First Quarterly Monitoring Report

Georgia Postpartum Extension

1115 Demonstration in Georgia

Demonstration Year 1

Quarter 1: July 1, 2021 – September 30, 2021

Submitted to the Centers for Medicare and Medicaid Services

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January 31, 2022

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I. Background

Overview of the Georgia Postpartum Extension

On April 16, 2021, the Center for Medicare and Medicaid Services (CMS) approved Georgia's Section 1115(a) demonstration project, "Georgia Postpartum Extension."[1] Implementation of the Georgia Postpartum Extension began statewide effective July 1, 2021 and will continue through March 31, 2026. This waiver will extend postpartum Medicaid coverage to women with incomes up to 220 percent of the Federal Poverty Level (FPL), from a previous period of 60 days to one hundred and eighty (180) days, or six months. Prior to the Georgia Postpartum Extension, the Georgia Department of Community Health (DCH) administered Georgia's Right from the Start Medical Assistance Group (RSM) for women with this income criteria throughout a woman's pregnancy and through a 60-day postpartum period. Georgia had applied for the waiver in October 2020 in recognition of the comparatively high rate of maternal mortality in the state.

In 2019, the Georgia General Assembly (GGA) passed House Resolution 589[2] to create the House Study Committee on Maternal Mortality. This Committee, which included seven members of the House, held five public meetings to gather information from maternal health experts, health care providers, and community organizations regarding potential strategies to address the state's high rate of maternal mortality. Between 2012-2015, data from the Georgia Department of Public Health Maternal Mortality Review Committee (MMRC) revealed that 60% of maternal deaths in Georgia were deemed preventable. Based on these and other data, the Georgia MMRC recommended the implementation of case management to promote postpartum follow-up particularly for high-risk women with chronic health conditions and pregnancy complications, extension of health insurance coverage for one year postpartum, and promotion of pregnancy spacing through increased access to contraception postpartum. In recognition of the need to collaborate within the state, the GGA worked with DCH and DPH to craft and advocate for the passage of H.B. 1114 (Postpartum Medicaid Extension) during the 2020 legislative session. The second provision in this legislation authorized the extension of Medicaid coverage postpartum through 180 days.

Through the Georgia Postpartum Extension, DCH seeks to extend access to quality care and ensure continuity of care and care coordination during the postpartum period, with the ultimate goal of reducing rates of postpartum maternal morbidity and mortality in the State. The demonstration was approved by CMS April 16, 2021.

Goals of Georgia Postpartum Extension

Under the Georgia Postpartum Extension, Georgia's Department of Community Health (DCH) expects to achieve the following goals to improve maternal health in the State:

- Reduce maternal morbidity and mortality for Medicaid members in Georgia; and

- Support the long-term fiscal sustainability of the State's Medicaid program by maintaining fiscal balance.

By providing extended Medicaid coverage for 180 days to postpartum women, DCH expects more women to attend their postpartum visit, access needed health care services and in turn, reduce the probability they will experience adverse outcomes such as maternal morbidity and mortality. DCH also expects these changes will lead to lower per capita Medicaid expenses in the postpartum period that will compare favorably to national measures.

Georgia Postpartum Extension Population Groups and Covered Services

Under the Georgia Postpartum Extension, postpartum coverage will be extended from 60 days to six months for the following eligibility groups:

- Women enrolled in any Medicaid eligibility group who have household income up to 220% of the Federal Poverty Level (FPL) (with up to 5% income disregard) and whose 60-day postpartum period is ending; and

- Women who are within the six-month postpartum period, were not enrolled in Georgia Medicaid at delivery, have household income up to 220% FPL (with up to 5% income disregard), and who meet all other Medicaid eligibility criteria.

Beneficiaries eligible for the Georgia Postpartum Extension will receive full Medicaid coverage (i.e., all medically necessary covered Medicaid state plan benefits). Medicaid enrollees are made aware of these benefits through their Care Management Organizations (CMOs) in a "welcome to Medicaid" package. Additionally, beneficiaries will be eligible to receive Resource Mother (RM) Outreach, a program which provides peer services in coordination with a nurse case manager to provide a range of paraprofessional and case management services to beneficiaries and their families. Resource Mothers have previously been available to women in the Interpregnancy Care (IPC) component of the pre-existing Section 1115 waiver, Planning for Healthy Babies (P4HB), which has been approved by CMS through 2029. Resource Mothers offer support to mothers and provide them with information on parenting, nutrition, and

healthy lifestyles, in addition to other services, such as assistance in dealing with personal and social problems, provision of supportive counseling, or serving as a liaison for health care and social services. Beneficiaries will not be subject to cost-sharing, copayments, or coinsurance for any Medicaid benefit provided under the Georgia Postpartum Extension.

