



## Perinatal Report 2020



**Illinois Department of  
Healthcare and Family Services**

**JB Pritzker, Governor  
Theresa Eagleson, Director**



*Theresa Eagleson, Director*

# A LETTER FROM THE DIRECTOR

Governor Pritzker and Honorable Members of the General Assembly:

I am pleased to present the 2020 Perinatal Report required by 305 ILCS 5/5-5.24. This is the eighth report presented by the Illinois Department of Healthcare and Family Services (HFS). Reports may be found on the HFS Website.

This report summarizes Medicaid prenatal and perinatal demographics and provides updates on various initiatives HFS has undertaken with its partners.

Since its first report in 2004, these reports have been a valuable guide for improving birth outcomes in Illinois. Please permit me to highlight a few indications of progress reflected in this report:

- Increased use of LARCs (Long-Acting Reversible Contraceptives), from 3.86% 2016 to 4.69% in 2017, a 21% increase.
- A 50% increase in the number of adolescents 13 years of age receiving the HPV vaccine; and
- A decrease in VLBW (very low birth weight) infants, from 17.89 to 16.82 per 1000 live births, among Medicaid births.

But there is much more work to be done. We believe that improving birth outcomes is central to addressing unacceptable inequities in healthcare delivery and foundational to empowering our customers to maximize their health and well-being. In fact, many initiatives to further accomplish these ideals are not reflected in the time period this report covers, such as Healthcare Transformation and first-in-the-nation postpartum Medicaid benefits of one year. We will be excited to bring you updates about these equity-focused initiatives throughout the next year and in the 2022 report.

Be assured we will continue fostering better care for all our customers. Our Department Vision states that "We Improve Lives." We firmly believe that this starts with improving birth outcomes.

Sincerely,

A handwritten signature in black ink that reads "Theresa Eagleson". The signature is written in a cursive, flowing style.

Theresa Eagleson,  
Director

# Table of Contents

- A LETTER FROM THE DIRECTOR..... 2**
- INTRODUCTION ..... 4**
  - Legislative Mandate ..... 4*
- Report Summary ..... 5**
  - Technical Notes ..... 6*
- DEMOGRAPHICS ..... 9**
  - Births ..... 9*
  - Birth Outcomes ..... 12*
  - Birth Costs..... 16*
  - Prenatal and Postpartum Care ..... 19*
- RECOMMENDATIONS AND INITIATIVES ..... 21**
  - Managed Care ..... 21*
  - Mental Health..... 21*
  - Doc Assist..... 22*
  - Text4Baby..... 22*
  - PROMOTE-IL ..... 22*
  - Oral Health ..... 23*
  - Smoking Cessation..... 23*
  - Perinatal Addiction ..... 23*
  - Family Planning ..... 25*
  - Better Birth Outcomes (BBO) Program ..... 28*
  - Birthing Centers..... 28*
  - Sexually Transmitted Diseases..... 28*
  - Human Immunodeficiency Virus (HIV) Counseling ..... 30*
  - Nurse Midwifery ..... 30*
  - Lactation Counseling ..... 30*
  - Case Management and Home Visiting ..... 30*
  - Collaborative Improvement and Innovation Network (CoIIN)..... 30*
  - Children’s Health Insurance Program Reauthorization Act (CHIPRA)Child Health Quality Demonstration Grant..... 31*

## INTRODUCTION

### Legislative Mandate

Pursuant to [305 ILCS 5/5-5.24](#), HFS must report to the General Assembly on the “effectiveness of prenatal and perinatal health care services reimbursed... in preventing low-birthweight infants and reducing the need for neonatal intensive care hospital services. Each report shall include an evaluation of how the ratio of expenditures for treating low-birthweight infants compared with the investment in promoting healthy births and infants in local community areas throughout Illinois relates to healthy infant development in those areas.”

This statute was enacted with the goal of improving birth outcomes for the over 80,000 births covered annually in the Medicaid program administered by the Illinois Department of Healthcare and Family Services (HFS). To achieve this goal, the statute authorizes HFS to reimburse for prenatal and perinatal health care services that prevent low birth weight infants, reduce the need for neonatal intensive care hospital services, and promote perinatal health.

Services that qualify for reimbursement include:

- Comprehensive risk assessments for pregnant women, women with infants, and infants
- Lactation counseling
- Nutrition counseling
- Childbirth support
- Psychosocial counseling
- Treatment and prevention of periodontal disease
- Other support services that have been proven to improve birth outcomes

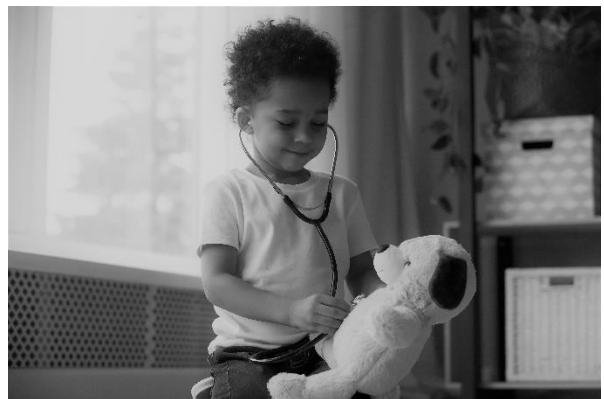
This report and prior Perinatal Reports are available on the [HFS website](#).



## Report Summary

This report summarizes Medicaid perinatal demographics and provides updates on various initiatives HFS has undertaken with its partners to improve birth outcomes and reduce the personal, medical, and social costs associated with poor birth outcomes. Much work remains to be done. Given that Medicaid covers approximately 50% of all Illinois births and approximately 90% of Illinois teen births, the imperative for action and the State's interests are not debatable. HFS anticipates that through current endeavors and the prioritization of improving birth outcomes and ongoing partnerships, it will see a positive effect on the lives of women, children, and Illinois families. Some of HFS' ongoing initiatives include:

- Transforming Illinois' health care delivery system [by enrolling approximately 80% (increased from 60% in calendar year (CY) 2017) of Medicaid clients in a managed care health plan beginning January 1, 2018]
- Collaboration with federal agencies on innovations in healthcare policy (e.g., Long-Acting Reversible Contraceptives, or LARC)
- Utilization of quality improvement science to evaluate data, implement evidence-based practices, and drive policy and program initiatives to improve quality and healthcare delivery
- Collaboration with other state agencies to coordinate, not duplicate, care delivery to women at risk for a poor birth outcome and providing cross agency data exchanges for evaluating program outcomes
- Early identification of high-risk populations to address urgent care needs
- Providing data to MCOs via the Care Coordination Claims Data (CCCD) files to identify high-risk pregnant women and to risk stratify their general covered population
- Continuing robust efforts to improve contraceptive uptake and enhance contraceptive policy development to improve inter-pregnancy spacing, improve poor birth outcomes, and decrease unintended pregnancy



## Technical Notes

**Covid-19** – The production timeline of this report was delayed due to the impacts of Covid-19.

**Results** – As general changes in the healthcare environment (Healthcare Effectiveness Data and Information Set [HEDIS], conversion to ICD-10, etc.) and updates to the methodologies used to prepare the analyses in each report cycle, the data presented herein is not always comparable to previous [perinatal reports](#). End users of this data seeking to compare it to prior year reports should do so with caution, as the data presented reflects a moment in time and not a longitudinal study.

**Data Charts** - Unless otherwise noted, the data charts are based on data from the Illinois Department of Healthcare and Family Services' (HFS) Enterprise Data Warehouse (EDW 2019) derived from HFS' paid claims and HFS-contracted Managed Care Organization (MCO) encounter data. Please keep the following in mind:

- This data is matched with shared data from Illinois Department of Human Services' (DHS) Cornerstone System and Illinois Department of Public Health's (DPH) Vital Records for CY2016 through CY2017 (see below summary for Vital Records).
- The reporting period for each measure varies per analysis and typically covers a two-year trend period.
- Unless otherwise noted, covered deliveries are those where the recipient had full benefits on the date of delivery.
- The charts and graphs show what is currently known about HFS births, including demographics, health care utilization, and outcomes.

**Births / Babies** – Data using the terms “births,” “baby,” or “babies” selects infants with full eligibility with a birth date in the specified calendar year. Additionally, births are identified using selected diagnosis related group (DRG) codes and diagnosis codes occurring within the specified calendar year.

**Birth Outcome** – Data using the term “Birth Outcome” selects birth weight and death year date fields from Vital Records. The classification hierarchy describes how attributes are analyzed, regardless of whether those attributes are populated with data. Using the available information Low Birth Weight (LBW), Very Low Birth Weight (VLBW), Infant Mortality (IM), Other Non-Normal DRG, and Normal DRG are categorized into mutually exclusive groups using the following hierarchy:

- If there is a death date, the Birth Outcome is set to: IM. and no further analysis is conducted (e.g. checking birth weight)
- If birth weight is between 0 – 1,500 grams, then Birth Outcome is set to: VLBW.
- If birth weight is between 1,501 – 2,500 grams, then Birth Outcome is set to: LBW.
- If none of the above conditions are true and if there is a claim with a non-normal DRG<sup>1</sup> within first year of life, then Birth Outcome is set to: Other Non-normal DRG.
- If none of the above conditions are true and there is a claim with a normal DRG, then Birth Outcome is set to: Normal.

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<sup>1</sup> Non-normal DRGs include: 985, 385, 986, 386, 987, 387, 388, 989, 389, or 390

- If none of the above conditions are true, then the Birth Outcome is set to: Unknown.

Using the above Birth Outcome hierarchy, LBW and VLBW rates are not comparable to LBW and VLBW rates reported as independent data points since the latter uses only known birth weights to define the numerator and denominator.

**Costs** – HFS has transformed its delivery system so that approximately 80% of the Medicaid population are enrolled in an MCO. In the MCO model, the capitation payment made to the MCO represents HFS’ monthly payment for the Medicaid client. HFS retains a withhold percentage of total capitation rates (Withhold) each month to ensure effective healthcare delivery. MCOs may earn a percentage of the Withhold based on performance and reporting as measured by both HFS and HEDIS® quality metrics. HFS’ [managed care contract](#) is available on its website.

**Deliveries** – Identified using All Patients Refined Diagnosis Related Groups (APR-DRG) diagnosis and procedure codes associated with the mother<sup>2</sup>.

- Diagnosis codes are from HEDIS® specifications defining deliveries.
- Beginning July 2014, consistent with HFS hospital rate reform, deliveries are identified using APR-DRG codes: 540-542 and 560.
- Multiple-day deliveries: In claims data, deliveries can span multiple days. Therefore, “Event Begin” and “Event End” dates are identified for each delivery corresponding to first admission date and last discharge date, respectively.
- Deliveries include only those individuals with full benefits on date of delivery.

**Family Planning** – This report includes contraception measures based on U.S. Centers for Disease Control and Prevention specifications included in the [Maternal and Infant Health \(MIH\) Initiative Contraceptive Care Measures](#).

- In prior reports, services were selected by specific diagnosis codes when they occur at any time in the year after delivery date.

**Level III Deliveries** – Deliveries occurring at a hospital identified with Provider Specialty Code 015.

**Level III Prenatal Services** – Identified when “Prenatal Services” occur at a Level III facility.

**Low Birth Weight (LBW)** – Identified when birth weight is between one and 2,500 grams.

- The exception is that LBW is between 1,501 and 2,500 grams when included in charts focused on birth outcomes that include the group, “Very Low Birth Weight” to ensure that each birth outcome group is mutually exclusive. See also the “Birth Outcome” note.

**Medicaid (or Medicaid-enrolled women)** – As used in this report including the data chart titles, this term is broadly inclusive of all those receiving medical services and reimbursed by HFS and is not indicative of a specific coverage category (e.g., Title XIX).

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<sup>2</sup> DRG Codes: 540-542, 560

**Mom / Baby Match** – Matching of moms and babies was done via a set of iterations. The majority matched in the first iteration that links those with the same Medicaid case ID, whose birth (baby) and delivery (mother) were at the same hospital and within 15 days of each other. The match is a hierarchy of iterations that become less strict with each pass through the data. DPH’s Vital Records data also were used to link moms and babies via birth certificate identifiers using an HFS matching algorithm based on various fields such as first name, last name, date of birth, and social security number.

**Postpartum Services** – Identified using diagnosis, procedure, and revenue codes defined in HEDIS® specifications of postpartum care and that occur between 21 and 56 days after the delivery date, per HEDIS® specifications.

**Prenatal Services** – Identified using diagnosis, procedure and revenue codes defined in HEDIS® specifications of prenatal care and that occur between the identified delivery date and 280 days prior to the delivery date.

**Unknown** – A grouping variable of instances that cannot be included in any other identified category of interest. For this report, “Unknown” often is removed from denominator counts and not depicted in the charts. This assures that rates for known categories are not reduced by including “Unknown” in the denominator.

**Very Low Birth Weight (VLBW)** – Identified when birth weight is between one and 1,500 grams. See also the “Birth Outcome” note.

**Vital Records** – Birth and Death File data collected by DPH. The data is matched to HFS claims data using a deterministic and probabilistic matching algorithm based on various fields such as first name, last name, date of birth and social security number. Data for CY2016 – CY2017 are certified by DPH.

