Eliminating Congenital Syphilis Through Improved Pregnancy Care: State Stories from Medicaid and CHIP Agencies-20240918 1801-1

[Derek Mitchell] Hello, everyone, my name is Derek Mitchell, an event producer with Mathematica. Welcome to today's webinar entitled Eliminating Congenital Syphilis through Improved Pregnancy Care.

Before we begin, we wanted to cover a few housekeeping items. All participants are muted upon entry. To enable closed captioning, click on the CC icon in the lower left corner of your screen or click control Shift A on your keyboard.

There will be questions and discussions at the end of the webinar. Please submit your questions through the Q and A panel, which is located on the right of your screen. Please contact Derek Mitchell, the host, through the Q and A panel with any webinar platform issues.

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We also want to let everyone know a recording of the meeting and slides will be available after the webinar on Medicaid.gov. You'll receive an email with the materials when they're posted.

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Now I'd like to get the meeting started. I'd like to turn it over to Lekisha Daniel-Robinson from Mathematica. Lekisha, you now have the floor.

Okay, we'll give Lekisha another moment might be having some audio issues. Lekisha, are you able to hear us?

[Lekisha Daniel-Robinson] Can you hear me?

[Jessica Lee] We can. I can just jump in and talk about some and talk through the objectives. Hi, I'm Jessica Lee. I'm the acting Chief Medical Officer for the Center for Medicaid and CHIP Services, and we're so excited to welcome you here today and hopefully to have Lekisha back when we're able to hear her. So, our objectives today are to describe trends in national congenital syphilis data, identify approaches used by five state Medicaid and Children's Health Insurance agencies to reduce the incidence of congenital syphilis, and finally, to discuss opportunities, challenges, and resources available to the states.

Next slide, please.

We're starting here with this welcome and then I'm going to do a brief overview of congenital syphilis in the United States, followed by really the highlight of this, and this is our state stories. We're going to have presentations from North Carolina, New York, Alaska, Texas, and Louisiana, followed by a question and discussion session.

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Derek, can you review how to submit a question, please?

[Derek Mitchell] Sure, I'll be happy to. So, this slide illustrates how you can submit questions during today's presentation. To submit questions, just click on the Q and A window, which is located in the bottom right corner of your screen. Select all panelists in the ask menu. Then you can type your question in the text box and then click send. Note that the presentation team will be able to see your questions and comments. As I mentioned before, if you have any technical issues, please select host in the ask menu and I'll be happy to help you with any questions that you might have technically. Jessica, back to you.

[Jessica Lee] Thank you so much. So, I'm going to review briefly why this matters today and why there are opportunities specifically in Medicaid and CHIP to end congenital syphilis.

Next slide please.

So congenital syphilis is a condition that occurs when people pass syphilis to their babies during pregnancy. Congenital syphilis is preventable yet the number of cases has nearly doubled since 2018. Left untreated congenital syphilis can lead to consequences like infant death, developmental delays, skeletal abnormalities, deafness, meningitis, and ongoing adverse outcomes throughout a child's life. Syphilis also carries risks for individuals who are pregnant, including miscarriage, ongoing infection, and more. A lack of timely testing and treatment before and during pregnancy contributes to 88 % of congenital syphilis cases. With Medicaid and CHIP agencies covering more than 41 % of births nationwide, states have an important role in reducing the incidence of congenital syphilis and improving health outcomes for both the Newborn and parents.

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The rise in congenital syphilis is in the context of a nationwide syphilis epidemic with syphilis cases increasing 80 % in the United States between 2018 and 2022 alone. On this graph, you can see the direct link between the rise and congenital syphilis cases shown by the purple bars, and the numbers on the left axis, and the population level rate of syphilis among females ages 15 to 44, shown with the purple line and with the rates on the right axis. Increases in congenital syphilis mirror trends observed in the rates of syphilis cases in women of reproductive age, which increased over 600 % from 2012 to 2021.

Next slide, please.

There's a great deal of variability by state. These maps show the rates per hundred thousand live births and how they've increased from 2013 to 2022. You can also check out our website on medicaid.gov under the quality resources to see the map in

terms of the absolute case numbers and how it changes over time. But you can see just from the increase that this is an important issue for every state.

