosenbaum: begin their pregnancy already as members, and even then

290
00:56:07.700 --> 00:56:34.290
Sara Rosenbaum: it you know, it could be the inverse, we could find that a lot of the late entry into care, poor care! Poor continuity of care is people who began as medicaid beneficiaries already enrolled, who became pregnant, who, for whatever reason either did not understand the pregnancy, were concealing the pregnancy, were, you know, in denial about the pregnancy. I just think that we

291
00:56:34.410 --> 00:56:39.090
Sara Rosenbaum: that if we're going to make managed care perform better, which is.

292

00:56:39.420 --> 00:56:51.800
Sara Rosenbaum: you know, our contracting work. It's Georgetown's performance work. We have to understand Medicaid's interaction with pregnancy much more than we understand it today.

293
00:56:51.810 --> 00:56:55.150
Sara Rosenbaum: And this is a place where Cms

294
00:56:55.260 --> 00:57:09.660
Sara Rosenbaum: and Cdc and state maternal mortality review committees and vital statistics offices could be a lot more helpful. It really doesn't help to just know that the person was enrolled in Medicaid at the time of the death.

295
00:57:10.090 --> 00:57:17.529
Sara Rosenbaum: There's so much more going on in Medicaid because of its peculiar nature. And

296
00:57:17.800 --> 00:57:24.380
Sara Rosenbaum: if we don't get to the bottom of this, we don't know how to structure the services correctly, and we don't know what to measure.

297
00:57:27.440 --> 00:57:43.969
Elisabeth W Burak - GCCF: Clearly. There's a lot of room for improvement about what we can understand. No and I wanted to. Arden, Handler in Illinois, had a really great comment that I'm sure you all will have thoughts on, and it's and and her point was plan. Accountability is different than provider accountability.

298
00:57:44.140 --> 00:57:52.070
Elisabeth W Burak - GCCF: and Illinois has a model contract looking at Mcos. But it's hard to really gauge that performance on the ground.

299
00:57:52.270 --> 00:58:02.639
Elisabeth W Burak - GCCF: And so any thoughts on how to think about sort of the multitude providers involved, and how to further look at this down beyond the plan level to the provider level.

300
00:58:03.280 --> 00:58:05.260
Sara Rosenbaum: Well, we found, I mean.

301
00:58:05.290 --> 00:58:11.360
Sara Rosenbaum: I just for starters. We found a total dearth of maternal

302
00:58:12.190 --> 00:58:15.360
Sara Rosenbaum: continuum expectations about networks.

303
00:58:15.990 --> 00:58:22.070
Sara Rosenbaum: You know. What's your network, what capabilities the networks had to have around maternal health!

304
00:58:22.390 --> 00:58:43.410
Sara Rosenbaum: What performance required, what, what what characteristics the providers had to have, what capabilities they had to have. How big, I mean, you know, just the just the presence of of the timeliness of visits. You know. How many providers do you have? It was. It was actually the thing that surprised me more than anything

305
00:58:43.460 --> 00:59:03.590
Sara Rosenbaum: was the limit. Limited nature of the connection to networks and the and the ability of the networks to speak to the hospital delivery programs. What you have is isolated hospital improvement efforts, you know, around the delivery. But you have.

306
00:59:03.650 --> 00:59:21.839
Sara Rosenbaum: We're hearing from some follow-up work we're doing with community health centers that there is no warm handoff to the hospital, and there's no warm handoff back from the hospital. And so all of these things go into how you structure the contract. And then what you measure.

307
00:59:24.400 --> 00:59:28.500
Andy Schneider: Yeah. So it's a very good question. We didn't look at this.

308
00:59:29.020 --> 00:59:47.250
Andy Schneider: We were focused, as I've explained, just on the Mcos, because they control the money. They organize their provider networks. They just they decide what to pay the providers, they measure the quality of the services their beneficiaries are getting, so that seemed to us an important

309
00:59:47.620 --> 00:59:48.849
focal point.

310
00:59:50.110 --> 00:59:52.449
Andy Schneider: We did make a recommendation

311
00:59:52.690 --> 01:00:11.729
Andy Schneider: based on some work that's going on at Cms on the Medicare side, where they are developing a designation called Birthing Friendly hospitals their designation, and they're as I understand it, they're about to. They're scheduled this fall to release the actual list of birthing friendly hospitals

312
01:00:12.270 --> 01:00:14.610
Andy Schneider: and

313
01:00:15.400 --> 01:00:30.929
Andy Schneider: and one of the recommendations we make to the State Medicaid agencies is to consider requiring all the Mcos they contract with to to to sub contract with a birthing friendly hospital once those designations are available.