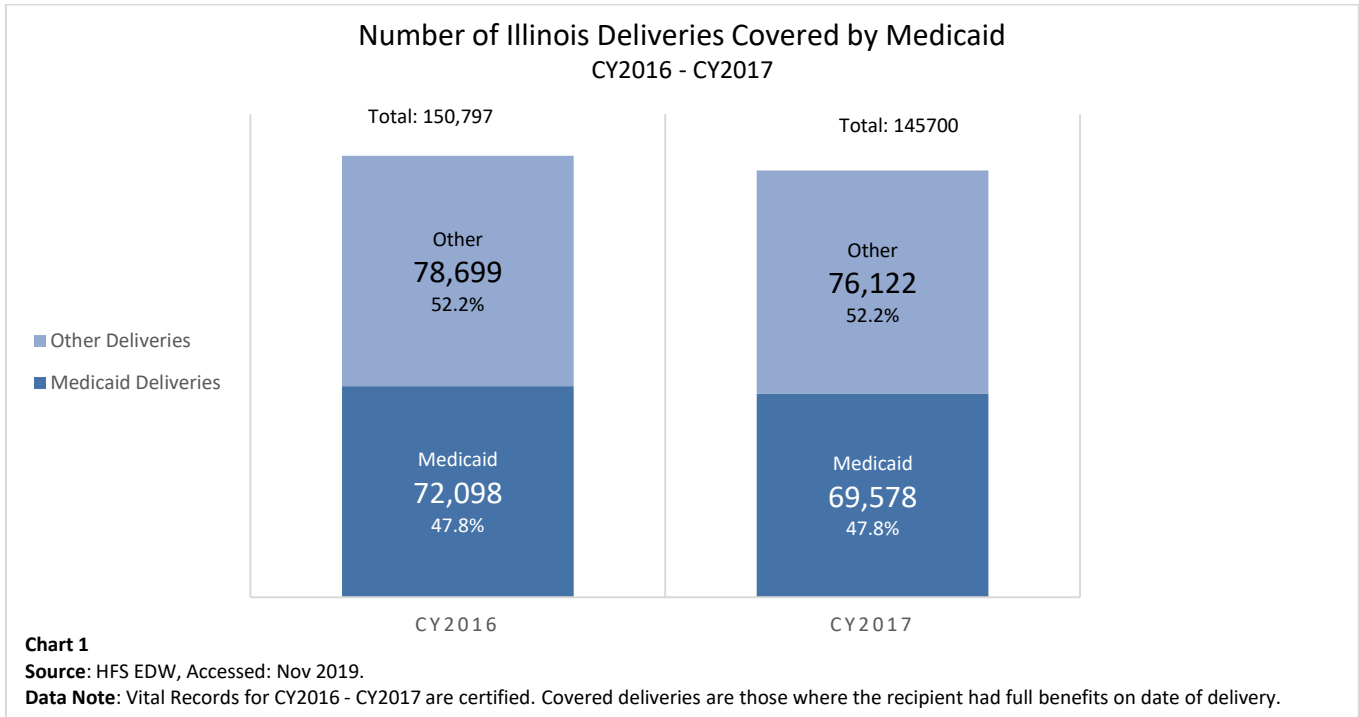




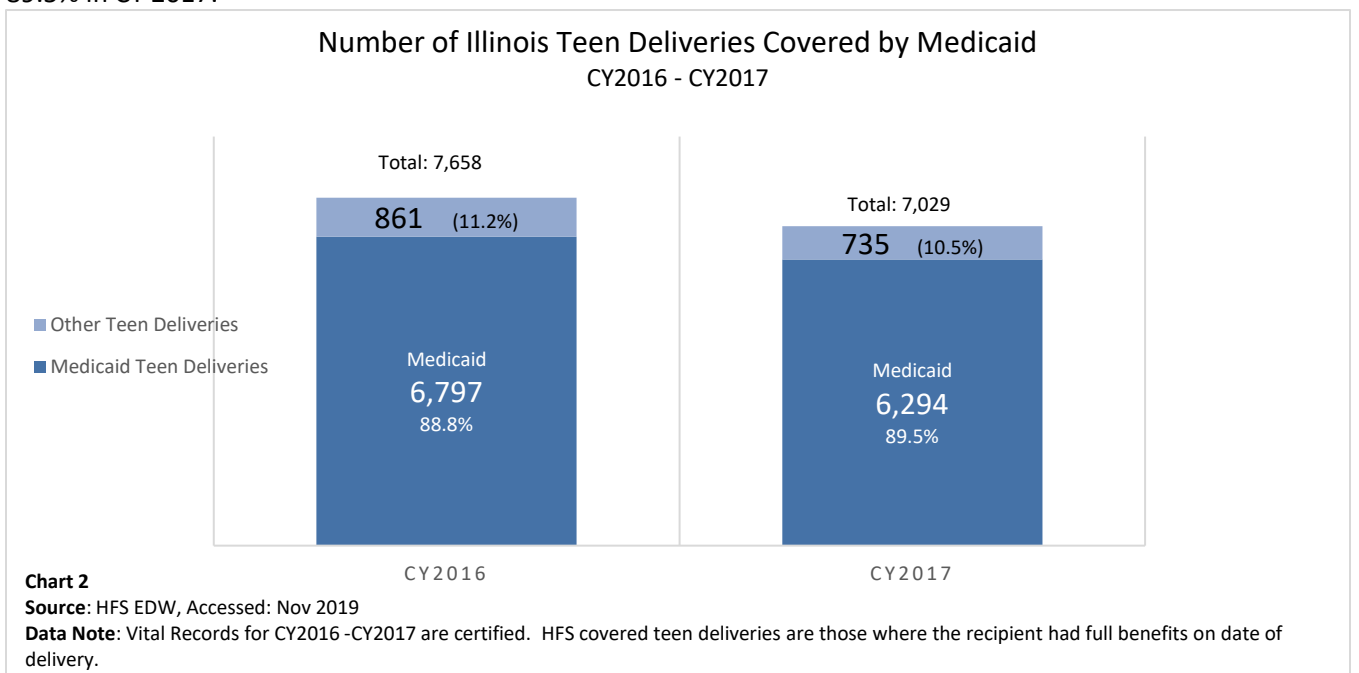
# DEMOGRAPHICS

## Births

In Calendar Years (CY) 2016 and 2017, while the overall number of births fell in the state, the total proportion of Illinois deliveries covered by Medicaid remained constant at 47.8%.



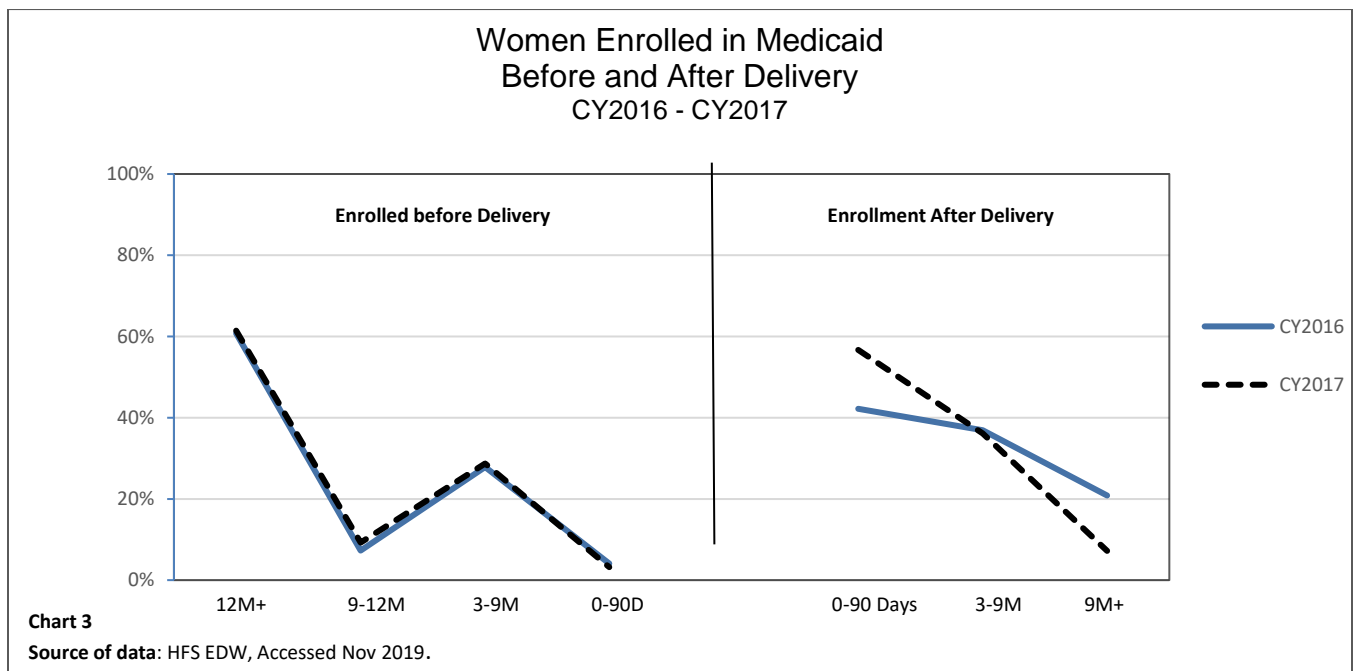
The number of Illinois teen deliveries, both in total and for those covered by Medicaid, is declining but the proportion of teen deliveries covered by Medicaid stayed roughly the same, increasing from 88.8% in CY 2016 to 89.5% in CY 2017.



In both CY 2016 and 2017, approximately 60% of Medicaid-enrolled women who gave birth had been enrolled for at least a year prior to the birth. There was also a subsequent rise in enrollment between 3-9 months prior to delivery in both years. There are significant differences between the two years with regards to the mother's ongoing enrollment after birth. In CY 2016 about 42% of women were enrolled for 3 months after the birth, 37% were enrolled from 3 to 9 months, and 21% were enrolled for more than 9 months. In CY 2017 almost 57% of enrolled women were enrolled for 3 months, 36% were enrolled for 3 to 9 months, and 7% were enrolled for more than 9 months.

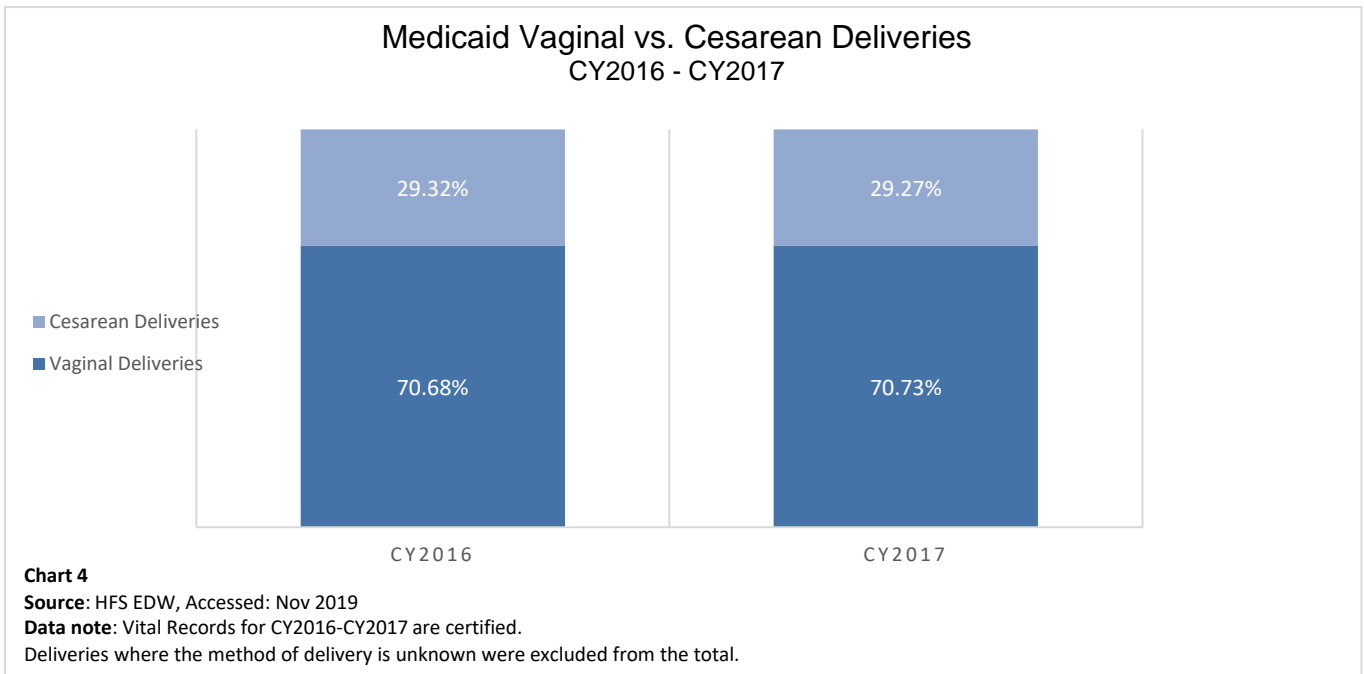
Women Enrollment in Illinois Medicaid:

	Before Delivery				After Delivery		
	12 Months + (12M+)	9-12 Months (9-12M)	3-9 Months (3-9M)	0 to 90 Days (0-90D)	0 to 90 Days (0-90D)	3-9 Months (3-9M)	9 Months+ (9M+)
CY2016	60.8%	7.3%	27.8%	4.1%	42.2%	36.9%	20.9%
CY2017	61.4%	9.3%	28.8%	3.2%	56.7%	36.1%	7.2%





