

## 2016 Maternal and Child Health Survey Update

### Executive Summary

Health care costs continue to rise around the country, and so states are looking for ways to reduce spending while improving health outcomes for their higher cost populations. Many states are moving away from traditional fee-for-service payments in favor of value-based payment systems to ensure high-quality and cost-effective health care. This trend is reflected in the most recent National Governors Association (NGA) Maternal and Child Health (MCH) Survey results, with states responding to the survey largely involved in broad delivery and payment reforms of Medicaid and the Children's Health Insurance Program (CHIP) or other initiatives to reduce health care costs. Furthermore, states are committed to developing and implementing programs and initiatives aimed at improving health outcomes for MCH populations, including reducing infant mortality, improving birth outcomes, and improving child and adolescent health. Additional survey topics included behavioral health, mental health and substance use disorder treatment for pregnant women.

The 2016 MCH Survey Update presents data that the NGA Center for Best Practices gathered in a survey of states and territories (collectively referred to as "states").<sup>1</sup> Previous updates have reported on Medicaid and CHIP eligibility and state initiatives to improve quality of care and reduce costs of providing services to MCH populations. The 2016 survey focused on key topics of interest to governors, such as Medicaid and CHIP coverage; infant mortality; and quality, reporting and payment initiatives. Thirty-five states provided information for at least some of the questions, although not all states responded to every question.<sup>2</sup> The number of states that responded to each question is noted in each key finding. The sections that follow summarize the findings from the 2016 MCH Survey.

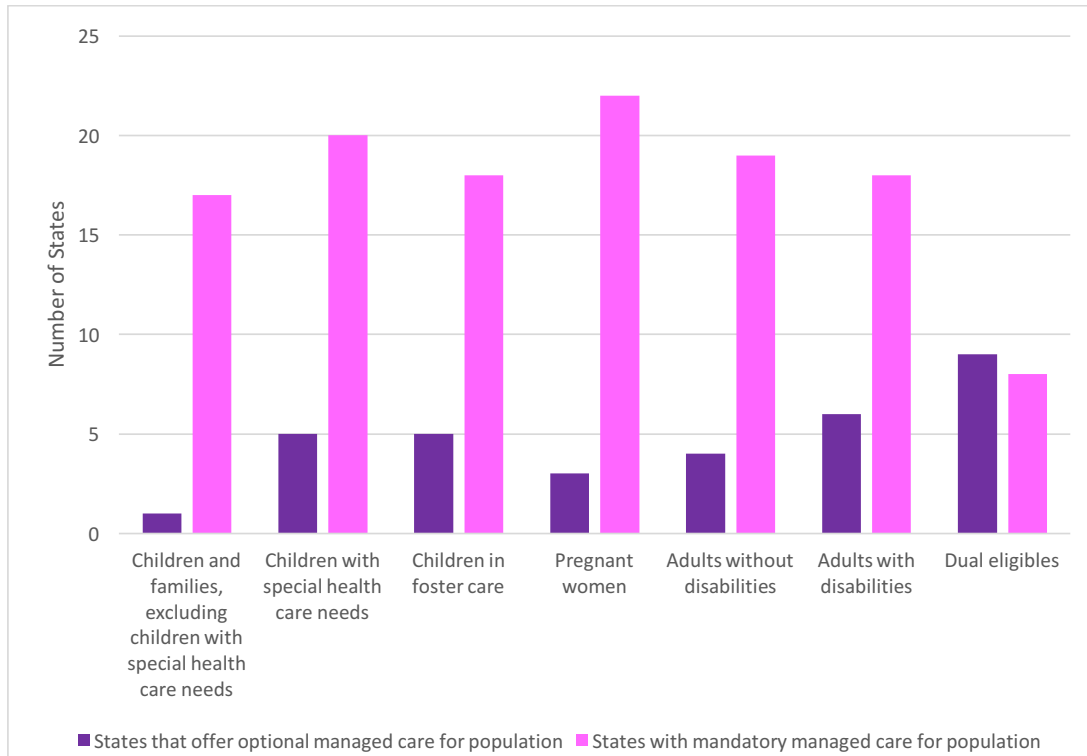
### Medicaid and Children's Health Insurance Program Coverage

