USING POLICY TO IMPROVE PRECONCEPTION HEALTH

Over the past 15 years, since the first meeting of experts convened by the US Centers for Disease Control and Prevention (CDC) in 2004 to discuss preconception health and health care, policy development has been part of the work undertaken. The Policy and Finance Work Group of the National Preconception Health and Health Care Initiative defined a set of principles for preconception in health reform and coverage policy. As embodied in a 2008 supplement to Women's Health Issues (Johnson et al, 2008; Rosenbaum, 2008), these principles said:

1. Adult women should have health coverage. Without trying to set precise age limits on childbearing age or menarche to menopause, this category would cover women ages 21-65 years.
2. Preventive services, including family planning, preconception, and prenatal care, should have first dollar coverage, without cost sharing (co-pays or deductibles).
3. An enhanced benefit (for use by public or private plans) should offer interconception care coverage for women who have had a prior (recent) adverse pregnancy outcome.
4. Patient protections (e.g., no gender rating, guaranteed issue, grievance process) should be in place.

What has been achieved in women's health policy over the past decade is remarkable. Among women ages 19-64, the uninsured rate dropped from 19% in 2013 to 11% in 2017, primarily through the Affordable Care Act (ACA) Medicaid expansions and subsidized Marketplace plans (Kaiser Family Foundation, 2018). As of February, 2019, 36 states and DC had expanded eligibility for Medicaid, to women (and men) with incomes below 138% of the federal poverty level regardless of their pregnancy, parental, or disability status (Kaiser Family Foundation, 2019). The ACA also set in place the patient protections for women and others. The opportunity for states to design an enhanced benefit for interconception care is available under Medicaid through waivers, and some changes can be made without new federal authority.

ACA IMPLEMENTATION

- On August 1, 2012, an estimated 47 million insured women gained coverage for select clinical preventive health services without cost-sharing. Insufficient attention has been given to effective implementation. Federal list of clinical preventive services for women includes: well-woman visits, preconception care, prenatal care; contraceptive methods and counseling; six other categories of women's preventive services; plus immunizations and other preventive services for all adults.

ACA IMPACT

- Among reproductive-age women (15-49 years), the ACA was associated with a 7.4 percentage-point decrease in the probability of being uninsured. ACA-related coverage was also associated with declines in cost-related barriers to medical care and fewer women lacking a usual source of care. These impacts were greatest among women with low incomes (Daw and Sommers, 2019). Declines were less among Latinas.

ROLE OF MEDICAID

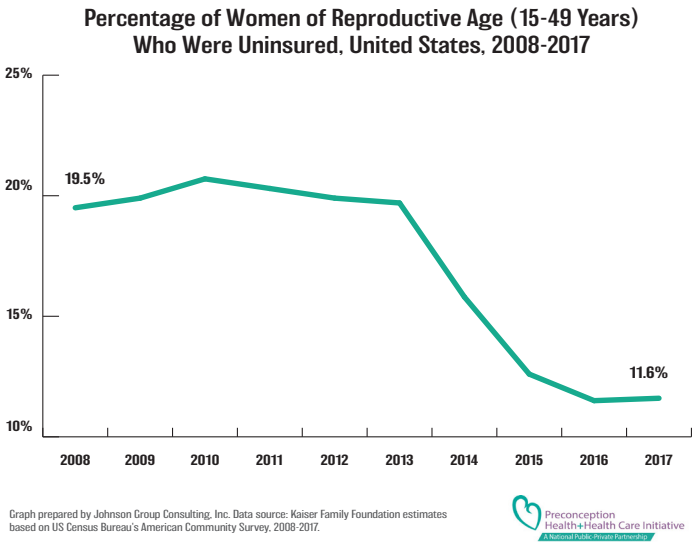
- More than 15 million women of reproductive age are enrolled in Medicaid. This includes: nearly one-third (31%) of African American women, over one quarter (27%) of Latinas, and about one in five (19%) of API women, particularly Southeast Asian and Pacific Islanders.

- ACA Medicaid expansions decreased uninsurance rates among low-income women of reproductive age and reduced likelihood of women experiencing a cost barrier (Johnston et al., 2018). Declines in the proportion of women who were uninsured were less significant in states that did not expand ACA Medicaid (Jones and Sonfield, 2016).

- Preconception coverage increased. Early results indicate post-ACA Medicaid expansion was associated with increased enrollment in Medicaid before pregnancy among low-income women (Clapp et al., 2018).

Equally important, preconception care as part of well-woman visits was recommended in the Institute of Medicine report on Clinical Preventive Services for Women (IOM, 2011) and the federal Women's Preventive Services Guidelines adopted to reflect these recommendations (HRSA, 2019). In addition, the Women's Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure that the recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained (ACOG; Phipps et al., 2018).

Progress in coverage since ACA



What is not happening but should be

At the same time, there is much left to do to implement those policies. Financial and other access barriers limit health and health care for many low-income women, particularly young adults of color, immigrants and those in the working class (Wisk and Sharma, 2019). Primary care is often discontinuous, and many young adults do not have a medical home. Most women have coverage for preventive visits including preconception services, but they and their providers are not aware or for other reasons are not using this public/private health insurance benefit (Hall et al., 2014; Johnson, 2010). Many providers are not focused on reproductive risks and are not aware of the value and effectiveness of preconception interventions. Access to family planning and other reproductive health services are threatened by federal policy restrictions and budget challenges. Women living with HIV, opioid use, and mental health conditions are marginalized, lacking access to appropriate and effective treatment in many communities across the nation. Too many women—particularly women of color—experience pregnancy-related deaths, in part due to their overall health status and inadequate access to care before, during, and after pregnancy. Unequal treatment, bias, and racism drive disparities in outcomes for women and any children they may choose to have.