Next slide, please.

There are important health equity implications for this condition as well as there are really large differences in rates by race and ethnicity. In particular, individuals who identify as American Indian, Alaska Native, Native Hawaiian or other Pacific Islander have been disproportionately affected by this epidemic and multiple initiatives have been deployed to increase access to testing and treatment to support these populations. When we look at where there are missed opportunities to prevent congenital syphilis, we're really looking at opportunities to improve care for individuals who are pregnant.

Next slide, please.

Looking at this flow chart you can see how these opportunities can map out in a single year, specifically in 2022 using CDC data. There were a total of 3755 cases of congenital syphilis. You can map out the missed opportunities in testing and treatment. You can see the most common missed prevention opportunity was, is in the purple section with inadequate treatment affecting 69 % of the positive cases. The other, the next largest gap, in treatment or testing is no documented timely test in red, shown as affecting 37 % of the total cases.

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In April of 2024, the American College of Obstetricians and Gynecology, or ACOG, issued a new practice advisory recommending syphilis screening for all pregnant individuals at the first prenatal care visit, followed by universal rescreening during the 3rd trimester, and again at birth. This is a change from previous guidance which recommended a risk-based testing approach in the 3rd trimester only for individuals living in communities with high rates of syphilis and for those who've been at risk of syphilis acquisition during pregnancy.

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Looking specifically at Medicaid, in a study of Medicaid enrollees in six states, congenital syphilis screening ranged from rates of 15 % to 62 % in the first trimester—remembering again that the goal there is 100 %—and from 56 % to 91 % during any time in pregnancy. Early and continuous Medicaid enrollment was associated with higher rates of screening and first trimester Medicaid coverage was the strongest predictor of prenatal syphilis testing. There were significant disparities in screening with black and Hispanic women less likely to have first trimester screening. In the study of seven state Medicaid Programs, barriers to timely prenatal screening included variabilities in state laws on timing of screening, incomplete data

on screening, Medicaid enrollment delays, and disenrollments, and a lack of clear understanding among providers on recommended testing.

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So, you've heard about why this condition matters right now; that there are data and new clinical recommendations to support opportunities for improvement that these opportunities specifically exist for Medicaid and CHIP. I'm thrilled today that we're showcasing the outstanding efforts of our state partners, highlighting a variety of approaches and tools to eliminate congenital syphilis. A variety that ensures that if you are looking for ideas, you can find an approach here today that will work for your state and your program. And with that, I'll turn it over to Lekisha.

[Lekisha Daniel-Robinson] Great, thank you, Dr. Lee. And as Dr. Lee mentioned, we would like to, we'd like to start the panel discussion with some of those state stories. I'd like to now turn it to Dr. Brittany Watson, the associate Medical Director Consultant of North Carolina Medicaid.

Dr. Watson?

[Brittany Watson] Can you hear me?

[Lekisha Daniel-Robinson] Yes, I can hear you now. Go ahead, please.

[Brittany Watson] Okay, so, [lost audio].

[Lekisha Daniel-Robinson] Dr. Watson, if you are presenting, we are unable to hear you.

[Robert Lawrence Alaska] Yeah.

[Lekisha Daniel-Robinson] Alright, so as we continue.

[Brittany Watson] Yes. You can hear me now?

[Lekisha Daniel-Robinson] I think we actually need to work on Dr. Watson's audio. So, let's move to our next presentation, Douglas Fish Chief Medical Officer of New York Medicaid Agency and deputy commissioner, Office of primary Care and Health Systems management.

[Douglas Fish] Very good, thank you Lekisha. And just a sound check. Can you hear me ok?

[Lekisha Daniel-Robinson] I can hear you well. Thank you.

[Douglas Fish] Okay, great. So, thank you for the opportunity to share, New York's story. So, if you'd like to go to the next slide, please.

This slide demonstrates the increase in both primary and secondary syphilis diagnoses among females aged 15 to 44, from 2013 through 2022. Okay. And while

syphilis was increasing among men who have sex with men, the newer syphilis epidemic among females suggest heterosexual transmission is also on the rise in New York. And you can see there was an over a 50 % increase between 2020 and 2021.