Medicaid and Children's Health Insurance Program (CHIP) are an important source of health coverage for pregnant women, mothers, infants and children. In the 35 states that responded to the survey, 46.5 percent of all births were covered through Medicaid and CHIP in 2014, and 46.2 percent of all births were covered through Medicaid and CHIP in 2015.<sup>3</sup> These figures support the reported national average of 45 percent.<sup>4</sup>

States are actively engaged in increasing the quality of the care provided by their Medicaid and CHIP programs. One strategy that states have increasingly used to control cost, reduce unnecessary utilization and improve quality is managed care. In managed care models, managed care organizations (MCOs) are responsible for delivering care for enrolled individuals, and states pay the MCOs a per-member per-month rate. Most states use managed care to cover all or portions of their Medicaid and CHIP populations. In fact, of the 33 states responding to this question, 26 states use managed care in parts of their Medicaid and CHIP programs. Ten of those states offer managed care for all Medicaid and CHIP populations; for five of those states, enrollment in managed care for Medicaid and CHIP recipients is mandatory (See Figure 1 on page 2).

States are continuing to innovate in their Medicaid and CHIP programs and have been using Medicaid Section 1115 waivers as a mechanism to achieve those goals. These waivers allow states to apply for approval from the Centers for Medicare & Medicaid Services for experimental, pilot or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Of the 34 states that responded and as of March 1, 2017, 15 had submitted a comprehensive Medicaid Section 1115 waiver application that affects

**Figure 1. Number of States Offering or Mandating Enrollment in Managed Care by Their Medicaid and Children’s Health Insurance Program Population**



coverage for children and pregnant women. At that time, nine of those waivers had been approved, none were denied and three were awaiting approval. An additional three states were planning to submit a waiver.

States are also using Medicaid to address important health priorities, such as mental health for pregnant women. Twenty-nine states (out of 32 that responded to this question) provide Medicaid coverage of behavioral risk screening or treatment and therapy during pregnancy. Twenty-one of those states cover these services through a combination of managed care and fee-for-service (FFS) payments, two cover these services entirely through managed care and six states cover these services entirely through FFS payments.

### Infant Mortality

For the 29 states that responded using 2015 data, the average infant mortality rate was 6.1 per 1,000 live births. This rate is similar to the national average in 2015 of 5.9 per 1,000 live births, as reported by the Centers for Disease Control and Prevention.<sup>5</sup>

Reducing infant mortality rates remains a top priority for states around the country. All 35 states that responded to the survey indicated that they have created a task force or working group on infant mortality or improving birth outcomes. All 34 states that responded to this question are involved in one or more federal initiatives to reduce infant mortality and improve birth outcomes. Eighteen states have created and begun implementing statewide plans to address infant mortality; six are currently creating their plans. In addition, 22 states have recently taken legislative, regulatory or executive actions to improve birth outcomes.

All 34 of the states that responded to the question reported having implemented evidence-based programs to improve birth outcomes, including home visiting and Centering Pregnancy. In addition, states are taking steps to identify and address early elective deliveries (EEDs) to improve birth outcomes. “Early elective delivery” is the voluntary induction of labor prior to 39 weeks without an indication of medical necessity; EEDs have been linked with significant

health complications for both mothers and babies.<sup>6</sup> Of the 34 states that responded, 19 have mechanisms to identify EEDs, and 5 of those states have eliminated reimbursement for EEDs.