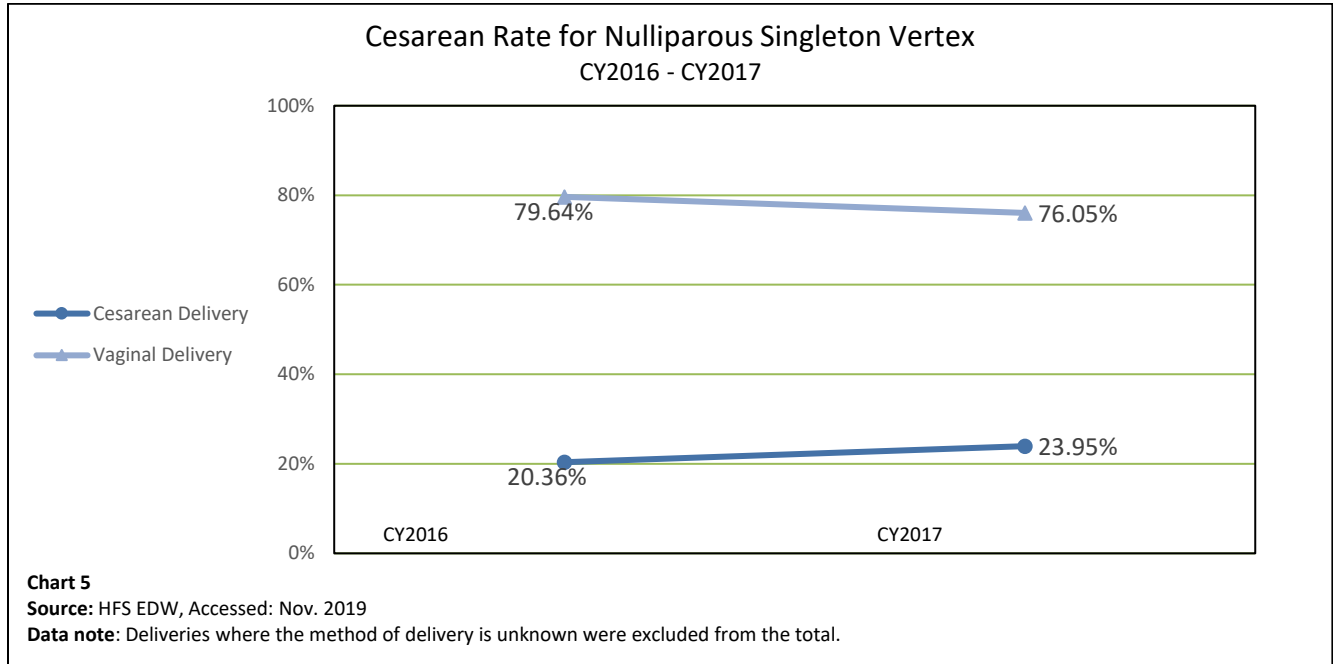
Percentages for vaginal and Cesarean deliveries remained essentially static over CY2016-2017.



From CY2016 through CY2017, the cesarean section rate among women experiencing a single first birth in vertex (head down) position increased from 20.36% to 23.95%.

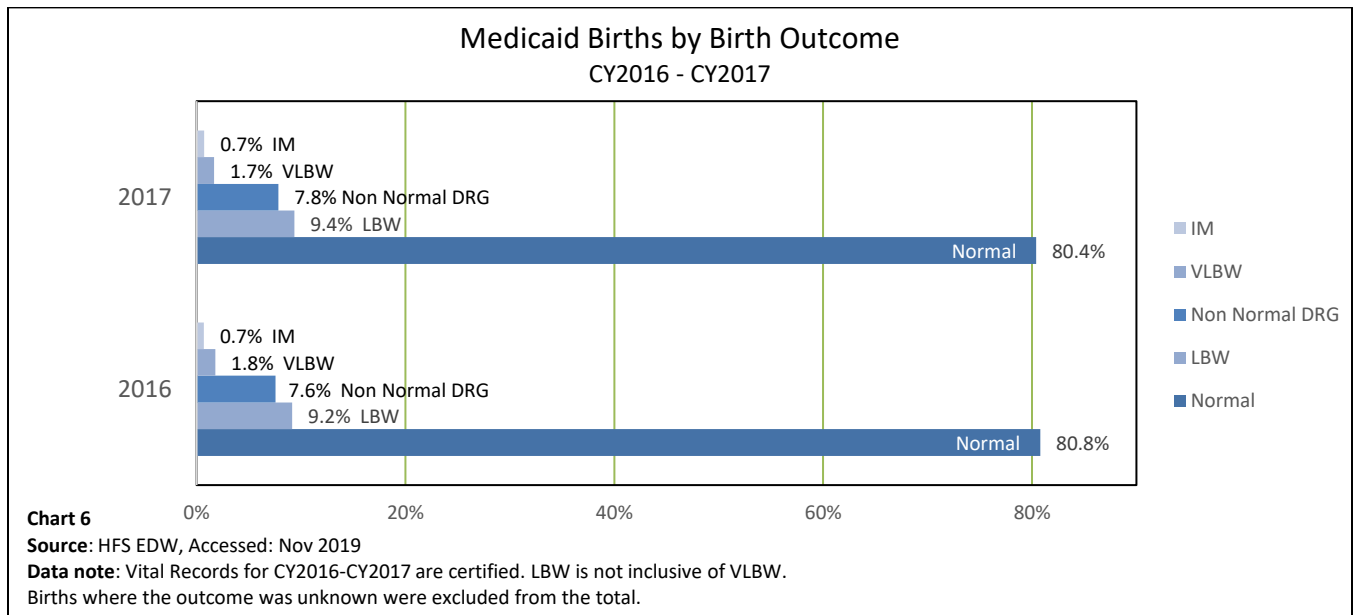
Cesarean Rate for Nulliparous Singleton Vertex

	CY2016	CY2017
Vaginal Delivery	79.64%	76.05%
Cesarean Delivery	20.36%	23.95%



**Birth Outcomes**

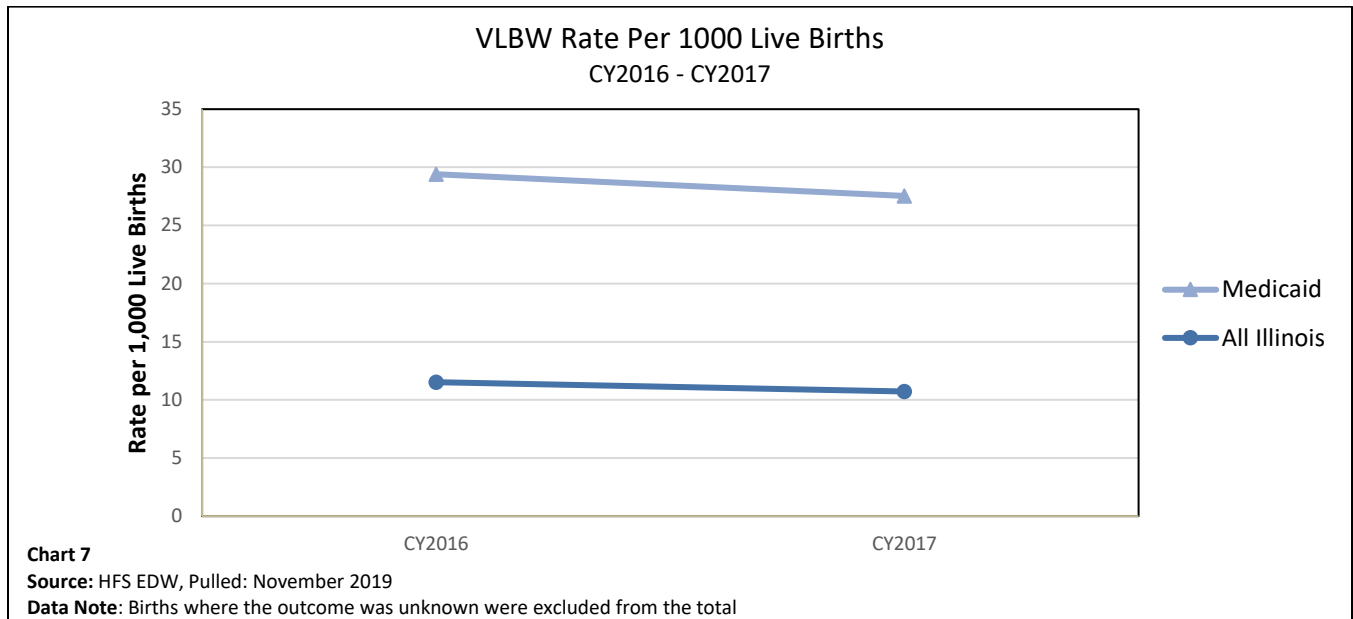
Based on vital records data indicated in the charts below, between CY2016 and CY2017, infants born in the weight range designated as "normal births" remain approximately 80% for the Medicaid population.



From CY2016 through CY2017, the VLBW (1 to 1500 grams) per 1,000 live births decreased for both the Medicaid and non-Medicaid population.

VLBW Rate Per 1000 Live Births

	CY2016	CY2017
Medicaid	17.89	16.82
All Illinois	11.52	10.72



From CY2016 through CY2017, the LBW (1 to 2,500 grams) rate per 1,000 live births increased slightly for both Medicaid and non-Medicaid populations.

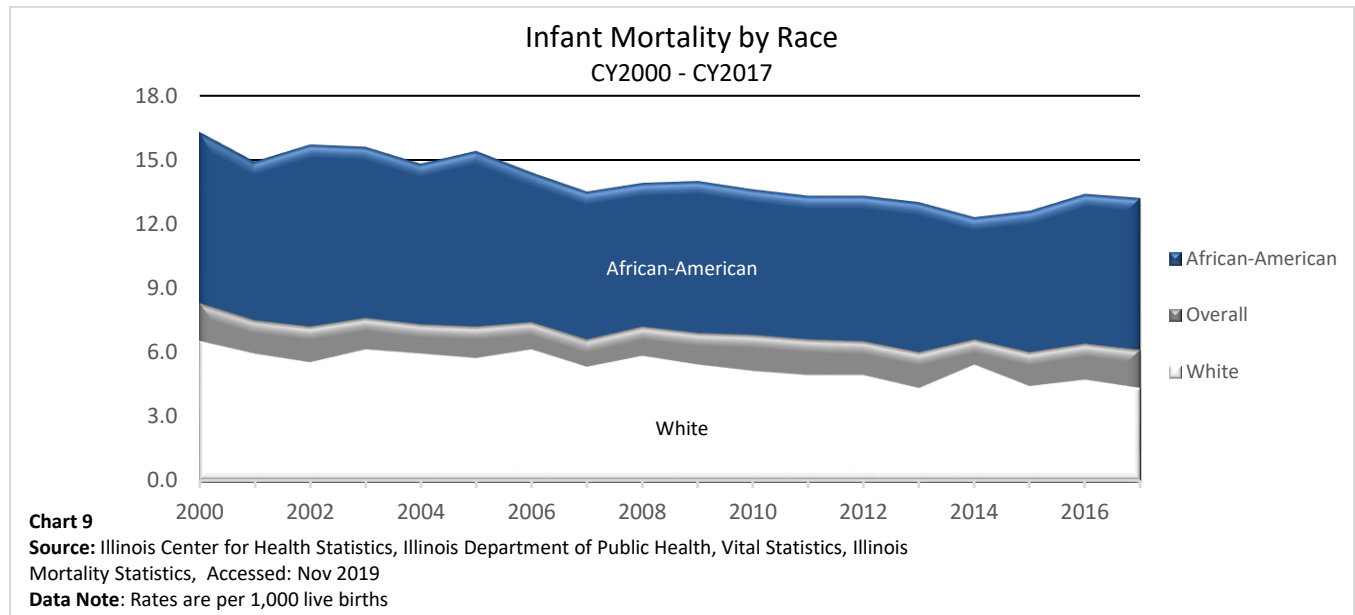
LBW Rate Per 1000 Live Births<sup>3</sup>

	CY2016	CY2017
Medicaid	109.41	110.36
All Illinois	79.20	79.81

<sup>3</sup> **Source:** HFS EDW, Accessed Nov 2019.

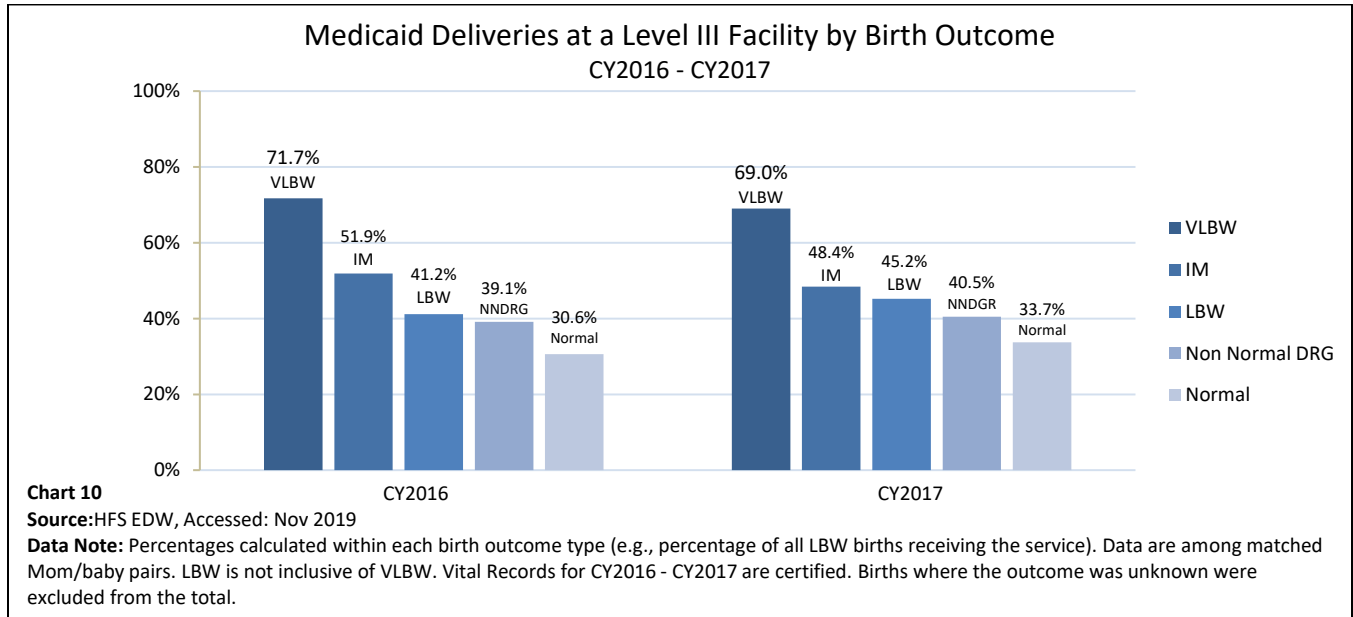
**Data Note:** Births where the outcome was unknown were excluded from the total. LBW is inclusive of VLBW.