Georgia Postpartum Extension Eligibility and Delivery System

Beneficiaries eligible for the Georgia Postpartum Extension will receive all eligible benefits for the six-month postpartum period, regardless of the point in the postpartum period they enroll in the program. Beneficiaries will remain enrolled regardless of changes in income throughout the duration of the six-month postpartum period. Beneficiaries will seamlessly transition into this program as they did under the 60-day postpartum benefit period. In the interest of equity, DCH extended a "transition period" to mothers whose 60-day postpartum benefits prior to the Georgia Postpartum Extension would have expired in the month prior (June 1, 2021 to June 30, 2021) to the July 1, 2021 effective date. For instance, mothers with an April 15, 2021 delivery would be eligible for extended postpartum coverage offered through the Georgia Postpartum Extension.

Consistent with the structure of RSM, DCH will employ a managed care delivery system to provide services to all eligible beneficiaries under the Georgia Postpartum Extension, with the exception of beneficiaries receiving Supplemental Security Income (SSI). Assignment and/or selection of Care Management Organizations (CMOs) will follow the same process utilized by DCH outside of this demonstration. Beneficiaries not enrolled in a CMO upon program enrollment will be automatically enrolled in a CMO and will have a 90-day window to switch to a different plan if they so choose. Beneficiaries receiving SSI will receive services through a fee-for-service delivery system as they currently do in the P4HB and other Medicaid programs.

Identifying Members in the Postpartum Extension Period

In their application to CMS, DCH estimated there would be an average monthly enrollment of 12,630 women in the first demonstration year (DY1) and 15,501 in DY5.[3] The enrollment estimates for the first year reflected that some enrollment of individuals that lost coverage prior to July 1, 2021, would re-enroll for coverage under the extended postpartum time period. For example, DCH assumed 10% of January 2021 deliveries would re-enroll July 2021 and higher percentages of subsequent 2021 deliveries would re-enroll with 100% of April 2021 deliveries receiving extended coverage. The state identified women within their 61st – 180th postpartum day window using internal analytic files.

DCH Communication with CMOs, Staff, Providers, and Beneficiaries Regarding Implementation

DCH has engaged in various forms of communication to inform CMOs, staff, providers, beneficiaries, and the general public about the Georgia Postpartum Extension. On April 21, 2021, Governor Brian P. Kemp and DCH announced via a press release[4] the approval of the section 1115 demonstration waiver by CMS, confirming that the State will extend Medicaid state plan benefits from 60 days to six months for postpartum women with incomes up to 220% FPL. To announce the extension, DCH released a banner message (dated August 30,2021) via the Georgia Medicaid Management Information System (GAMMIS), the primary web portal for Medicaid, PeachCare for Kids, and all related waiver programs administered by DCH, for Medicaid and PeachCare for Kids providers regarding the Postpartum Extension. The banner message read:

> "*Dear Medicaid and PeachCare for Kids Providers:*
>
> *Effective July 1, 2021 postpartum coverage for pregnant women increased from 60 days (2 months) to 180 days (6 months) for Medicaid eligible postpartum women with incomes up to 220% of the Federal Poverty Level (FPL). The extension of postpartum coverage will apply to eligible women regardless of the Medicaid aid category they are enrolled in. This includes but is not limited to: Low Income Medicaid (104), Pregnant Women Medicaid (170), and SSI Medicaid (300s).*
>
> *Eligibility for postpartum services will continue throughout the entire postpartum period, regardless of a change in income, ensuring continuity of coverage. Prior to the end of the 6-month postpartum period, a redetermination review will be conducted for each beneficiary to identify any other categories of eligibility."*

Lastly, on November 4, 2021, DCH released an announcement[5] for a community forum to be conducted on December 8, 2021. According to the announcement, CMS required a Post Award Forum be held within six months of implementation, with a 30-day period for public comment prior to the forum. The forum occurred at noon on December 8, 2021 via Microsoft Teams; however, no comments relating to the Postpartum Extension were received from the public to review and discuss.