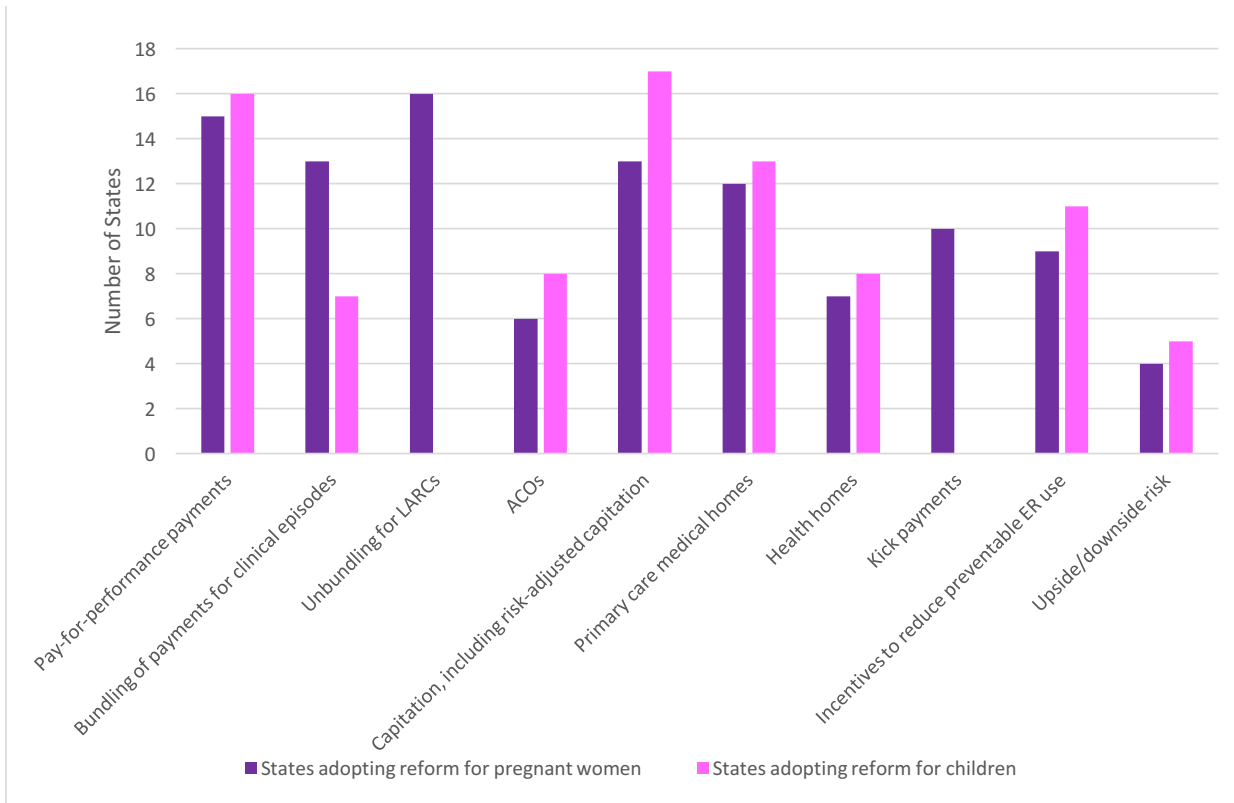
## Quality, Reporting and Payment Initiatives and Reforms

States are working to improve health outcomes for children and pregnant women through the implementation of broad payment or delivery reforms. These reforms aim to reduce health care costs while improving health outcomes for Medicaid and CHIP populations. Thirty-three states provided information for at least some of the questions concerning payment and delivery reforms. Most states indicated that they have adopted one or more broad payment or delivery reforms that affect pregnant women, children and births in Medicaid or through multipayer efforts (See Figure 2 below). Of the 33 states that responded to this

question, 30 have adopted one or more broad payment or delivery reforms that affect pregnant women, and 29 have adopted one or more broad payment or delivery reforms that affect children. In addition, states are taking cross-sector approaches to their payment or delivery reforms, including collaboration between health and human services and education agencies.

States are also using data to drive their innovative policymaking decisions to improve the health of their Medicaid population. Thirty of the 34 states that responded are analyzing Medicaid claims data to better understand their Medicaid population’s health care needs and to develop policies and programs and evaluate their effectiveness. An additional three states are currently in the planning phase of analyzing Medicaid claims data. Fourteen states are analyzing Medicaid claims data in coordination with other payers, and another seven states are in the planning phase.