The Medicaid infant mortality rate increased slightly from 5.8 per 1,000 live births in CY2016 to 6.1 in CY2017. And while infant mortality rates are trend downward in CY2017 from CY2016, the racial disparity for African American infants is pronounced, with a mortality rate for infants nearly 3x higher than for white infants.

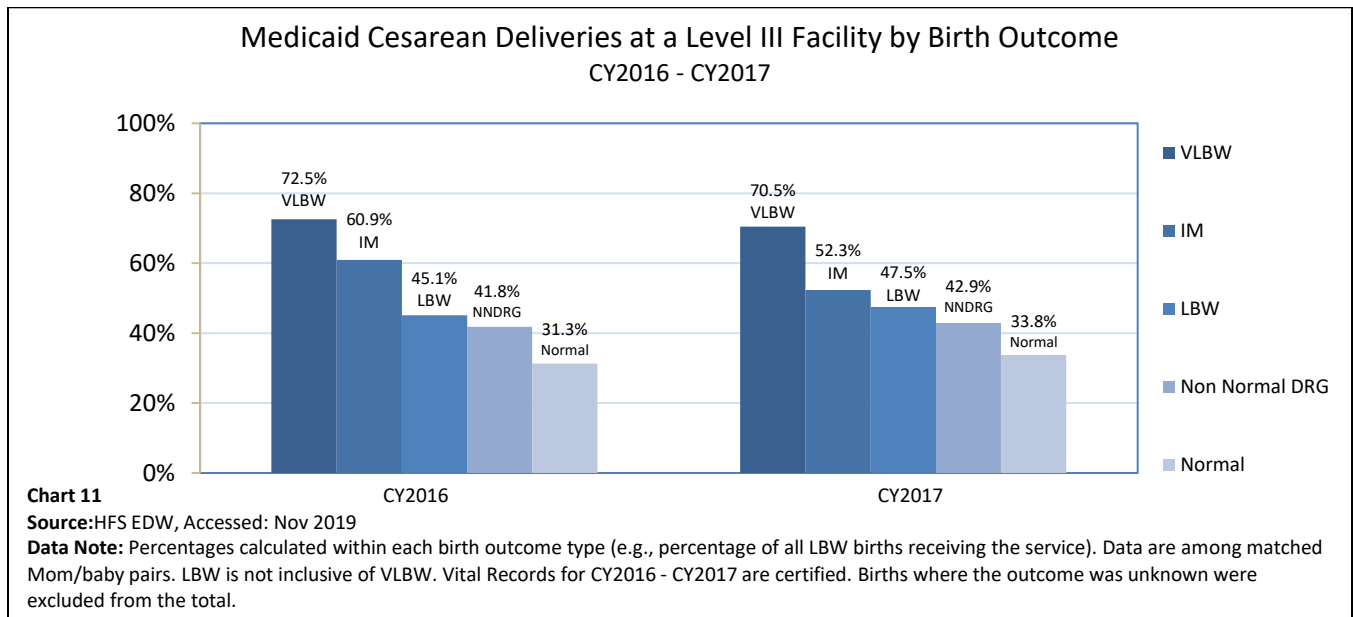


Infant Mortality by Race CY2000 – CY2017								
CY	White	Overall	African-American		CY	White	Overall	African-American
2000	6.5	8.3	16.3		2010	5.1	6.8	13.6
2001	5.9	7.5	14.9		2011	4.9	6.6	13.3
2002	5.5	7.2	15.7		2012	4.9	6.5	13.3
2003	6.1	7.6	15.6		2013	4.3	6.0	13.0
2004	5.9	7.3	14.8		2014	5.4	6.6	12.3
2005	5.7	7.2	15.4		2015	4.4	6.0	12.6
2006	6.1	7.4	14.4		2016	4.7	6.4	13.4
2007	5.3	6.6	13.5		2017	4.3	6.1	13.2
2008	5.8	7.2	13.9					
2009	5.4	6.9	14.0					

Among Medicaid covered deliveries, over two-thirds of all VLBW births (69% in CY2017) were delivered at a Perinatal Level III facility, followed by 45.2% of LBW births and over 40% of other non-normal DRG deliveries. This data shows that more high-risk infants continue to be delivered at a Perinatal Level III facility.

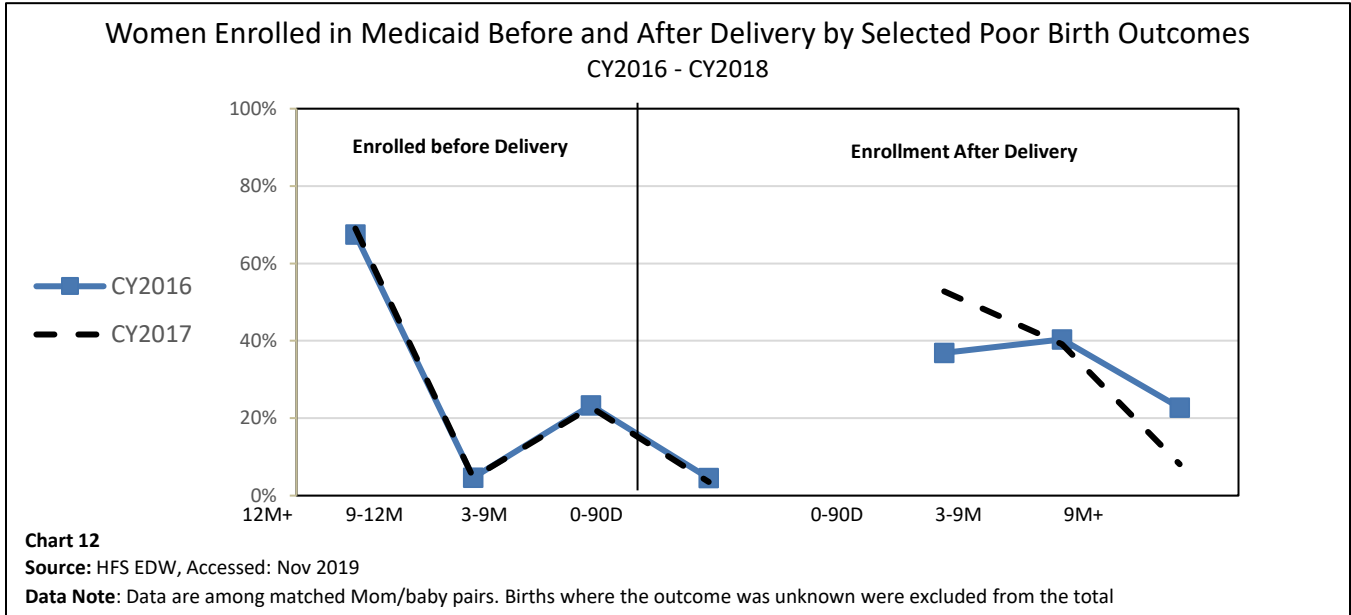


By the end of CY 2017, for Medicaid covered deliveries at a Perinatal Level III facility, approximately 70% of VLBW births, 52% of births resulting in IM, 47% of LBW births, 42% of other non-normal DRG births, and almost 34% of normal births were delivered by cesarean.



## Birth Costs

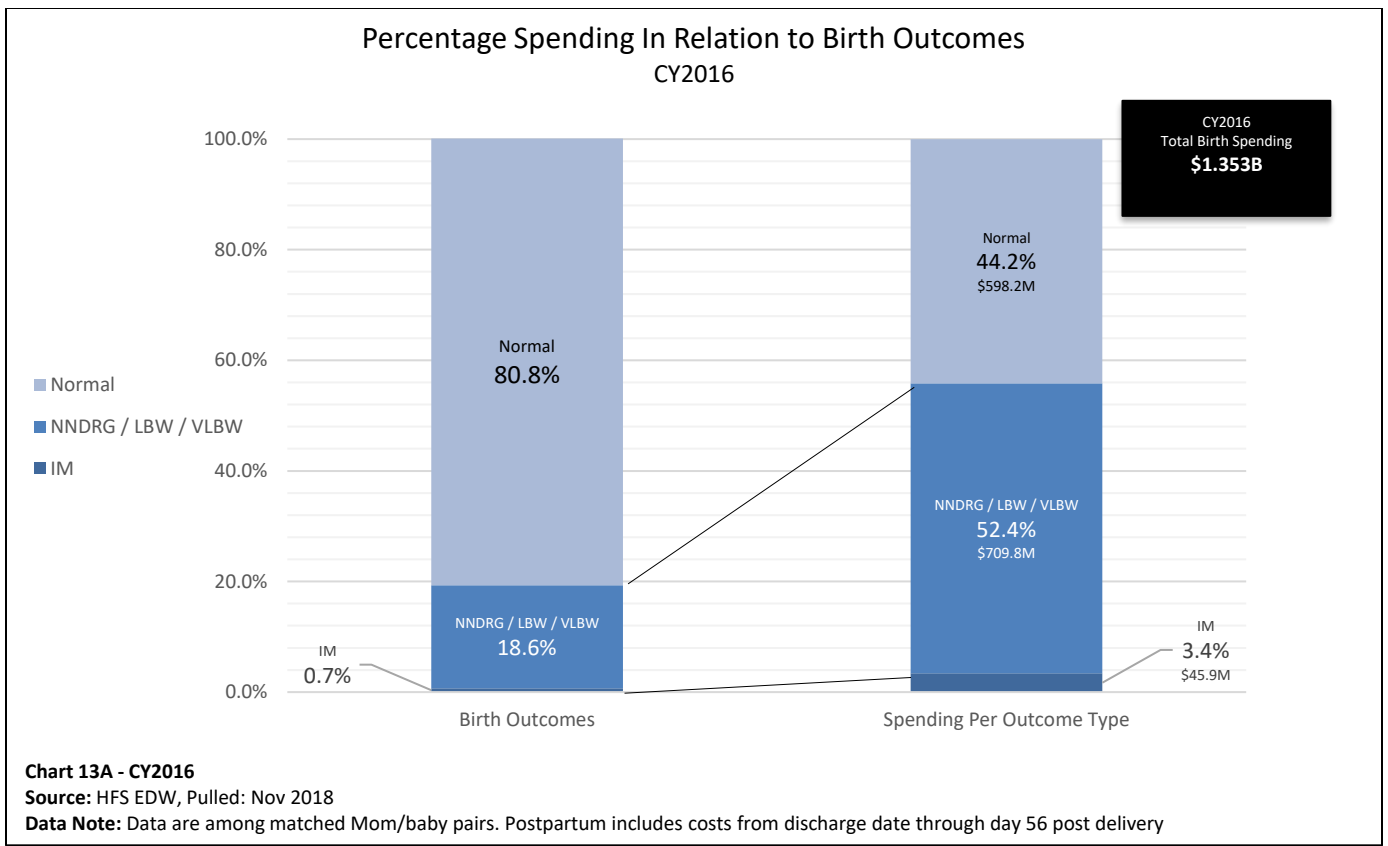
Of women whose infants had poor birth outcomes, the data demonstrates that more than 50 percent were enrolled in Medicaid for more than 12 months prior to delivery and about 20% were enrolled in the first 2 trimesters of the pregnancy. For most of this same group, Medicaid enrollment continued for 9 months postpartum while a smaller group remained enrolled for more than 9 months after delivery.