Next slide.

This slide shows the total number of congenital syphilis cases reported in New York, including New York City from 2013 to 2022, so the same time frame that you saw in the previous slide. With the gray bars reflecting the congenital syphilis cases and the blue add on bar is showing the syphilitic stillbirths. So, you combine the sets of numbers for each year to get the total number of cases. 2022 accounted for over a quarter of the total congenital syphilis cases reported over the past ten years with half of the syphilitic stillbirths occurring in the past two years.

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This slide demonstrates the five critical categories of missed opportunities for prevention of congenital syphilis in New York State, and this data excludes New York City. We identified a major missed prevention opportunity among mothers of congenital syphilis cases in New York State specifically late identification of seroconversion during pregnancy. As you can see in 2022, in the yellow golden bar, no timely prenatal care and screening, emerged as the greatest missed prevention opportunity that year. However, the previous trend of late identification seems to have resumed in our preliminary analysis of data for 2023.

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Effort to address congenital syphilis have been modeled after New York's perinatal HIV elimination strategy. We treat every case of congenital syphilis as a sentinel event. So, what happens is sentinel event letters are sent to the birthing hospitals where a congenital syphilis birth has been reported recommending that a root cause analysis be undertaken. We also perform morbidity and mortality case review meetings following reported cases and request medical records from those facilities. We've engaged the community and have convened a congenital syphilis elimination strategic planning group as of spring of 2023, and we continue to support data driven policy changes right now requiring by law three syphilis screenings for pregnant persons in New York State which I'll highlight further in the next slide.

So effective May of this year, 2024, New York state law and regulation now requires screening pregnant persons at least three times during pregnancy at the time of first examination on presentation for prenatal care, newly during the 3rd trimester, and then at delivery. And then we also implemented because this was done in our budget cycle a year ago, and the law wasn't going into effect until this year, we were able to quickly pivot and ensure in our Medicaid policies last summer in 2023, updated guidance that the law was coming and recommending this for Medicaid providers

and also making sure that our codes were all turned on so that all the claims that would be submitted would pay and remit and that there wouldn't be any barriers to this testing. We also sent out a dear provider letter that you can see on the right, last summer, prizing providers of, what had passed in the legislative session and the new law going into effect.

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So, in terms of advice for state Medicaid programs. I think the biggest advice that I would recommend is working closely with public health colleagues. In New York State, we are fortunate that we are all in the same department of health. We're in different offices. The Medicaid agency is in one office and the public health another, but we work together significantly and closely on many issues including syphilis and HIV. I'd also say to know your data and own your data and have a data analyst that can really work with your teams, a multi-pronged approach is certainly important and thinking about the multiple levers that you have. In our experience, policy levers can be implemented faster than legislative ones, but we were glad to have the legislative support, though alone I think that's probably insufficient; so that we were fortunate to have the law to really boost the efforts and make sure that providers were aware. So, in closing I will just say that New York State is committed to ending preventable epidemics. Every case of congenital syphilis is entirely preventable, so it requires a tailored prevention message and timely identification and treatment, and we work to remove barriers to screening and treatment and addressing stigma and health disparities as being critical tools to reducing our congenital syphilis rates in New York and improving health outcomes. So, I'll turn it back to you Lekisha, thank you.

[Lekisha Daniel-Robinson] Thank you, Dr. Fish, and we'll certainly come back to you when we get to the discussion portion of the webinar today. I would now like to introduce Robert Lawrence, the Alaska Chief Medical Officer, and Liz Ohlsen Division of Public Health in Alaska. She's a staff physician there. I'll turn it over to the Alaska team. Thank you.

[Robert Lawrence] Very good. Good morning, everyone. This is Dr. Lawrence, a Chief Medical Officer with the State of Alaska. We're going to do a quick sound check and introduce Dr. Liz Ohlsen, who is a physician in our division of public health.

[Elizabeth Ohlsen] Thanks, Dr. Lawrence. I think we can go to the next slide.