**Figure 2. Number of States Adopting Broad Payment or Delivery Reforms That Affect Children and Pregnant Women by Type of Reform<sup>7,8</sup>**



ACO = accountable care organization; ER = emergency room; LARC = long-acting reversible method of contraception.

## Strategies for Improving Child and Adolescent Health

In addition to infant mortality and perinatal care, states have been focused on strategies for improving care and health outcomes for children and adolescents. Bright Futures is a national health promotion and prevention initiative led by the American Academy of Pediatrics. The Bright Futures Guidelines provide recommendations for all preventive care screenings and well-child visits. Twenty-eight of the states that responded to the survey report adopting or undertaking initiatives to implement or increase use of Bright Futures Guidelines. Furthermore, of all the states that responded to the survey, 30 reported having statewide health programs or initiatives specifically targeting adolescents.

States have also been using medical homes as a strategy to improve care coordination for Medicaid- and CHIP-enrolled children. Medical home programs include patient-centered medical homes, primary care case management and enhanced care coordination programs. Seventeen states out of the 34 that provided data for this question have a medical home program for both Medicaid- and CHIP-enrolled children. Five have a medical home program for Medicaid-enrolled children only, and two have a program for CHIP-enrolled children only.

## Substance Use Disorder

For the second time, the Maternal and Child Health (MCH) Survey asked states about rates of tobacco use among pregnant women and about pregnant women's use of tobacco cessation treatment. Twenty-three states were able to provide information about the percentage of pregnant women covered by Medicaid or CHIP who reported using tobacco between 2013 and 2016.<sup>9</sup> In the 23 states that responded to this question, the average percentage of pregnant women covered through Medicaid or CHIP who reported using tobacco during pregnancy was 15.8 percent, compared with 13.6 percent of all adult women nationwide (regardless of coverage or pregnancy status) who reported using tobacco in 2015.<sup>10</sup> Most states were not able to report

the number of pregnant women covered by Medicaid or CHIP who received tobacco cessation therapy. Of the 10 states that were able to report both the number of pregnant women covered by Medicaid or CHIP who received evidence-based cessation therapy in 2015 or 2016 and the number of pregnant women covered by Medicaid or CHIP who used tobacco during pregnancy for that year,<sup>11</sup> an average of 26.5 percent of pregnant women who used tobacco during pregnancy received evidence-based tobacco cessation therapy through Medicaid or CHIP at any time during their pregnancy. Evidence-based cessation therapies include all five U.S. Food and Drug Administration–approved forms of nicotine replacement therapy; bupropion (Wellbutrin); varenicline (Chantix); and individual, group and telephone counseling.

As drug overdose deaths continue to rise across the country, quadrupling since 1999, opioid use disorder remains a significant issue for states.<sup>12</sup> According to the American Society of Addiction Medicine, in 2015, 2 million Americans ages 12 and older had substance use disorders (SUD) involving prescription opioid pain relievers, and 591,000 had SUDs involving heroin.<sup>13</sup> Opioid use among pregnant women has increased more than 127 percent over 14 years from 1998 to 2011.<sup>14</sup> Furthermore, from 2000 to 2012, incidences of neonatal abstinence syndrome increased 383 percent.<sup>15</sup> The opioid epidemic has severe implications for pregnant women and children, including poor fetal growth, premature labor and birth defects.<sup>16</sup> For the first time, the MCH Survey asked about medication-assisted treatment (MAT) for pregnant women covered by Medicaid or CHIP. MAT includes methadone, buprenorphine, and naltrexone. Not enough states reported the number of pregnant women who had used opioids during pregnancy for meaningful analysis, but 13 states were able to provide data on the percentage of pregnant women who received MAT for opioid use disorder through Medicaid or CHIP at any time during their pregnancy in 2015 or 2016.<sup>17</sup> In those states, an average of 2.3 percent of pregnant women received MAT through Medicaid or CHIP at any time during their pregnancies.