National, state, and local leaders in women's health and preconception health have a key role to play in continuing implementation efforts through both macro-level legislative policy action and other administrative and finance action. This brief discusses opportunities for both.

STARTING QUESTIONS

Shift the question and paradigm

- How can our state improve the quality and use of well-woman visits for women in Medicaid, to apply the evidence on what is effective and important about preconception care?
- How can our state improve the quality and use of postpartum visits for women in Medicaid, to reduce the risk of pregnancy-related mortality and complications and improve the outcomes of any future pregnancies?

Focus on health care access and quality

- How can our state better serve eligible women before, during and after pregnancy, regardless of Medicaid expansion? Do we use options or waivers to increase use of family planning and postpartum services?
- How can our state advance quality improvement projects that drive change? Can we use collaboratives or performance improvement projects to increase use of postpartum visits and/or to improve care for women with diabetes, obesity, and hypertension?
- How can our state promote access to and use of quality care? Have we considered unbundling maternity services and tying reimbursement to quality indicators for prenatal, labor/delivery, and postpartum care?
- Are we providing incentives for providers and health plans to deliver interconception care? What is the role of managed care organizations and other providers?
- Has our state developed mechanisms to identify women with adverse pregnancy outcomes and link them to more intensive services and risk-adjusted reimbursements (e.g., case management)?
- How can our state increase the use of evidence-based care, including: women's clinical preventive services defined in HHS guidelines, primary care, prenatal, birth, postpartum, and interconception care for women?

Ask about "how many"

- What do we know about the numbers of women in Medicaid and the costs, utilization, and outcomes related to reproductive and pregnancy care?
- What percentage of births are financed by Medicaid? How many women were enrolled prior to pregnancy?
- How many women with a birth financed by Medicaid have billing for (i.e., complete) a postpartum visit?
- What proportion of women with a birth financed by Medicaid lose coverage after 60 days? What proportion of women transition to family planning eligibility?
- How many women have a repeat preterm or low birthweight birth financed by Medicaid?
- What are the direct Medicaid costs for medical care to mother and infant for recurring preterm or low birthweight birth?

Policy and policy Change for to Preconception Health and Health Care

Policy: Most of these opportunities require action by Congress or state legislatures. Many, but not all, have substantial budgetary implications. A few require federal approval.

- Expand Medicaid eligibility to the ACA level of 138% of federal poverty level.
- Extend Medicaid pregnancy-related eligibility from 60 days to one year postpartum for all women with a Medicaid financed birth (parallel to their infants).
- Extend Medicaid coverage for a package of interconception care for the smaller group of women who had a recent adverse pregnancy outcome (e.g., preterm birth, very low birthweight birth).
- Maintain Medicaid family planning coverage before and after pregnancy.
- Cover recommended clinical preventive services for all women in Medicaid without cost sharing (required for most other women in ACA exchange plans, ACA Medicaid expansions, and private employer-based insurance).
- Maintain or increase funding for family planning clinics, other providers' services, and all contraceptive methods.
- Adopt policies to address social determinants of health and income disparities (e.g., tax credits, paid family leave, TANF option as for family leave).

Research and Measurement

Last but not least, researchers not involved in policy advocacy or implementation have an important role to play in monitoring implementation of policy change. Baseline data from the National Health Interview Survey (NHIS), National Survey of Family Growth (NSFG), Behavioral Risk Factor Surveillance System (BRFSS), and Pregnancy Risk Assessment and Monitoring System (PRAMS) have been published in multiple studies (Daw and Sommers, 2019; Robbins et al., 2018; Pazol et al., 2017; Arora and Desai, 2016). In addition, studies of women's attitudes that listen to women's voices deepen understanding of barriers to care (Handler et al., 2018; Williams and Dhillon, 2019).

policy: These opportunities require no new authority or eligibility. Some may need additional funding. Most require only agency will and staff commitment, as well as partnerships.

- Use an array of approaches for informing related to health coverage options (e.g., navigators, online eligibility and enrollment).
- Develop a Medicaid interconception care benefit package/program for enrolled higher risk mothers, including those with adverse pregnancy outcomes such as preterm birth or serious/chronic maternal health risks such as diabetes, hypertension, and heart disease (Johnson, 2011).
- Encourage Medicaid health plans to provide the IMPLICIT model of care and/or other approaches designed to improve postpartum care for mothers as a part of well-child visits (Srinivasan et al., 2018).
- Add performance/quality standards for well-woman visits to Medicaid managed care contracts.
- Create incentives for high performance/quality in well-woman visits.
- Implement strategies to increase use of mental health coverage for women in Medicaid and private insurance, relying on laws related to mental health parity.
- Adopt Title V national performance measure (NPM-1) for well-woman visit access as a state priority.
- Develop Medicaid pilot projects in partnership with managed care and accountable care organizations.
- Better implement Medicaid's underutilized smoking cessation benefits and monitor progress.
- Provide support for integration of preconception care into publicly available clinics (e.g., federally qualified health centers, local health departments, public hospitals).
- Use Title V funds to support provider training related to well-woman visits/ preconception care.
- Set statewide priority in home visiting for completed referrals to postpartum and well-woman visits.

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Preconception Health+Health Care Initiative

A National Public-Private Partnership

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