So, this is an overview of congenital syphilis in Alaska. This graph shows in blue congenital syphilis rates nationally per 100,000 live births and orange Alaska rates. Before 2018, Alaska had zero cases of congenital syphilis most years and very low rates of syphilis overall before an increase in 2017 among men who have sex with men. Congenital syphilis cases rose in 2020 following a spike in syphilis among women that began in 2019. And in 2022, Alaska had a record high of twelve cases

reported, but that translates to the rate of 128 cases per live births and Alaska surpassed the national average in 2020 and 2022.

You can go to the next slide.

During late 2023, we did in-depth reviews of each congenital syphilis case since 2020 and found consistent patterns that mothers had no or inadequate prenatal care, were frequently experiencing homelessness, and most were experiencing substance use especially in methamphetamine. A majority of mothers had had a previous STI before this pregnancy and about half had had syphilis before this pregnancy. Some had never completed syphilis treatment and others had had a reinfection. These patterns differ from nationally published data in that we identified very few missed opportunities among women who had engaged in prenatal care. So, we then shifted our focus to eliminating barriers women face in engaging in prenatal care when they're experiencing homelessness and substance use.

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[Robert Lawrence Alaska] Thank you, Dr. Ohlsen.

On this slide we illustrate how Alaska has approached congenital syphilis on a legislative, policy, and programmatic levels. Just for example, we extended the income thresholds and expanded postpartum Medicaid coverage. We have released guidance for clinicians to increase testing during pregnancy. We've established an interdisciplinary congenital syphilis review board to make and communicate meaningful recommendations to communities across Alaska. And establishing this review board required us to seek and make legislative changes in order to lift a statutory requirement which previously limited the review boards to just licensed Clinicians. And we made that legislative change in order to introduce other disciplines like law enforcement, child protective services and bring them into the process. The Alaska state legislature has also allocated additional ongoing funding to support congenital syphilis interventions such as expanding prenatal care, substance use treatment, and STI testing and treatment. All of this dovetails with existing work to expand behavioral health and substance use treatment through an 1115 Medicaid demonstration waiver, which in Alaska has been in place since 2019 and was most recently extended in 2024.

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We've recognized the importance of prioritizing expanding partnerships. The whole of the Department of Public Health approach is to enhance our state laboratory's capacity for syphilis testing and scaling up epidemiology workforce of disease intervention specialists, expanding testing and treatment for syphilis and public health centers, and improved communication between our investigation service officers in the public health nursing. And one of the partnerships that has made a

significant impact is our really partnership between the Department of Health and our Department of Corrections, which since 2023 has facilitated an opt out testing initiative for the identification and treatment of syphilis, HIV, other STIs and hepatitis in our prisons and jails across Alaska. In addition, building on existing partnerships within tribal health and other Alaska clinicians, as well as healthcare facilities across the state, we've communicated new testing guidance, including rapid testing with same visit treatment through letters, calls, emails, and other efforts. We worked closely with our clinicians and laboratories to ensure that treatment availability, including providing Bicillin when needed, and expanding rapid testing with starter kits for outpatient clinics was available. We recognize that media is a key conveyor of information in our communities, and so we partnered with them to raise awareness of the syphilis outbreak and encourage testing. We also distribute pregnancy tests with community specific labeling, promoting public health services and lowering the barrier for prenatal care services. These are distributed in bars and shelters and at discharge from our correctional facilities to reach the higher risk women in our communities.

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So, Alaska's approach really centers on understanding the intersectionality of congenital syphilis recognizing it cannot be solved with testing and treatment alone and it's not adequately addressed by one single existing health care system. Just like all things public health, Alaska has come to recognize that addressing congenital syphilis is something that we do as an entire Alaska community. And our job is to pull together the healthcare professionals and the organizations and the larger community, including ensuring that our Medicaid system supports all of this collaboration.

[Elizabeth Ohlsen] Alaska prioritized congenital syphilis as a public health policy focus because it intersects with many unmet health needs of Alaskans and presents a clear narrative for the necessity of prevention and harm reduction. Our next steps involves taking a statewide shared risk factors approach to expand prenatal care access, lower barriers to sexual and reproductive health care, including family planning, and reduce substance use by improving access to medication assisted treatment including during pregnancy, and also continuing efforts to improve housing stability, enhancing food security, and addressing sexual violence. Thank you.