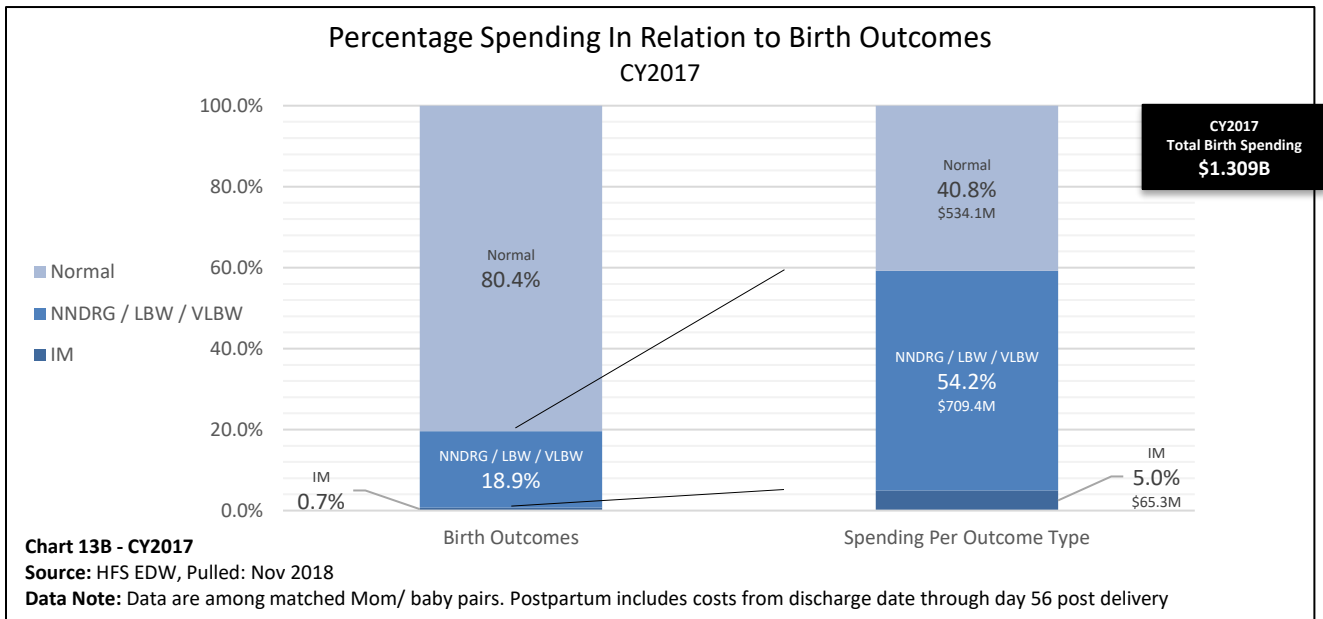
**Technical Note Regarding the Following Analysis:** The births and costs in the next 4 charts are for those mothers and babies that HFS has linked in the analysis, so that the total cost of the birth (the mother’s prenatal, delivery, and postpartum costs as well as the cost of the baby’s first year of life) can be analyzed. Therefore, all births may not be represented in these charts.

Although births with poor birth outcomes comprise just less than 20% of all Medicaid-covered births, these births account for most Medicaid birth costs.



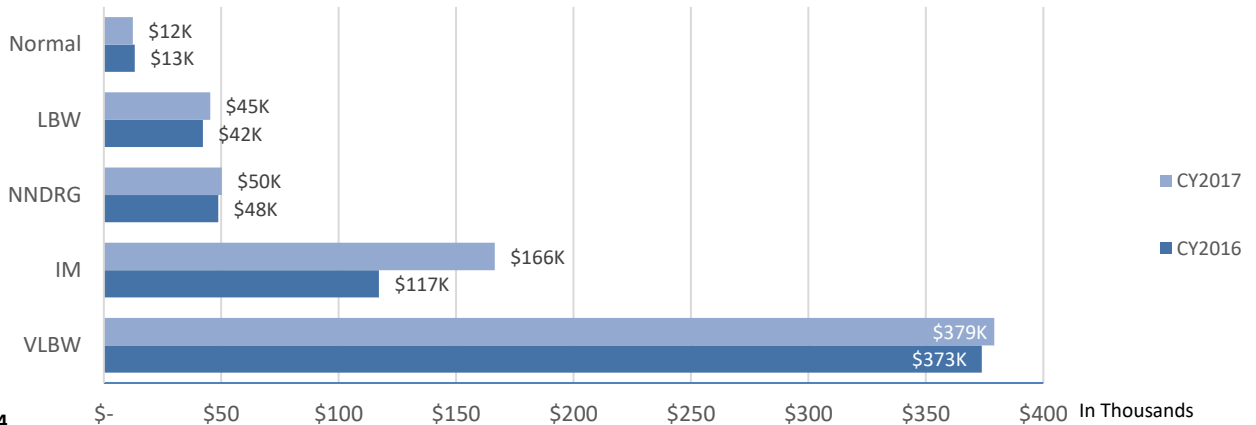


And while the total number of covered births and total costs for Medicaid covered births decreased slightly from 2016 to 2017, percentage of spending on births with poor birth outcomes continues to increase from 55.8% of spending in CY2016 to 59.2% of spending in CY2017.



In CY2017, the average cost of a normal birth fell to just over \$12,000 per birth (prenatal care, delivery, postpartum, and infant's first year of life) while the average cost of a VLBW birth topped just over \$379,000.

### Medicaid: Average Cost of Birth by Outcome CY2016 - CY2017



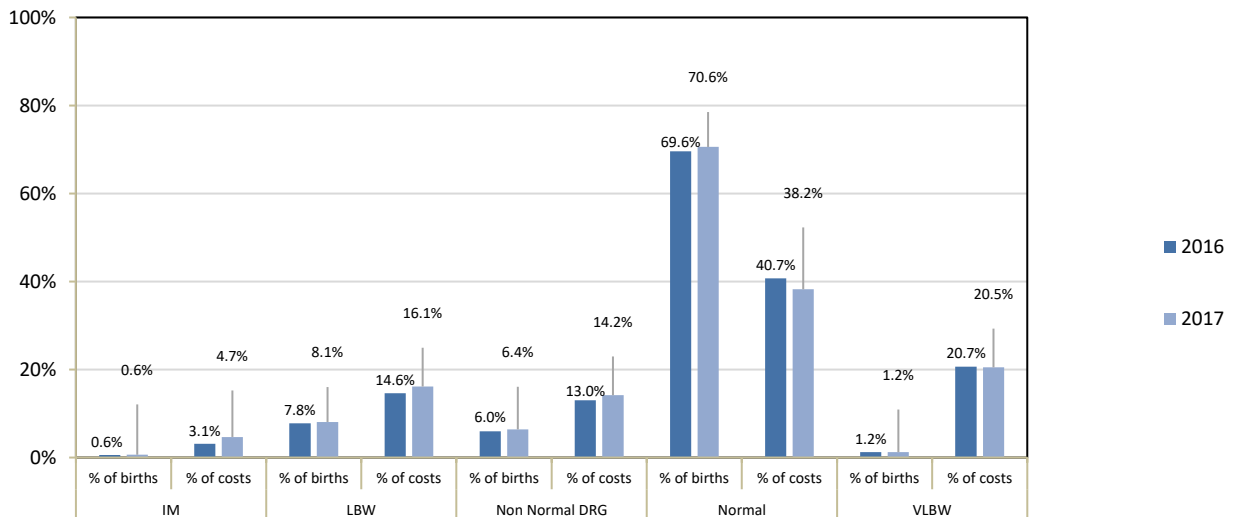
**Chart 14**

Source: HFS EDW, Accessed: Nov 2019

Data Note: Data are among matched Mom/baby pairs. Postpartum includes costs from discharge date through day 56, post-delivery. LBW is not inclusive of VLBW. Costs includes Mom's Prenatal, Delivery, Postpartum Costs, and Baby's 1st Year of Life Costs.

VLBW births represent the lowest percentage of live births, at nearly 1.2%, but they account for over 20% of total birth costs (mom's prenatal care, delivery, postpartum, and infant's first year of life.) Conversely, approximately two-thirds of matched births are normal outcome births and in CY2017, accounted for less than 40% of total birth costs.

### Percentage of Medicaid Births and Costs by Outcome CY2016 - CY2017



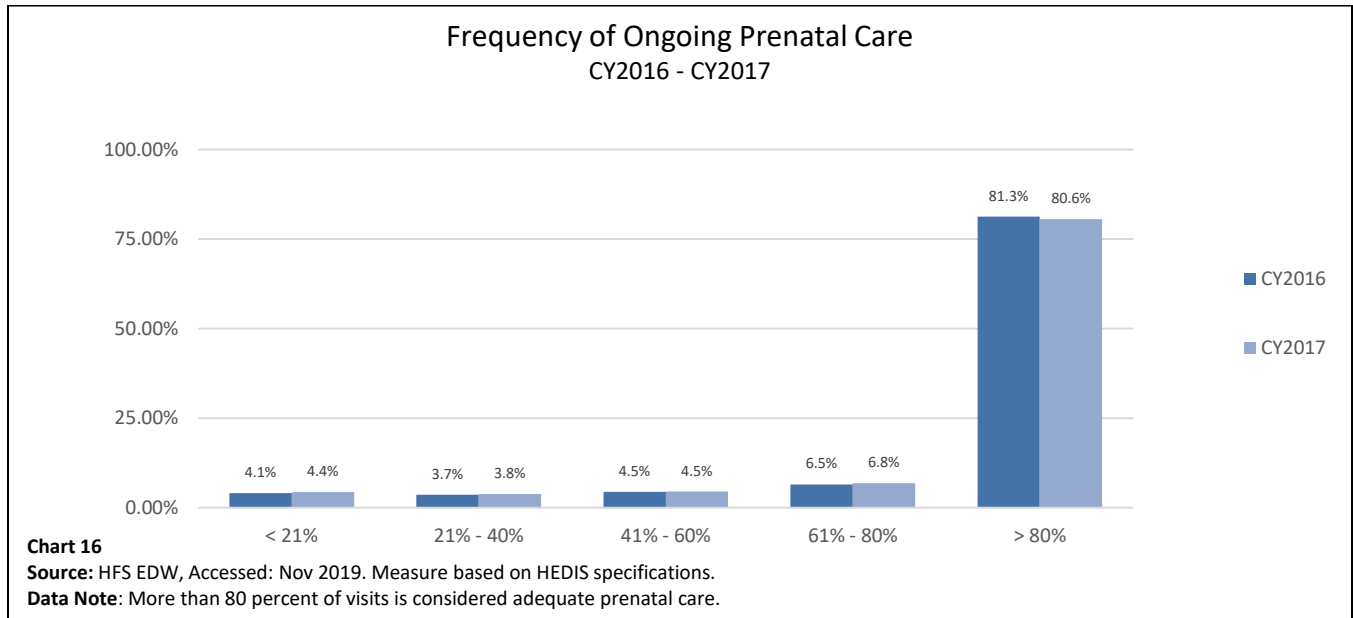
**Chart 15**

Source: HFS EDW, Accessed: Nov 2019

Data Note: : Data are among matched Mom/baby pairs. Postpartum includes costs from discharge date through day 56 post delivery. LBW is not inclusive of VLBW. CY2016 - CY2017 Includes Mom's Prenatal, Delivery, and Postpartum Costs; and Baby's 1st Year of Life Costs.

## Prenatal and Postpartum Care

In CY2016 and CY2017, less than 5% of Medicaid-enrolled pregnant women received less than 21% of recommended prenatal care visits while over 80% of Medicaid-enrolled pregnant women receive 80% or more of the recommended prenatal care visits.



The percentage of Medicaid-enrolled women who received timely postpartum has remained constant between CY2016 (56.59%) and CY2017 (56.40%).<sup>4</sup>

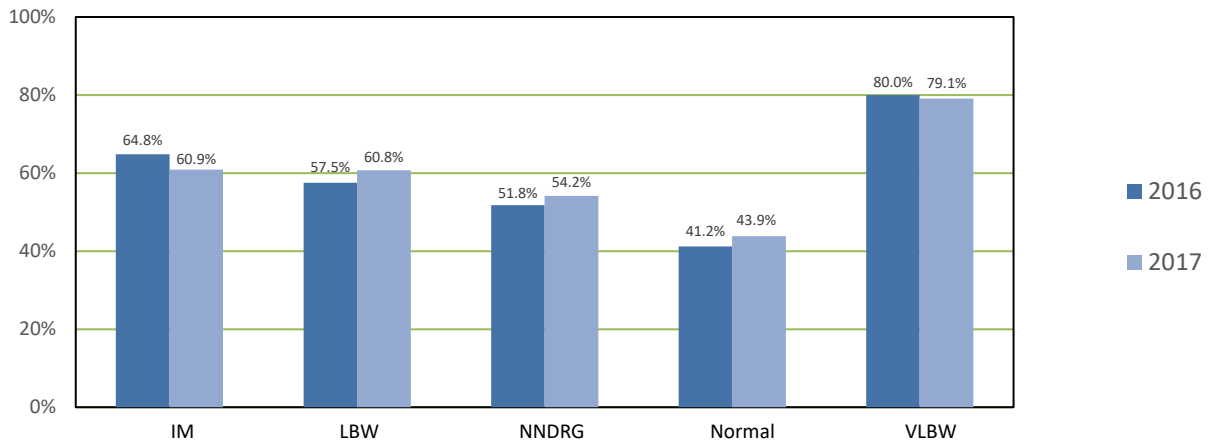
Higher rates of women experiencing VLBW, LBW and other non-normal DRG deliveries received their prenatal care at a Perinatal Level III hospital compared to women who had a normal birth outcome.

<sup>4</sup> Prior Report – Chart 20.

**Source:** HFS EDW, Accessed: Nov 2019

**Data Note:** Timely prenatal care is defined as a visit in the first trimester or within 42 days of enrollment, as defined by HEDIS specifications.