## State Survey Response Sources

States used a variety of data sources to respond to our survey. Commonly used sources include the Medicaid and CHIP data warehouses, Medicaid eligibility and

claims data, vital statistics data, Pregnancy Risk Assessment Monitoring System data, birth certificate data, hospital discharge data and death certificate data.

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## Endnotes

<sup>1</sup>Data for this survey were collected in the winter of 2016–2017. States were instructed to use the most current data available, with the exception of a few specific metrics (such as infant mortality and Medicaid/Children’s Health Insurance Program enrollment) for which they were asked to use data from a specific calendar year to allow for uniformity in responses among states. When possible, we have specified the year associated with reported data. Please contact the National Governors Association Center for Best Practices if you would like more information about the specific data sources states used for individual questions.

<sup>2</sup>Thirty-five states responded to the survey by March 1, 2017, when all responses were collected. The thirty-five states that responded to the survey are as follows: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New York, North Carolina, Northern Mariana Islands, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia and Wyoming.

<sup>3</sup>This year’s Maternal and Child Health Survey Update asked about the percentage of births covered by Medicaid or the Children’s Health Insurance Program in 2014 and 2015. Thirty-two states provided data for 2014, and 30 states provided data for 2015. The figures reported are the average percentage of covered births across all reporting states for both years.

<sup>4</sup>Galewitz, P. (2013, September 3). Nearly half of U.S. births are covered by Medicaid, study finds. Retrieved from Kaiser Health News website: <http://khn.org/news/nearly-half-of-u-s-births-are-covered-by-medicaid-study-finds>.

<sup>5</sup>Infant mortality rate by state. (2016). Retrieved from Centers for Disease Control and Prevention National Center for Health Statistics website: [https://www.cdc.gov/nchs/pressroom/sosmap/infant\\_mortality\\_rates/infant\\_mortality.htm](https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm).

<sup>6</sup>Elective delivery before 39 weeks. (2013, June). Retrieved from The American Congress of Obstetricians and Gynecologists website: <https://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks>.

<sup>7</sup>“Kick payments,” or Maternity Supplemental Payments, are payments made to providers above the capitated rates for deliveries and other pregnancy-related costs.

<sup>8</sup>“Upside/downside risk” is a risk-sharing payment model in which providers have the opportunity for both financial gains and losses as a result of the cost of care for a patient.

<sup>9</sup>We asked states to report data for the most recent year available. Two states reported for 2013, 6 reported for 2014, 13 reported for 2015 and 2 reported for 2016. States reported retrieving this data from various sources, including the Pregnancy Risk Assessment Monitoring System and birth certificate data.

<sup>10</sup>Smoking & Tobacco Use Fast Facts. (2017, March 29). Retrieved from Centers for Disease Control and Prevention website: [https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/fast\\_facts/index.htm](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm).

<sup>11</sup>Eight states reported data for 2015, and two states reported data for 2016.

<sup>12</sup>Opioid Overdose Understanding the Epidemic. (2016, December 16). Retrieved from Centers for Disease Control and Prevention website: <https://www.cdc.gov/drugoverdose/epidemic/index.html>.

<sup>13</sup>Bose, J., Hedden, S. L., Lipari, R. N., Park-Lee, E., Porter, J. D., & Pemberton, M. R. (2016, September). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm#sudy08>.

<sup>14</sup>Massachusetts General Hospital Center for Women’s Mental Health. (2015, January 22). Opioid abuse and dependence in pregnancy: Impact on obstetrical outcomes. Retrieved from <https://womensmentalhealth.org/posts/opioid-abuse-dependence-pregnancy-impact-obstetrical-outcomes>.

<sup>15</sup>Incidence of Neonatal Abstinence Syndrome – 28 States, 1999–2013. (2016). Retrieved from Centers for Disease Control and Prevention Morbidity Weekly Report (MMWR) website: <https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm>.

<sup>16</sup>Ibid.

<sup>17</sup>Eleven states reported data for 2015, and two states reported data for 2016.