Other Relevant Contextual Factors

Planning for Healthy Babies

Beginning on January 1, 2011, Georgia's Planning for Healthy Babies Program (P4HB), Georgia's section 1115(a) Medicaid Demonstration, expanded the provision of family planning services to low income and uninsured women. The P4HB program was designed to meet primary and reproductive health care needs of women deemed eligible by meeting the following criteria: 1) U.S. citizens or person with qualified proof of citizenship; 2) residents of Georgia; 3) otherwise uninsured and not eligible for

Medicaid; 2) 18 through 44 years of age; 3) not pregnant but able to become pregnant; and 4) with incomes at or below 200% FPL [now 211% FPL]. The P4HB program has a unique component which provides Interpregnancy Care (IPC) services, inclusive of nurse case management/Resource Mother outreach, to women who meet the above eligibility criteria and recently delivered a very low birth weight (VLBW) infant (<1500 grams or < 3 pounds 5 ounces).

This interpregnancy care (IPC) component provides coverage for primary health care services, limited dental services, management of chronic health conditions, mental health or substance abuse treatment and detoxification, and case management services in addition to family planning services. P4HB also offers these nurse case management/Resource Mother outreach services to women enrolled in the Georgia LIM (Low Income Medicaid) or ABD (Aged, Blind and Disabled) Medicaid programs who delivered a very low birth weight infant on or after January 1, 2011. CMS recently extended the P4HB waiver program effective August 29, 2019, through December 31, 2029. Findings from the evaluation of the 2011-2019 waiver period include (but are not limited to):

- Implementation of P4HB resulted in a total of 20,261 averted births that would otherwise be paid for by Georgia's Medicaid program and achieved cost savings for the Medicaid program each year.
- Implementation of P4HB was associated with: 1) decreased unintended pregnancies; 2) decreased teen births; 3) decreased very short (<6 months) interpregnancy intervals; and 4) increased age at first birth among women eligible for pregnancy Medicaid.
- Implementation of P4HB was not associated with reductions in LBW and VLBW births in Georgia.
- Enrollment in the family planning only component of P4HB and use of any contraceptive method was associated with a lower rate of short interpregnancy intervals (<6 months; 12 months; 18 months).
- Enrollment in the family planning only component of P4HB and use of long-acting reversible contraceptives (LARCs) was associated with a higher rate of normal birthweight infants among those who did conceive a pregnancy after enrollment.
- Enrollment in the IPC component of P4HB among those eligible was also associated with a *significantly* ($p<.05$) lower likelihood of an adverse outcome (fetal death, stillbirth, VLBW or LBW infant) for deliveries within 18 months of the index delivery.

COVID-19 State of Emergencies

An additional contextual factor includes the public health and economic state of emergencies declared by Governor Kemp due to the COVID-19 pandemic. On March 14, 2020, Governor Kemp declared a Public Health State of Emergency (PHE) in the State of Georgia via Executive Order 03.14.20.01[6], ordering all resources of the State be made available to assist in activities designed to address the

emergency, control the spread of COVID-19, and aid recovery efforts. Governor Kemp renewed the PHE via Executive Order continuously through June 2021, citing a need to protect vulnerable populations in the State, provide comprehensive testing, permit economic flexibility with reduce regulations, provide increased hospital capacity, and allow the state expanded flexibility for procurement.

The State of Georgia's PHE was originally set to expire on July 1, 2021, at 12:00 AM. However, in response to the State's experience of ongoing emergency due to the impacts of COVID-19 on the economy, supply chain, and healthcare infrastructure, on June 30, 2021, Governor Kemp declared a State of Emergency for Continued COVID-19 Economic Recovery in the State via Executive Order 06.30.21.01[7], ordering all resources of the State be made available to assist in activities designed to address this emergency and aid in recovery and response efforts. Governor Kemp renewed the Economic State of Emergency continuously through January 26, 2022; the current Economic State of Emergency, authorized via Executive Order 1.18.22.01[8], shall terminate on February 25, 2022 at 11:59 PM, unless it is again renewed by Governor Kemp.

II. Challenges

Ongoing Public Health Emergency

Beginning in 2020, the federal government began to pass a series of legislative initiatives to provide economic relief to American workers, families, small businesses, and industries, including state Medicaid programs. The Families First Coronavirus Response Act[9] (FFCRA) – which was passed by Congress and signed into law on March 18, 2020 – included a provision authorizing a 6.2 percentage point increase in the Federal Medicaid Assistance Percentage (FMAP), or federal Medicaid matching rate, for the emergency period. The enhanced FMAP, which could be applied retroactively to January 1, 2020, was available to states meeting certain maintenance of eligibility requirements and provided through the quarter in which the public health emergency (PHE) period ends, which is currently slated to occur on February 25, 2022. As such, the enhanced FMAP is likely to continue through at least the end of March 2022.

