DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling	2-26-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000541	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Kerr	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
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4.			

Reg- Bowling
"Nec. Action"
cc: Kerr

DEPARTMENT OF HEALTH & HUMAN SE
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
DICARE & MEDICAID SERVICES

Family and Children's Health Programs Group

RECEIVED
FEB 26 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

To: State Medicaid Directors

From: Director, Family and Children's Health Programs
Center for State and Medicaid Operations

Subject: Neonatal Outcomes Improvement Project

Date: FEB 13 2007

We are writing to provide an update on the Neonatal Care Outcomes project jointly sponsored by the Centers for Medicare & Medicaid Services (CMS) and the National Initiative for Children's Healthcare Quality (NICHQ). As you are no doubt aware, the Institute of Medicine has recently published a report on preterm birth which calculates the annual costs of premature births in the USA to be 26.2 billion dollars a year in excess medical and social costs. The incidence of premature is of particular interest to State Medicaid programs which desire healthy outcomes for their citizens. Additionally, State Medicaid programs finance forty percent of US deliveries. The literature supports that women in low-income groups have the highest incidence of prematurity.

Consequently, we are writing to advise you that we are launching a pilot project which will involve NICHQ, CMS and four State Medicaid Agencies in a voluntary effort to improve outcomes of neonatal care of premature infants over the next few years.

We have, in consultation with experts from across the country, selected seven clinical interventions which reflect the most current evidence-based practices that would minimize the mortality and morbidity associated with premature birth in the USA for consideration of use in this project. A short attachment to this letter describes the interventions in more detail.

Currently, about fifteen states have expressed preliminary interest in partnering with us on this project. We anticipate sending out invitations by January 2007 to a national stakeholders/experts meeting in March 2007. Interested states, experts and other partner organizations are invited to attend the meeting to participate in completing the final draft of the Operational Plan for the Project. Details of the meeting will follow in January and will be sent to all Medicaid State agencies.

Only four states will be selected for full participation in the pilot which will require that your state attend approximately two meetings per year and submit data in a uniform manner. Participating states are not required to utilize all seven measures, but will be free to use anywhere from two to all seven at the state's discretion. It is expected that states that are interested, but not selected, will be offered the option to participate in the program on a more limited basis to be determined.

Those states which are selected will receive the training sessions and some funding, the amount of which is not yet certain as this is a public and private partnership effort. Medicaid-eligible clinical care for the mothers and babies involved in the project will be funded as determined by the State's Medicaid reimbursement schedules. Federal match for eligible services will be provided in the usual manner for eligible services at your state's present match rate.

We look forward to working with you as we strive to move the nation forward.

Jean K. Sheil

Jean K. Sheil
Director
Family and Children's Health Programs

Enclosure

Cc: Charles Homer, MD, Medical Director, National Initiative for Children's Healthcare Quality (NICHQ)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

NEONATAL OUTCOMES IMPROVEMENT PROJECT

Overview: The Centers for Medicare & Medicaid Services (CMS), in partnership with the National Initiative for Children's Healthcare Quality (NICHQ), is embarking upon an exciting initiative to work with States and other partners to improve neonatal outcomes through broader adoption of proven clinical interventions. With the strong evidence of the impact of prematurity on neonatal morbidity and mortality presented in the Institute of Medicine's significant new study, Preterm Birth, it is now time for a major effort by nonprofit organizations, government agencies, and the healthcare sector to collaboratively address this significant health problem.

Background: Premature birth has been the major contributor to infant mortality figures in recent US vital statistics. Deaths associated with premature birth were the highest contributor to the United States' infant mortality rate of 6.84 deaths per thousand births, ranking our country 36th amongst the world's nations in infant mortality.

Of the roughly four million babies born in the USA in 2003, about 500,000 were born with a gestational age of less than 37 weeks, which is the medical definition of prematurity. About 9,000 babies died in 2003 as a consequence of premature birth. The rate of infant mortality within the African-American population in 2000 was 14.1 per thousand births, more than twice the national average for that year.