### Medicaid Prenatal Services Provided at Level III Facilities CY2016 - CY2017



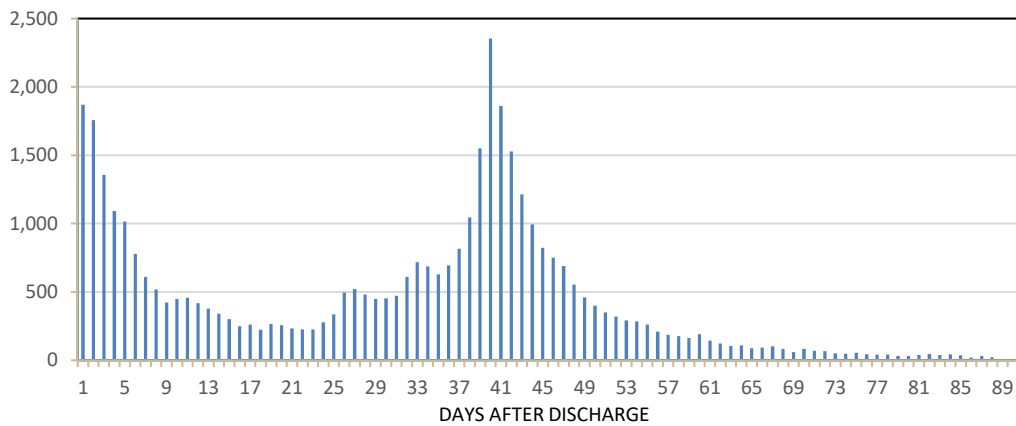
**Chart 17**

**Source of data:** HFS EDW. Accessed Nov 2019

**Data Note:** Percentages calculated within each birth outcome type (e.g., percentage of all LBW births receiving the service). Data are among matched Mom/baby pairs. LBW is not inclusive of VLBW. Births where the outcome is unknown were excluded from the total.

The number of postpartum visits by mothers in CY2017 peaks at about the 40th day post discharge from hospital.

### Mothers with a Postpartum Visit by Days After Discharge From Hospital CY2017



**Chart 18**

**Source:** HFS EDW, Accessed: NOV 2019

**Data Note:** Measures based on HEDIS Specification.

# RECOMMENDATIONS AND INITIATIVES

To further the objectives set forth in [305 ILCS 5/5-5.24](#), the Department of Healthcare and Family Services (HFS) has made several recommendations and implemented various initiatives. This report contains recommendations and initiatives for which there is new information since the last perinatal report (January 1, 2016). Refer to past [perinatal reports](#) for historical information.

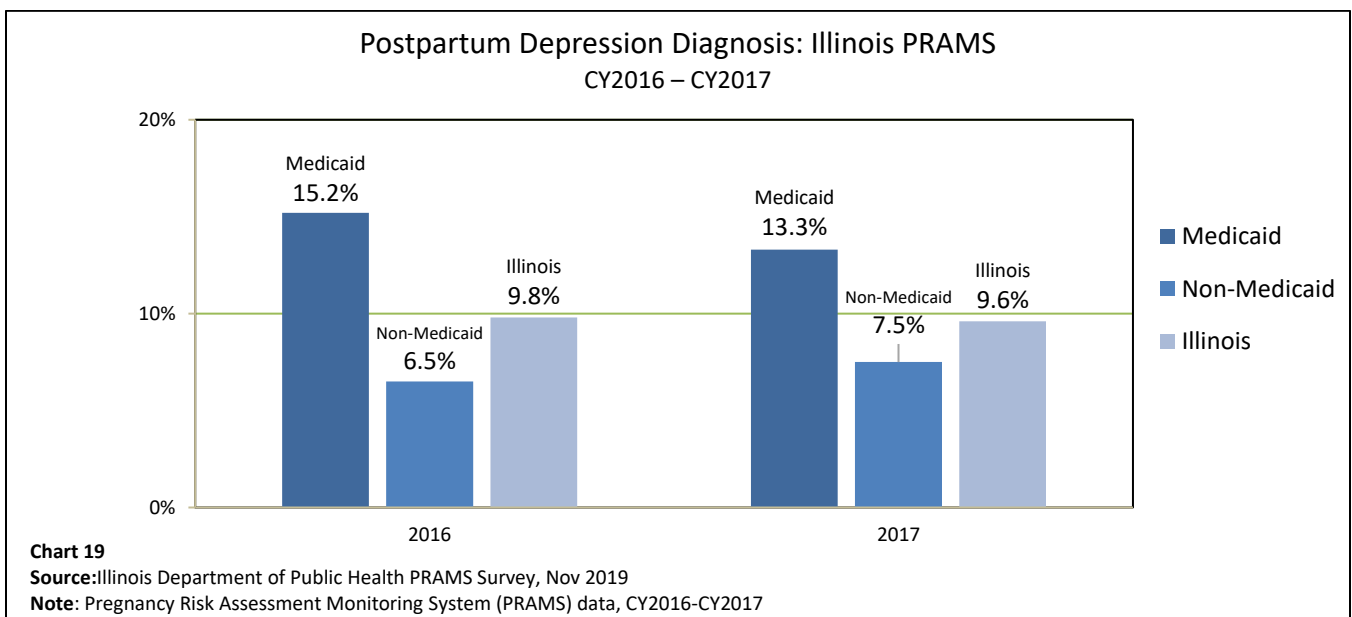
## Managed Care

Beginning January 1, 2018, HFS enrolled approximately 80% of its clients into managed care plans (MCO). This transformation has affected women of child-bearing age who are the focus of this report. The goal of MCOs is to improve care through care coordination (e.g. care transition and follow-up), provision of evidence-based practices, promotion of timely care and access to prenatal care, behavioral health services, substance use services, contraceptive services, and other specialty care. The MCOs are being held accountable to nationwide Healthcare Effectiveness Data and Information Set (HEDIS®) measures to track MCO timeliness and performance in delivering prenatal and postpartum care.

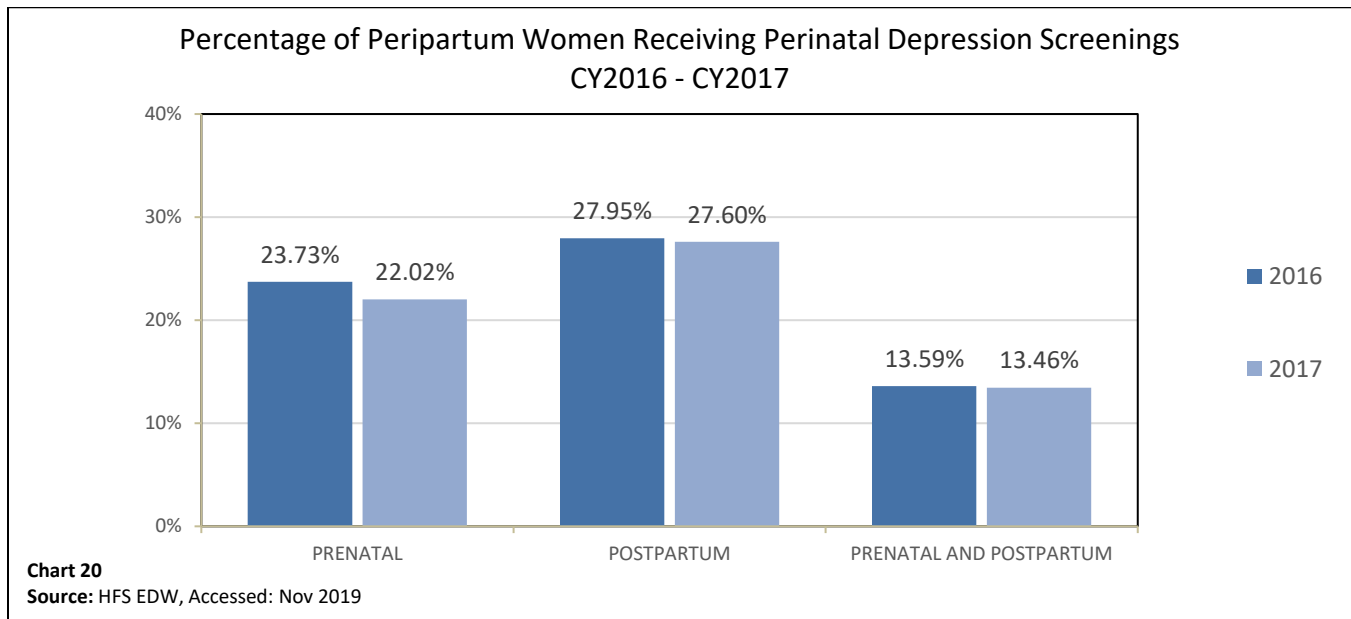
Beginning June 2017, the MCOs received an additional indicator in the Care Coordination Claims Data (CCCD) files flagging women who are enrolled in the Illinois Department of Human Services (DHS) Better Birth Outcomes (BBO) program (see below). This permits coordination between the MCOs and DHS for women who receive medical services through HFS and who are enrolled in DHS' BBO program. In areas where the DHS BBO program does not operate, the HFS MCOs have primary responsibility to provide early intensive prenatal care to high-risk pregnant women. This data analysis will help analyze birth outcomes data utilizing predictive analytics to better understand factors affecting the health of births.

## Mental Health

Women enrolled in Medicaid reported being diagnosed with postpartum depression at a higher rate than other women.



From CY2016 through CY2017, there was a slight decrease in the rate of women receiving perinatal (including prenatal and postpartum) depression screening. A prior year recommendation was to make information and training available to providers on how to use the depression screening tools. HFS has educated providers on the screening tools and partnered with other organizations to provide training on depression screening. HFS has seen an increased trend in non- mental health specialty healthcare providers requesting information on treatment options. Postpartum depression screening is now also covered by Medicaid when it is performed using the appropriate tools during the pediatric follow up visits in the first year postpartum if the child is a Medicaid recipient.



### Doc Assist

Beginning on Jan 1, 2015, Illinois Doc Assist began providing phone consultation for primary care health professionals to screen, diagnose, and treat the mental health problems of women during the perinatal period, including issues within the family.

### Text4Baby

Since 2012, WellCare has provided the text4baby application. It sends texts three times weekly to women who choose to subscribe, with helpful tips on what to expect on their individual stage of pregnancy, breastfeeding, infant care, well child-care, etc. It is also customizable to program provider appointments for both mother and child. There are videos and other links available for support as well.

### PROMOTE-IL

The Illinois Maternal Health Task Force was first assembled in March of 2020 in order to improve healthcare for all women of reproductive age in the state of Illinois. It has established a statewide group who are working on:

- Improving state level maternal data sharing and surveillance
- Improving care of women statewide through review boards such as MMRC/V
- Coordination of maternal childcare and case management services statewide
- Addressing obstetric deserts throughout IL
- Addressing health inequities, particularly as they apply to maternal childcare

## Oral Health

No updates to report.

## Smoking Cessation

Medicaid-enrolled women were more likely to smoke than other women before and during pregnancy. In CY2016, more than 27% of Medicaid-enrolled women smoked in the three months before pregnancy and 13.7% smoked during the last three months of pregnancy compared to 12.5% of non-Medicaid women who smoked before pregnancy and 2.9% who smoked during pregnancy. Smoking by women before and during pregnancy is a contributing factor to low birth weight. Various initiatives have been implemented to decrease smoking among Medicaid-enrolled women. These initiatives are detailed in previous reports and include provider assessment of smoking status, referrals to smoking cessation services (separately reimbursed by HFS) and encouraging patients to quit by such methods as motivational and self-help booklets.

<b>Prevalence of Smoking Before and During Pregnancy: Illinois PRAMS CY 2016</b>		
<b>Women who smoked 3 Months Before pregnancy</b>	<b>Percentage</b>	<b>95% CI</b>
Illinois	16.70%	14.6-19.1
Medicaid Enrolled Women	27.20%	22.4-32.7
Non-Medicaid Enrolled Women	12.50%	10.3-15.0
<b>Women who smoke during last 3 Months of pregnancy</b>	<b>Percentage</b>	<b>95% CI</b>
Illinois	0.076	6.1-9.4
Medicaid Enrolled Women	13.70%	10.7-17.3
Non-Medicaid Enrolled Women	2.90%	1.8-4.6

Chart 21: Illinois Department of Public Health, Illinois Center for Health Statistics, 2016 Pregnancy Risk Assessment Monitoring System (PRAMS).

## Perinatal Addiction

Medicaid-enrolled women are less likely to use alcohol in the three months before pregnancy and during pregnancy than other women, but both groups of women self-report high levels of alcohol use.

<b>Prevalence of Drinking Before Pregnancy: Illinois PRAMS CY2016</b>		
<b>Women who drank 3 months before pregnancy</b>	<b>Percentage</b>	<b>95% CI</b>
Illinois	59.90%	57.0-62.8
Medicaid Enrolled Women	46.80%	41.1-52.6
Non-Medicaid Enrolled Women	65.00%	61.6-68.2

Chart 22: Illinois Department of Public Health, Illinois Center for Health Statistics, 2016 Pregnancy Risk Assessment Monitoring System (PRAMS).