Georgia followed the requirements of the FFCRA and no Medicaid enrollee has been (involuntarily) removed from the program since March 2020. Consequently, the Georgia Postpartum Extension was put in place (July 1, 2021) during a time when women in their postpartum period were already retaining their Medicaid benefits for 6 months or longer. The communication to Medicaid recipients has been limited and the CMOs were responsible for communicating program changes to enrollees. As a result,

confusion may have occurred among women and their providers regarding their Medicaid enrollment status, potential end date and as discussed below, the content and extent of their additional RM benefits.

Lack of Standardized Resource Mother Manual

A key aspect of the Georgia Postpartum Extension is that eligible women will receive the same RM and care management services as P4HB IPC women. A major challenge to the successful implementation of the postpartum extension is the lack of a standardized state manual for RM services although DCH has recently updated its policies/guidance[10]. This is the description contained in the STCs of the postpartum extension (see Appendix A for complete description of RM Outreach included in STCs):

> "All demonstration beneficiaries will also receive Resource Mothers Outreach which provides peer services in coordination with a nurse case manager. The Resource Mother Outreach provides a broad range of paraprofessional services…[and] performs certain aspects of case management… The CMOs have the responsibility for training the Resource Mother and must utilize the standardized Resource Mother training Manual specified by the state… Resource Mother Outreach must be coordinated within the contact of a comprehensive plan that addresses specific program goals of:
>
> - Increase the beneficiary's adoption of healthy behaviors such as healthy eating choices and smoking cessation;
> - Support the beneficiary's compliance with primary care medical appointments, including assisting with arranging non-emergency medical transportation;
> - Assist the mother to obtain regular preventive health visits and appropriate immunizations for her child;
> - Support the beneficiary's compliance with medications to treat chronic health conditions;
> - Assist with coordination of social services support; and,
> - Assist with linking beneficiaries to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)."

DCH is aware that each CMO has proceeded with their own interpretation and implementation of these general guidelines.

The other challenge for both DCH and the CMOs is that there is no billing code for these RM services. As a consequence, they cannot be tracked and evaluated using the claims data as is done in other parts of the evaluation process. The CMOs provide 'spotty' data in their Quarterly Reports on the number of outreach efforts, acceptance, or rejection of help from the RMs and little data on the actual support services provided to the women. The level of detail in this reporting varies markedly across the CMOs.

CMO Capacity to Meet Increased Demand for Services

In prior reports to CMS for the P4HB evaluation, DCH has noted the variation across CMOs in the number of RMs hired and trained to serve IPC and RM only eligible women. This variation has resulted in differences in the level of contact made with enrolled women and in turn, enrollee utilization of the RM benefit across the CMO's enrollees. [See the August 27, 2021 "*Semi-Annual Report Planning for Healthy Babies Program® (P4HB®) 1115 Demonstration in Georgia*, *January 1-June 30, 2021*".]

Lack of Marketing Plan

While a marketing plan was noted in the State's waiver application to CMS, there is not one underway at this point. DCH is working on other means of finding out about women's understanding of the postpartum extension.

III. Successes

Innovation of Postpartum Expansion Program

It is clear the state has entered into an innovative form of a postpartum expansion program. While other states have expanded postpartum coverage either through a waiver or the newly available option of a State Plan Amendment (SPA), Georgia's is the only approved waiver to extend postpartum coverage for 6 months and included the additional benefit of RM services to all postpartum women.

Collaboration with Georgia Stakeholders to Develop Georgia Postpartum Extension

As noted, the comparatively high rate of maternal mortality in the state led to intra-state collaboration that helped in the successful application and receipt of the postpartum extension. One reason for this success was a strong collaboration with interested stakeholders in the community. These groups represented maternal and child health organizations, health care provider associations, and CMOs. Staff members from DCH also serve as members of the Georgia Maternal Mortality Review Committee and helped develop stronger liaisons with DPH and increased the data sharing agreement to include maternal mortality data.