314
01:00:31.110 --> 01:00:55.420
Andy Schneider: That may be going on already, because we don't know who they are. But that's about as far as we went. In looking at the the provider issues, and it may be that, you know, to Sarah's point in the conversations that hopefully will start to happen if they aren't already between the Mrrc's and the Mcos that there are some hard questions being asked about low performing providers.

315
01:00:56.180 --> 01:01:06.760
Sara Rosenbaum: Exactly right exactly, I mean, and and the limited nature of the measurement system. Birthing. Friendly hospitals are fine, but if the measure does not handle

316
01:01:06.890 --> 01:01:36.080
Sara Rosenbaum: and this has been my concern. Are we even asking the right questions around the certification categories? If you're birthing friendly hospital? But you have no way of communicating with the place where the prenatal care is happening, and you discharge somebody with a 2 week follow up. You know the social worker tells you to follow up in 2 weeks, but no warm handoff back to the post. Pardon,

provider, then I don't know how birthing friendly a hospital you are so there it is, it is

317
01:01:36.180 --> 01:01:53.320
Sara Rosenbaum: the managed care plans can be used to overcome, as you're saying, Andy, a lot of the siloing qualities of looking at providers in isolation, instead of a long continuity of care.

318
01:01:53.330 --> 01:01:57.760
Sara Rosenbaum: you know. Is this an integrated? Is the vision an integrated vision?

319
01:01:57.850 --> 01:02:13.800
Sara Rosenbaum: And are the Mcco requirements and the provider requirements or the indirect provider requirements, working with what's covered and working with what's in the service area and working with the nature of the population.

320
01:02:14.030 --> 01:02:30.740
Sara Rosenbaum: It's very. It's very complicated. But the great thing about the Georgetown study is that it adds this piece that I think just has not gotten enough attention, which is not just the metrics, but the fact that you have these committees working in isolation, I mean

321
01:02:30.780 --> 01:02:49.560
Sara Rosenbaum: doing tremendous work. The review committees but sort of again outside of the managed care process, except to note that somebody was a medicaid beneficiary and maybe was in a plan, you know. But but the full richness of what they have to say is just not

322
01:02:49.860 --> 01:02:51.600
not integrated.

323
01:02:55.270 --> 01:03:05.559
Elisabeth W Burak - GCCF: So much more discussing we could do. And I'm gonna take a moderators privilege because there's a lot to get our hands around. And I'm gonna point the last word to Jc, because I think

324
01:03:05.610 --> 01:03:08.519
Elisabeth W Burak - GCCF: there's so much to think about as an advocacy

325
01:03:08.680 --> 01:03:17.650
Elisabeth W Burak - GCCF: angle, and especially when we think about there's so many power dynamics in play in terms of money. And who can make people do things with the state capital.

326
01:03:17.900 --> 01:03:24.949
Elisabeth W Burak - GCCF: What are your final thoughts on advocates and maternal health? Especially as we try to in engage

327
01:03:25.190 --> 01:03:30.660
Elisabeth W Burak - GCCF: parents and moms with lived experience and ha and policy change.

328
01:03:30.700 --> 01:03:35.780
Elisabeth W Burak - GCCF: How do we? What's the right approach to kind of get our hands around this? What's the first step in your mind?

329
01:03:36.270 --> 01:03:57.250
Jacy Montoya Price: Excellent question. I think the first step is things like this that really can help break down the information in more accessible ways. It would be awesome to see an infographic or some other way of sharing this data that doesn't get as much into acronyms and medicaid policy deeply.

330
01:03:57.260 --> 01:04:24.819
Jacy Montoya Price: The stories that people with lived experience can share, could really put flavor or strength behind these findings. So that when advocates are going to legislators or medicaid agencies to ask for changes. They have excellent data and research, and they have stories from real folks who maybe have a challenge navigating maternal care through their Mcco.

331
01:04:24.990 --> 01:04:43.990
Jacy Montoya Price: I would also say that this kind of information is a great foundation for advocates to then figure out what's available and continue pushing for transparency without transparency we can't address the disparities that exist. And

332
01:04:43.990 --> 01:04:57.400
Jacy Montoya Price: in a system that incentivizes, minimize costs and services for pregnant people, there needs to be strong advocacy by the

community to ensure that pregnant people are getting the services they need.

333
01:05:00.790 --> 01:05:13.390
Elisabeth W Burak - GCCF: Thank you. II think that that sums us off quite well. We have many more questions. We're gonna try to answer offline, and we appreciate all the participation. And

334
01:05:13.670 --> 01:05:22.800
Elisabeth W Burak - GCCF: we hope we'll have the slides and recording out soon, and we look forward to continuing this conversation. Thanks everyone for joining us today.

335
01:05:24.140 --> 01:05:24.910
Jacy Montoya Price: Thanks.