The new data cited in Preterm Birth give us a clearer picture of the total cost of premature births in the USA. As disturbing as the mortality rate is, the morbidity associated with prematurity is also of concern. The 491,000 premature babies who survive their first year of life will suffer significantly higher rates of respiratory, cardiovascular, neurologic, gastrointestinal, metabolic, visual, and hearing disorders than the general population throughout their lives. Preterm Birth estimates, conservatively, that the annual medical and social cost to the United States of premature babies is 26.2 billion dollars a year. Of this total, 16.9 billion dollars (about two thirds) are attributable to medical costs. Forty percent of these annual medical costs (about 6.76 billion dollars) are paid by Medicaid.

The CMS Response: CMS has selected, with the help of national experts on neonatal care, seven interventions that States can use to significantly reduce the burden of mortality and morbidity associated with premature birth in the Medicaid and general populations. There is

scientific evidence to support these measures that can be effective in the treatment of premature birth.

The seven interventions are:

1) Early identification of mothers at high-risk for prematurity and prenatal transfers of these expectant mothers to facilities with tertiary care NICUs (Neonatal Intensive Care Units).
2) Use of antenatal steroids in pregnant women at risk of preterm delivery.
3) For those seriously ill premature babies born at facilities without tertiary care neonatal intensive care units (NICU), optimal resuscitation and stabilization of the baby before transfer to the appropriate facility.
4) Prophylactic or early administration of the first dose of surfactant to premature infants at risk for Respiratory Distress Syndrome.
5) Vitamin A prophylaxis in infants with a birth weight less than 1000 grams to prevent chronic lung disease.
6) Proper Infection Control Practices in the NICU and hospital to prevent infection.
7) Optimizing NICU discharge planning and follow-up.

States will also be encouraged to couple primary prevention with these interventions. The most appropriate methodology will be determined during the stakeholders meeting.

Coordination with CMS Partners: The effective implementation of these interventions will require the cooperation of many private and governmental entities at both the federal and the state levels. Presently, CMS is partnering with NICHQ to coordinate activities involving the various stakeholders. Fifteen States have expressed preliminary interest in participating in the project. In addition, several nonprofit private charitable organizations, such as the March of Dimes, have expressed interest in cooperating with government and providers in supporting this initiative. Within the federal government, CMS seeks collaboration in this effort with other agencies such as AHRQ (Agency for Healthcare Research and Quality), CDC (Center for Disease Control), and NIH (National Institutes of Health).

Next Steps: Current plans with NICHQ call for an initial meeting within the next few months where all interested stakeholders will be invited to provide input to the final project design and the most appropriate measures for inclusion in the program. We anticipate that four states will ultimately be selected to develop collaborative projects with technical assistance from NICHQ and CMS. Each State will be required to focus their efforts on at least two of the seven interventions and to report on standardized measures in these focus areas. States can, at their discretion, address additional areas and / or report on measures reflecting all seven interventions. States are likely to differ in the interventions they target and in how they operate their projects. Therefore, a uniform reporting system will be necessary to facilitate data analysis and conclusions regarding the overall impact of the initiative.

It is expected that the participating states will each identify a project leader and establish a broad project team to work with NICHQ for approximately two years to implement the individual state plan. One strategy to be reviewed at the planning meeting is the conduct of a conventional Breakthrough Series ™ learning collaborative (www.ihi.org) within each participating state, coupled with a supplemental mechanism for sharing and coordination across the collaboratives

through leadership sessions and a common Website. The first learning session would probably occur about nine months to a year after the stakeholders meeting.

In anticipation that some states may require additional sources of funding, NICHQ plans to contact interested nonprofit organizations that have expressed an interest in providing funding for the advancement of these efforts. Medicaid-eligible clinical care for the mothers and babies involved in the project will be funded as determined by the State's Medicaid reimbursement schedules. Federal match for eligible services will be provided in the usual manner for eligible services at the State's present match rate.

Conclusion: CMS seeks a future in which premature infants survive with a high quality of life. We expect that this project will help support State Medicaid programs throughout the nation in their efforts to decrease infant morbidity and mortality. Evidence supports that the sustained and appropriate use of these seven interventions in the care of premature infants is a sound investment in the public health of our nation.