Postpartum Expansion Program Addresses Trends in Adverse Outcomes in State

During 2013-2017, Georgia had the second highest maternal mortality in the nation (66.3 per 100,000), with the rate for each Georgia racial/ethnic group far exceeding US rates and a 60% higher rate for Black vs White Georgians (95.6 vs 59.7 per 100,000).[11] As noted, the state was motivated by these data and the DPH report citing factors that contribute to Georgia's high rates of adverse maternal health outcomes. These include the high proportion of women without health insurance (20%), low proportion of reproductive health needs met by publicly available services (16%), high percentage women without a dedicated health care provider (66%), and low attendance of postpartum care (< 40%).[12]

Maternal morbidity and mortality represent a continuum of risk in which progression in severity can be reduced through access to and utilization of appropriate health care services[13] – from maternal morbidity that requires a primary care visit, to maternal morbidity that requires an emergency department visit and/or hospitalization, to severe maternal morbidity (SMM), defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health and include 'near miss' events, to maternal mortality events. In fact, access to and utilization of health care is recognized as a fundamental pathway for improving maternal health and reducing health disparities.[14-16] In particular, while there is evidence that improving the quality of delivery hospital care reduces maternal health disparities,[17] current data support that postpartum SMM is increasing faster than SMM during the delivery hospitalization[18] and a growing majority of maternal deaths and SMM occur after discharge from the delivery hospital.[19] Preliminary analyses of 2017 Georgia Medicaid data[20] involved identifying occurrences of the 21 SMM indicator conditions designated by the Centers for Disease Control and Prevention[21] during delivery through 12 months postpartum, which showed: 1) stark differences in the Black-White rates of SMM at delivery; 2) a widening of the Black-White gap in SMM from delivery through 3- and 12-months postpartum. *These data support a focus upon factors affecting women's utilization of and access to risk-appropriate care in the initial months following birth as a strategy for improving maternal health in Georgia, particularly for Black women.*

IV. Lessons Learned

Opportunities Exist to Address Service Access Barriers

As shown in the data below there was a total of 11,844 Medicaid deliveries in May, June, and July, 2021. Whether services were supplied through CMOs or FFS, the percentage of women using any postpartum service is a little over half at 56%. DCH is formulating plans to identify and address existing and potential barriers.

Period	FFS	CMO	Total
May-21	620	3,112	3,732
Jun-21	619	3,327	3,946
Jul-21	632	3,534	4,166
Total Deliveries			**11,844**
Who had a postpartum service			
Jul-21	111	2,155	2,266
Aug-21	107	2,088	2,195
Sep-21	81	2,136	2,217
Total			**6,678**

V. Evaluation Design Activities

The state is in the process of contracting with its existing P4HB evaluator, Emory University, Rollins School of Public Health to develop and implement the evaluation of the postpartum extension. The evaluator has outlined evaluation design and activities that will be used going forward. The draft evaluation design is due to CMS on March 15, 2022. In the text below, are the initial set of performance metrics than can be monitored, note the challenge posed by previous policies (e.g., the PHE) that affected retention in Medicaid postpartum and the issues this and other policies (e.g., the Georgia Gateway system initiated in 2017) raise regarding the potential treatment and control groups for a more in-depth evaluation.

Performance Metrics

An initial set of performance metrics for the evaluation of the postpartum extension is listed below for process and outcomes related to the extension. The ability to measure and report on these will be enabled through a new Data Use Agreement (DUA) with DCH and the outside evaluator.

Process Measures

Identified below are key process measures being proposed for use in the evaluation design. A brief description of the proposed plan to measure and report these process measure performance metrics is included.

Retention in Medicaid/Months

- Proportion of women giving birth on Medicaid (LIM, RSM) who remain enrolled in Medicaid for 1 through 6 months postpartum.

Utilization during 6-month extension

- Postpartum visit:
    - Proportion of women giving birth on Medicaid (LIM, RSM) who have a visit coded as a postpartum encounter during 1 through 6 months postpartum.

- Receipt of primary/preventive care:
    - Proportion of women giving birth on Medicaid (LIM, RSM) who have an office visit for any service other than postpartum care during 1 through 6 months postpartum.

    - Proportion of women giving birth on Medicaid (LIM, RSM) who have an office visit for specific primary/preventive care services during 1 through 6 months postpartum.

    - Number (and % of total enrolled) who received age-appropriate STI screening, cervical cancer screening, vaccinations, mental health/depression screening during their enrollment postpartum.

- Receipt of family planning/contraceptives
    - Proportion of women giving birth on Medicaid (LIM, RSM) who have a FP and/or FP related service encounter during 1 through 6 months postpartum.