The Illinois Advisory Council on Alcoholism and Other Drug Dependency's Women's Committee (Women's Committee) released the Women's Plan and Practitioner's Toolkit 2017-2019 (Toolkit) in December 2016. The Toolkit is divided into the following topic areas:

- Opioid Use
- Trauma-Informed Care
- Co-Occurring Disorders

- Criminal Justice Involved Women
- Family Centered Services
- Harm Reduction
- LGBTQ+ specific Needs
- Utilizing Evidence-Based Practices from Mental Health
- Interdisciplinary Cooperation/Integrated Care

These nine sections are further broken down into subcategories with recommendations to facilitate assessment and modification of practice in the following areas:

- Agency Level Changes
- Recommendations for Workforce and Program Development
- Screening and Assessment
- Policy Changes
- Resources

Specific recommendations HFS made which are aligned with the Toolkit are:

- Provide access to substance abuse treatment specialists
- Identify existing resources needed to establish a Maternal Child Health (MCH) team with a substance abuse treatment specialist
- Include a substance abuse specialist in the Targeted Intensive Prenatal Case Management (TIPCM) and Healthy Start programs
- Promote interdisciplinary cooperation and integrated health promotion to expand access to health and wellness education and care for women served by each state agency
- Establish a formal network for consultation, as needed, by primary care providers
- Build collaborative teams between child welfare, public health, substance use disorder and mental health community providers and medical professionals to address policy and practice to address the needs of pregnant women. The teams should be comprised of professionals from various disciplines, agencies and organizational bodies, including agencies involved in the continuum of healthcare services such as the Illinois Department of Public Health (DPH) and HFS
- Provide training for physicians on the signs, symptoms and screenings for addictions
- Women who have adverse childhood experiences are at increased risk of health problems and substance use issues later in life. The primary care provider is often the first and sometimes only point of contact in the healthcare system for women with substance use disorders (SUDs). Some women with SUDs do not receive adequate preventative care and education, resulting in higher rates of preventable chronic illnesses, in addition to health outcomes more directly associated with substance use. It is therefore vital not only that primary healthcare providers be effectively trained in screening and providing resources related to substance use recovery, but also that providers of substance use and mental health services provide increased access to primary healthcare for the women they serve.

The Toolkit recommends:

- Increase training for opioid use disorders best practices, including safe opioid prescribing and the use of medication assisted treatment (MAT) and overdose prevention, including naloxone distribution
- Promote building collaborative teams between child welfare, public health, substance use disorder and mental health community providers and medical professionals to address policy and practice to address the needs of pregnant women with opioid use disorders
- Screen each woman for a history of opioid use and overdose risk factors, including women without opioid use disorder (OUD)
- Implement universal screening such as those addressing Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Syndrome (FAS)

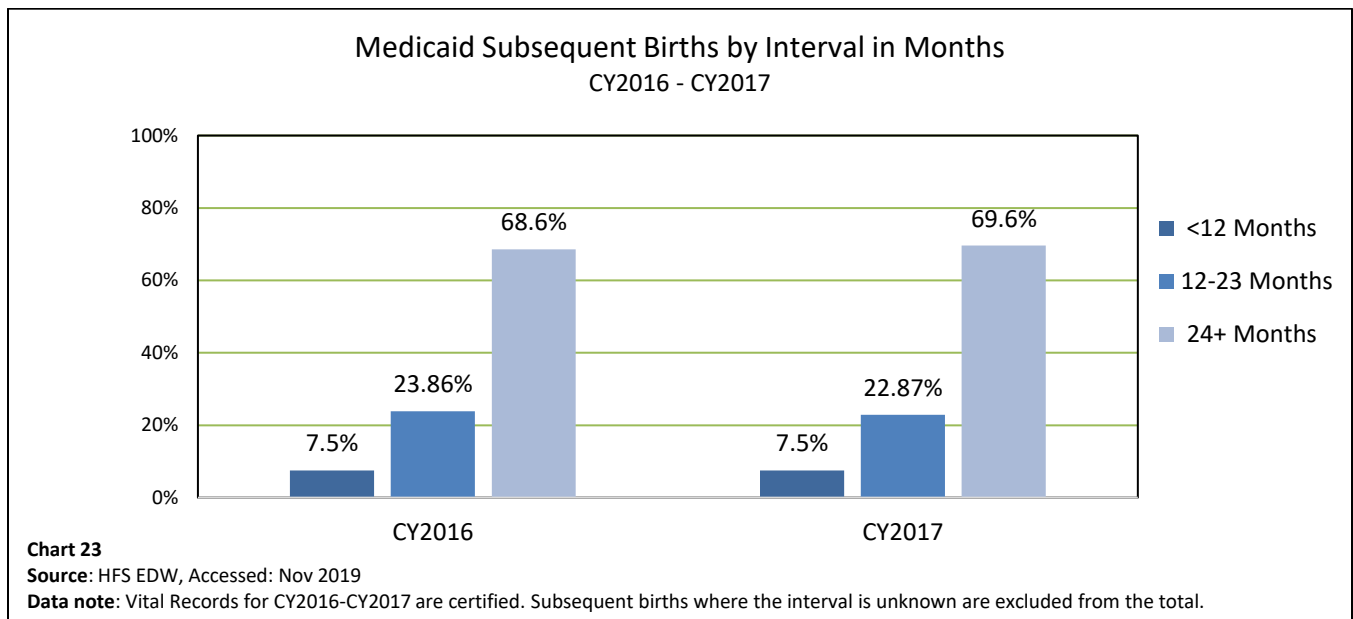


Substance Abuse Prevention has been moved back into the Division of Substance Use Prevention and Recovery (SUPR). This includes the oversight of the following tobacco programs: Synar, the Tobacco Enforcement Program, and the FDA Compliance and Enforcement Tobacco Retail Inspection Program. Funding for a smoking cessation specialist position in DASA was recommended. It is envisioned that this smoking cessation specialist would review and recommend smoking cessation programs and provide smoking cessation training.

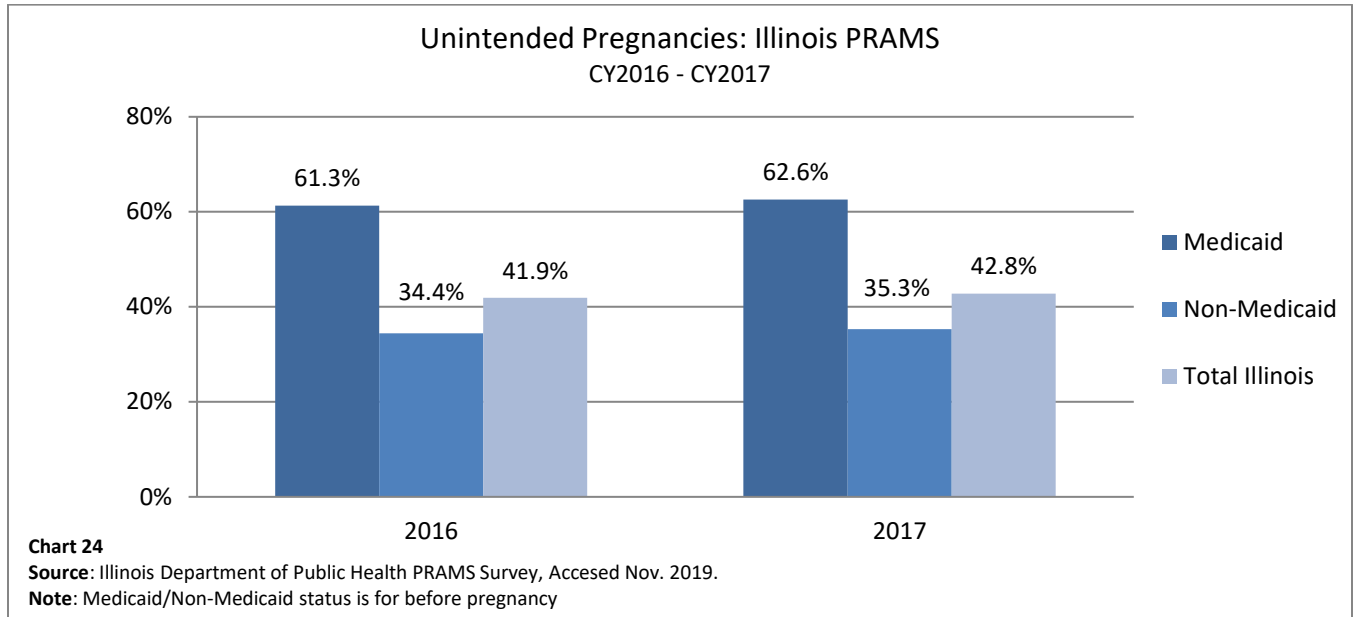
### Family Planning

HFS continues its robust efforts to improve contraceptive uptake, enhance contraceptive policy development to improve inter-pregnancy spacing, improve birth outcomes, and decrease unintended pregnancy rates.

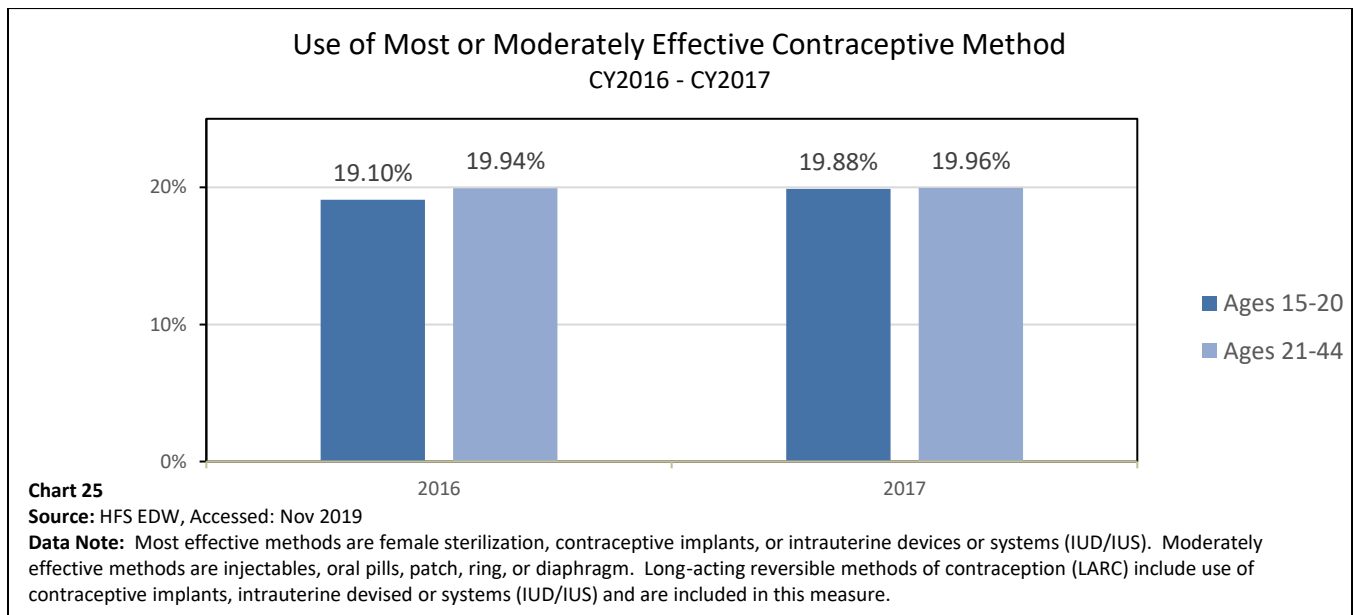
Pregnancies that start less than 18 months after birth are associated with delayed prenatal care and adverse birth outcomes, including preterm birth, neonatal morbidity, and low birthweight.

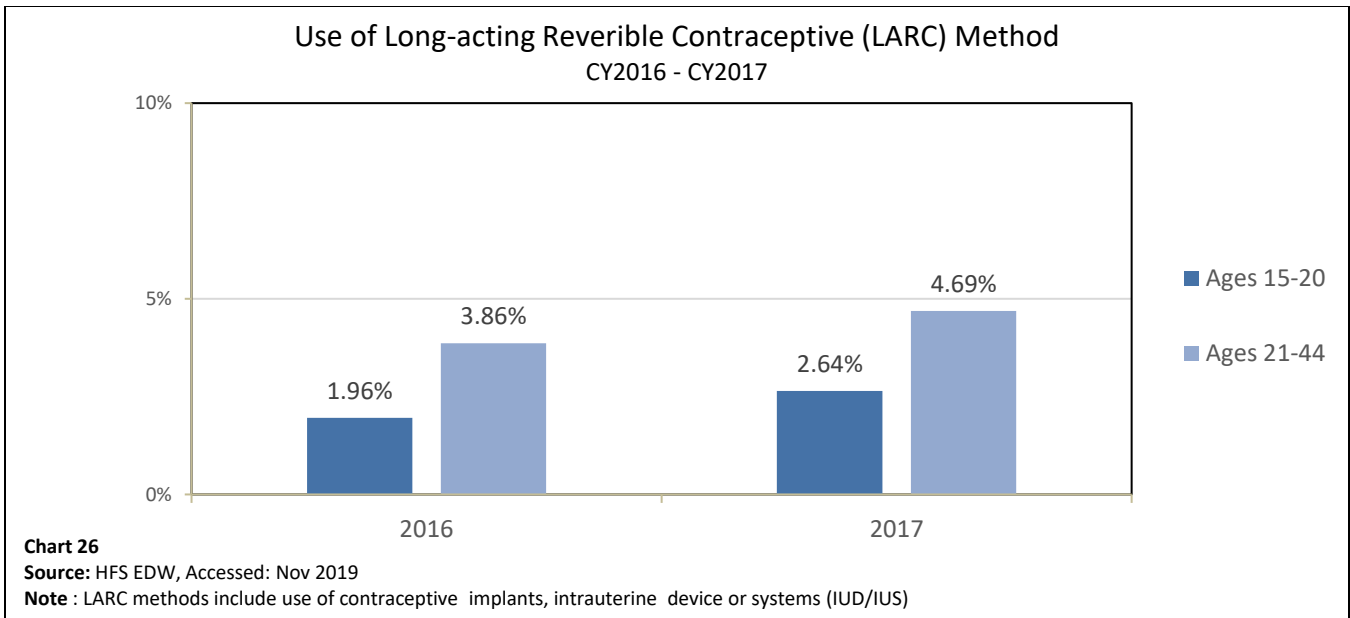


The number of unintended pregnancies was essentially unchanged at sixty percent over 2016-17.