    - Number (and % of total enrolled) who obtained any contraceptive method in the six-month period.

    - Number (and % of total enrolled) who obtain contraceptive methods by WHO tier of effectiveness.

- Receipt of health care for chronic conditions
    - Proportion of women with diagnoses of chronic conditions known to impact reproductive health and pregnancy outcomes (including chronic or gestational diabetes and hypertension, mental health conditions, substance use disorders) receiving any postpartum visit, any visit, and any visit for medically appropriate preventive and disease management services (e.g., glucose testing, visit for encounter with ICD coding for condition management) in the six-month period.

Outcome Measures

The State implemented the Georgia Postpartum Extension with the intent of reducing the probability that women with deliveries paid by Medicaid experience adverse outcomes such as morbidity and mortality postpartum. Listed below is a preliminary set of outcome performance metrics to be proposed for use in the evaluation design.

- Hospitalization
    - Proportion of women giving birth on Medicaid (LIM, RSM) who have a hospitalization from the delivery discharge through the enrollment period stratified according to receipt of any postpartum/primary care/other visit or not.

- ER visits
    - Proportion of women giving birth on Medicaid (LIM, RSM) who have an Emergency Department visit [for pregnancy-related or other conditions] from the delivery discharge through the enrollment period, stratified according to receipt of any postpartum/primary care/other visit or not.

- Short inter pregnancy interval [<6months]
    - Proportion of women giving birth on Medicaid (LIM, RSM) who conceive a subsequent pregnancy, stratified according to receipt of any postpartum/primary care/other visit or not.

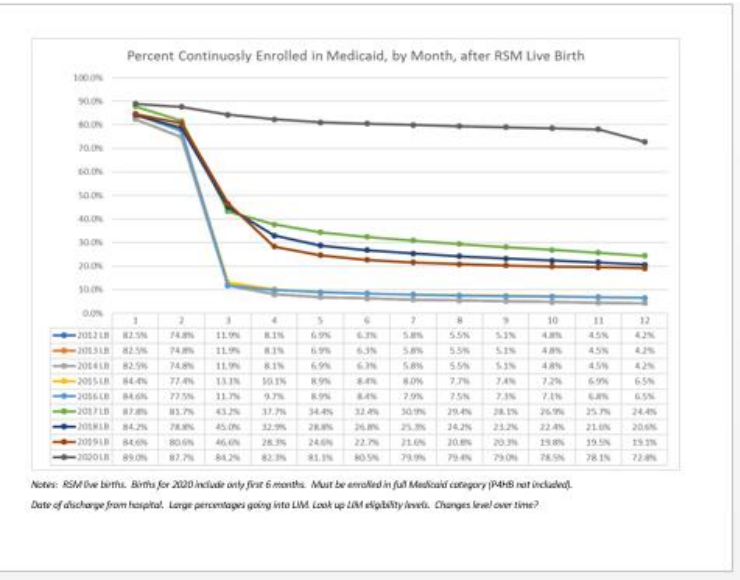
- Rates of Severe Maternal Morbidity
    - Rate of postpartum (from discharge of index pregnancy through the covered period and through 12 months post-birth) severe maternal morbidity among pregnancies (#/1000) for those delivering on Medicaid (LIM, RSM), stratified according to receipt of any postpartum/primary care/other visit or not.

    - Rate of postpartum (from discharge of index pregnancy through the covered period and through 12 months post-birth) severe maternal morbidity among pregnancies (#/1000) for those with chronic health conditions known to impact women's health and/or subsequent pregnancy outcomes (e.g., gestational hypertension, gestational diabetes, chronic hypertension, chronic diabetes, mental health conditions, substance use disorders), stratified according to receipt of recommended clinical screenings and follow-up management of these conditions.

- Rates of Maternal Mortality
    - Rate of maternal death (any death to a woman within 12 months of the end of the index pregnancy; these will not be the MMRC-adjudicated deaths as the adjudication is presently only done through 2017) among pregnancies for those delivering on Medicaid (LIM, RSM), stratified according to receipt of any postpartum/primary care/other visit or not.

Finding a Comparison Period

As noted above, a key process measure is the retention of women in Medicaid during their postpartum period in order to access needed primary/preventive and other health care services. One way to assess the effects of the postpartum extension is to compare the outcomes for women affected in the time period after the postpartum extension is in place to a prior period in which women lost Medicaid eligibility 61 days postpartum. As the chart below indicates, an appropriate comparison period may be the RSM women delivering in the 2018/2019 time period.