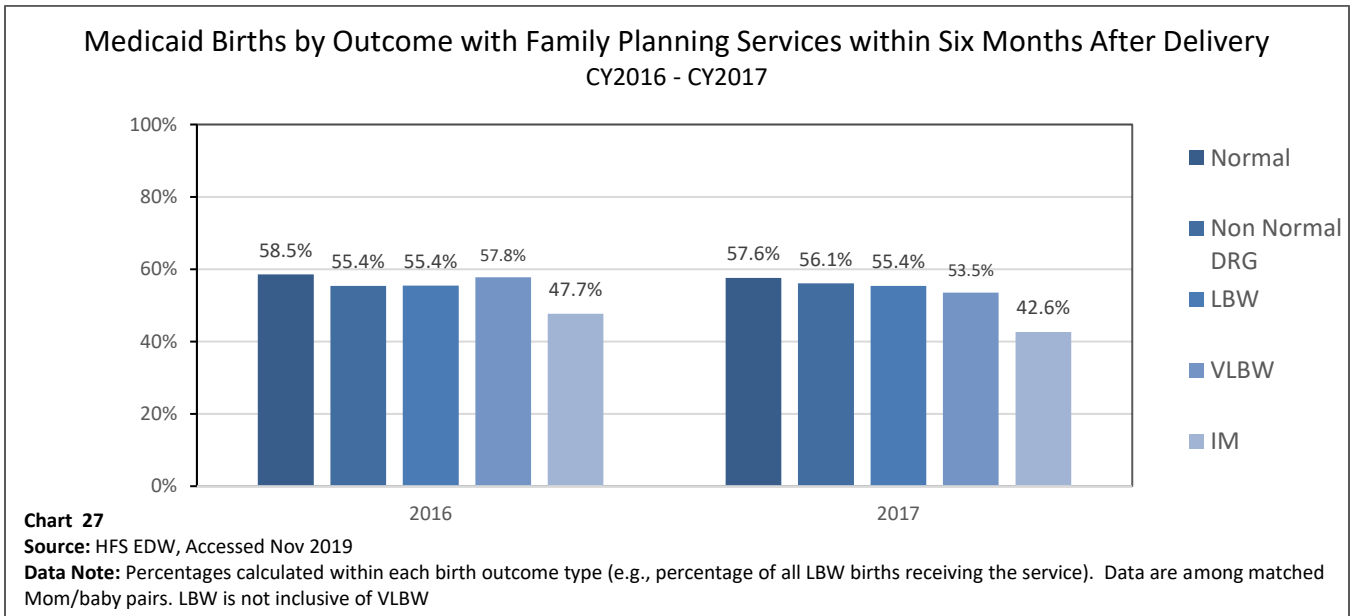


In the Medicaid managed care program, HFS continues to ensure that each MCO has family planning protocols which include a comprehensive list of FDA-approved contraceptives on its formulary. However, the use of most or moderately effective contraceptives slightly increased for younger women from CY2016 to CY2017, although it stayed about the same for the older age group. However, the use of long-acting methods of contraceptives increased substantially for both age groups from CY2016 to CY2017.





The percentage of women who deliver under Medicaid and receive family planning at six months post-delivery vary by birth outcome. Overall, 56.8% received family planning services within 6 months in 2016, and 55.9% in 2017.<sup>5</sup> Family planning services are important postpartum especially in non-normal births because of high correlations of outcomes in subsequent pregnancies, e.g. VLBW births are highly correlated with a subsequent VLBW birth. Through provision of family planning services postpartum, subsequent unplanned pregnancies can be avoided and birth outcomes can be improved through contraception utilization which allows for greater birth intervals between pregnancies. HFS continues to promote access to contraceptive services.



<sup>5</sup> Source: HFS EDW, Accessed Nov. 2019

One of HFS' enhancements to promote more effective family planning and improve inter-pregnancy spacing is to permit separate reimbursement for immediate LARC insertion immediately postpartum in the inpatient hospital setting. In a [provider notice](#) dated July 1, 2015, HFS described the new policy by stating: "LARCs, specifically the intrauterine devices (IUDs) and the contraceptive implant, are the most effective reversible forms of female contraception...with high rates of continuation and client satisfaction. The immediate postpartum period is a perfect opportunity to offer the use of LARCs among women for whom a rapid repeat and unplanned pregnancy carries serious ramifications. Supporting immediate postpartum LARC insertion contributes to optimal pregnancy spacing, thereby improving maternal and infant health and averting potentially substantial financial and social risks."

### **Better Birth Outcomes (BBO) Program**

HFS partners with DHS in the BBO Program. Women with high-risk pregnancies in targeted areas of the state are enrolled in this program.

BBO offers:

- a standardized prenatal education curriculum emphasizing the importance of regular prenatal medical care visits,
- home visits each trimester,
- monthly engagement with the BBO case manager for continued prenatal education,
- care coordination and communication with the client's prenatal medical provider.

Women are enrolled in BBO throughout the pregnancy and up to six weeks postpartum. Since the target population for these services are women who may not tend to seek out early prenatal medical care or services, agencies participating in the BBO program are expected to develop an annual outreach plan.

The BBO Program demonstrates significant value by improving birth outcomes and the associated costs through data sharing, early identification, expedited interagency referrals, aggressive outreach and better care management.

In SFY 2020, there were 22 BBO providers. BBO providers are defined by geographic areas of the state where data indicates higher than average Medicaid costs associated with poor birth outcomes.

### **Birthing Centers**

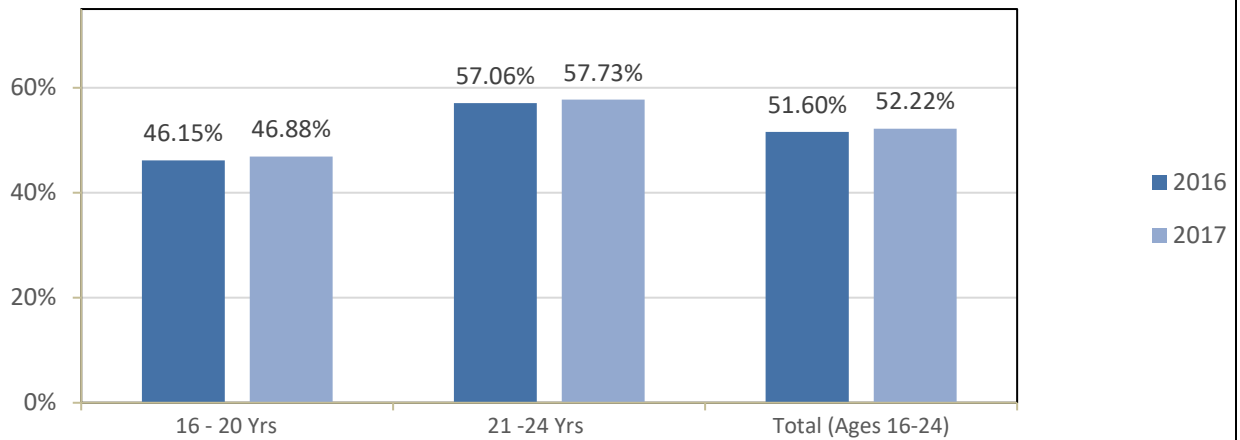
Birthing centers as alternatives to hospitals are encouraged as a way to cut healthcare costs. Birthing centers are licensed by the DPH. Women at low risk for complications may prefer the low-tech environment provided by birthing centers, which employ licensed professionals (usually a midwife and a nurse) with a backup hospital nearby and a doctor on call in case of an emergency.

In SFY 2020 there were three licensed birthing centers in Illinois. At present, there is insufficient data available to assess the effectiveness of birthing centers in reducing the incidents of low birthweight and neonatal intensive care.

### **Sexually Transmitted Diseases**

Chlamydia screening rates among 16-24-year-old women on Medicaid have shown an increase. In women, Chlamydia can be asymptomatic. If the infection is left untreated, it may lead to infertility. The infection also presents certain other risks for mom and baby should pregnancy occur.

### Chlamydia Screening Among Females 16-24 Years of Age CY2016 - CY2017



**Chart 28**

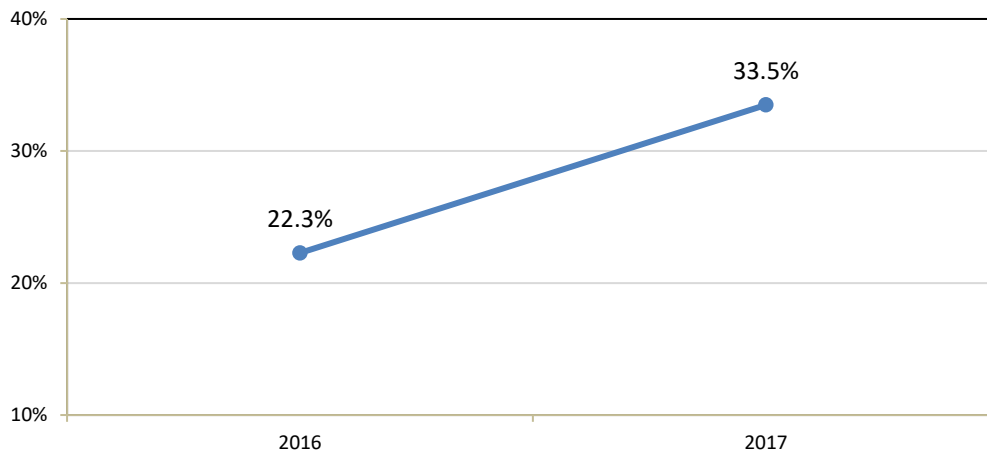
Source: HFS EDW, Accessed: Nov 2019

Data Note: Measures based on HEDIS specifications

The Human Papillomavirus (HPV) vaccine is important because it protects against cancers caused by HPV infection. HPV is a very common virus; nearly 80 million people – about one in four – are currently infected in the U.S. About 14 million people, including teens, become infected with HPV each year. Most people with HPV never develop symptoms or health problems. Most HPV infections (9 out of 10) go away by themselves within two years. However, some HPV infections last longer and can cause cancers and other diseases: cancers of the cervix, vagina, and vulva in women; cancers of the penis in men; and cancers of the anus and back of the throat in both men and women. Source: <https://www.cdc.gov/hpv/parents/vaccine.html>.

From CY2016 to CY2017, there has been a significant increase in the rate of the HPV vaccination among 13-year-old females (22.3% to 33.5%). While the trend shows a positive increase, the rate of vaccination remains low with approximately 1 in 3 adolescents receiving the vaccine.

### Human Papillomavirus (HPV) Vaccine for Adolescents 13 Years of Age CY2016 - CY2017



**Chart 29**

Source: HFS EDW, Pulled: Nov 2019

Data Note: Measures based on HEDIS specifications. Note that both male and female adolescents are included in this data.

## **Human Immunodeficiency Virus (HIV) Counseling**

No updates to report.

## **Nurse Midwifery**

No updates to report.

## **Lactation Counseling**

No updates to report.

## **Case Management and Home Visiting**

No updates to report.

## **Collaborative Improvement and Innovation Network (CoIIN)**

CoIIN is a multi-year, national initiative supported by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in the federal Department of Health and Human Services (DHHS). Illinois will continue to implement its four key strategies to decrease disparities in infant mortality: increasing safe sleep practices; enhancing pre- and interconception care, assuring that very pre-term babies are born in hospitals with the appropriate capacity to meet their complex health needs, and addressing the social determinants of health.



## Children's Health Insurance Program Reauthorization Act (CHIPRA) Child Health Quality Demonstration Grant

The CHIPRA Quality Demonstration Grant in Illinois concluded in February 2016. Activities completed under the CHIPRA grant were:

- The Perinatal Care Quality Tool (PCQT) was developed to assist providers in providing evidence-based prenatal care and making appropriate high-risk referrals based on American College of Obstetricians and Gynecologists/American Academy of Family Physicians (ACOG/AAFP) guidelines and the Illinois Perinatal Act. The tool was intended to be incorporated into electronic health records. The PCQT was pilot tested by two obstetric practices in the final year of the CHIPRA grant.
- The Prenatal Minimum Electronic Data Set (PMEDS) is a tool that electronically provides prenatal providers and hospitals a minimum set of available prenatal data when the prenatal health record is not available. The data set is based on ACOG/AAFP guidelines. The tool provides basic information to enable practitioners to make treatment decisions and to avoid duplication of services, thereby improving outcomes and efficiency. The PMEDS tool was pilot tested in two federally qualified health centers (FQHCs) and affiliated hospitals in the final year of the CHIPRA grant.

The final reports for the PCQT and PMEDS tools are in Health Management Associates' CHIPRA library at [www.healthmanagement.com/what-we-do/government-programs-uninsured/chip/chipra/library](http://www.healthmanagement.com/what-we-do/government-programs-uninsured/chip/chipra/library). The reports provide positive feedback on the relevance and need for these tools, but also states that competing priority projects within the pilot practices did not allow for full use of the tools.

CHIPRA developed an electronic Perinatal Education Toolkit for clinical and non-clinical providers to increase awareness of the benefit of preconception, prenatal, postpartum, and interconception care. The toolkit contains images/tag lines to promote preconception, prenatal, postpartum and interconception care, prenatal and postpartum checklist brochures, and resources and links to educational materials. The toolkit was made available to HFS providers on September 30, 2015. The toolkit is housed and maintained by EverThrive Illinois and is available to any interested clinical or non-clinical provider on [EverThrive's](#) web site.