In this time period, between 23% to 27% of these women were still enrolled in full Medicaid benefits [e.g., not P4HB] in their 6th month postpartum. We note this was an increase from the <10% still enrolled 6 months postpartum in the period prior to the implementation of the Georgia Gateway enrollment system. The marked increase to ~81% once the PHE was in place means the PHE offers a 'natural experiment' in the effects of extending postpartum coverage to RSM women. It does not include the additional RM benefits that the postpartum extension brings to the women, and this will be a key focus of the evaluation design.

Sources of Data

The key source of data will be the Medicaid enrollment and claims data which are already in hand at Emory University and being used for the ongoing evaluation of the P4HB family planning waiver. It is anticipated that there will be interactions between the two waivers since RSM woman delivering after July 1, 2021 will have full Medicaid benefits for a longer period and hence, will not be offered the P4HB family planning only option until the end of their sixth month postpartum. The ability to use the same data source and continue with the P4HB evaluation as the Georgia Postpartum Extension is implemented will help the state understand the full impact of these two programs intended to improve maternal and infant health. While the enrollment and claims data will be the key source for analysis, the state's Pregnancy Risk Assessment Monitoring System (PRAMS) also offers a rich source of data on women in the six months postpartum. These questions and potential comparison groups that could be derived from these survey data will be reviewed.

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VII. Appendix - Resource Mother Outreach Guidance from Special Terms and Conditions (STCs)

Resource Mother Outreach. All demonstration beneficiaries will also receive Resource Mothers Outreach which provides peer services in coordination with a nurse case manager. The Resource Mother Outreach provides a broad range of paraprofessional services to beneficiaries and their families. The Resource Mother Outreach performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to beneficiaries and their families and/or serve as a liaison for social services. The Resource Mother Outreach benefit is part of the CMO PMPM capitated rate.

a. **Qualifications and Technical Competencies**

The CMOs will employ or contract with Resource Mothers who meet the following qualifications:

- High School diploma or GED with two-years' experience in social services related position or
- Bachelor's degree in a social service-related field
- Valid Driver's license
- Reliable vehicle with motor vehicle insurance coverage
- Good communication skills

The Resource Mother must meet the Technical Competencies:

- Successfully complete Resource Mother training module and participate in ongoing in- service training as provided.
- Knowledge of agency policies and procedures.
- Ability to coordinate and organize the delivery services.
- Ability to interview clients and/or families using established techniques.
- Ability to develop client profile.
- Knowledge of agency confidentiality policies.
- Knowledge of state and federal confidentiality laws and regulations.
- Knowledge of available community resources.
- Ability to make appropriate referrals.
- Knowledge of crisis intervention
- Knowledge of what qualifies as an emergency situation.
- Ability to develop Georgia Postpartum Extension participant service plan to assist the participant in attaining social, educational, and vocational goals.
- Ability to contact health care professionals to obtain additional background information.
- Knowledge of target population.
- Knowledge of agency specific software.
- Knowledge of available databases.
- Ability to prepare reports and case history records.
- Knowledge of eligibility requirements.
- Knowledge of what qualifies as an emergency situation.

b. **Training**

The CMOs have the responsibility for training the Resource Mother and must utilize the standardized Resource Mother training Manual specified by the state.

c. **Supervision**

CMOs using Resource Mother Outreach are required to provide supervision by a competent nurse case manager or similarly qualified program staff member. The amount duration and scope of supervision will vary depending on demonstrated competence and experience to provide peer support. The CMOs must ensure the Resource Mother Outreach is effective through monitoring of the Resource Mother's performance including an evaluation of the Resource Mother's Georgia Postpartum Extension participant contact activities and contact duration.

d. **Outreach**

Resource Mother Outreach must be coordinated within the contact of a comprehensive plan that addresses specific program goals of:

i. Increase the beneficiary's adoption of healthy behaviors such as healthy eating choices and smoking cessation;
ii. Support the beneficiary's compliance with primary care medical appointments, including assisting with arranging non-emergency medical transportation;
iii. Assist the mother to obtain regular preventive health visits and appropriate immunizations for her child;
iv. Support the beneficiary's compliance with medications to treat chronic health conditions
v. Assist with coordination of social services support; and,
vi. Assist with linking beneficiaries to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).