[Lekisha Daniel-Robinson] Thank you both. I'd now like to circle back to our previous presenter, Dr. Brittany Watson, associate Medical Director, and consultant in North Carolina Medicaid.

[Brittany Watson] Hello, can you all hear me now?

[Lekisha Daniel-Robinson] Yes, we can hear you great. Thank you. Dr. Watson, please proceed.

[Brittany Watson] Hello.

[Lekisha Daniel-Robinson] Yeah.

[Brittany Watson] I can't hear myself, but we're going to go ahead with it. But good [lost audio].

[Lekisha Daniel-Robinson] Alright, not sure what is happening, so we'll continue to troubleshoot the audio connection for Dr. Watson. So perhaps now we will move on to our Texas presenter.

Thank you, and I'd like to introduce Dr. Emily Rocha, Director of Clinical Innovation Texas Medicaid and CHIP Services along with Lisa Glenn Senior Associate Medical Director of Texas Medicaid and CHIP Services.

[Emily Rocha] Okay good afternoon, this is Emily Rocha. Can you hear me ok?

[Lekisha Daniel-Robinson] Oh, you're coming in well, thank you.

[Emily Rocha] Okay, thank you so much. My name is Emily Rocha. I'm the Director of Clinical Innovation with Texas Medicaid and CHIP Services.

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I'm going to talk a little bit about the state of congenital syphilis here in Texas. I've got some data up on the screen for you all. So, in 2022, Texas reported 922 cases of congenital syphilis, which as you can see in the graph, which goes back to 2013, there has been an increase, really a sudden increase, in congenital syphilis cases and rates. The blue bars are the cases the red line is the case rate. We've seen approximately a 34 % increase relative to 2021 when 608. [cross-talk]

I think we may intermittently be getting North Carolina speaking at the same time.

[Lekisha Daniel-Robinson] We're about to make a change. Go ahead.

[Emily Rocha] So the increase from 2021 to 2022 is about a 34 % increase, and we unfortunately then continue to have an increase of cases since then. We have 109 counties that reported at least one case of congenital syphilis throughout the state of Texas and in our largest areas of Harris, Dallas, Bear, Tarrant, and public health region eleven, which is a couple of counties combined. Those areas reported over 62 % of cases. So, all in all from 2018 to 2022, which of course encompasses the COVID pandemic, we saw a 148 % increase.

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Similar to what the state of New York was mentioning, our Texas Health and Safety code requires testing for congenital syphilis three times throughout pregnancy. The testing should take place during the first prenatal visit whenever that may occur, again during the 3rd trimester, no earlier than 28 weeks of gestation, and then finally at the time of delivery.

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And so, what is the state of Texas doing to try to address congenital syphilis here? Well, between our state agencies of Texas Health and Human Services, which is where the Medicaid and CHIP program lives along with our Department of State Health Services, which is our public health agency. We roll up to the same executive commissioner, but we're technically two separate agencies. So, we have convened a maternal health interagency work group. This work group has been meeting quarterly with both leaders and staff of various areas in the agencies. We each report out. So, each of the agencies and a few different departments within the agencies report out updates and new items related to congenital syphilis, whether that be any kind of policy changes, new data, new data modernization and any of those things. We primarily use this as a communication channel.

And then we also work together to brainstorm ideas and action items for each agency. Knowing things with each agency such as what are our typical channels of communication, which levers can we pull where, you know. For example, in Medicaid, our primary channel of communication is going to be with our managed care organizations and the medical directors for each of those organizations. Whereas our Department of State Health Services is going to primarily reach out to hospital chief medical officers, regional health organizations and whatnot. So, we know that we definitely have some pretty clear communication channels and that way we get really good coverage whenever we need to send out any sort of information.

And so far, this interagency work group has ensured case management in all programs across agencies. We have case management in a variety of programs and so we make sure that there's case management for individuals identified to have a syphilis diagnosis. We've done some contracts contract amendments that have made infectious diseases a condition that necessitates service coordination, knowing that that could kind of clue us into some other things that are going on with our members or beneficiaries.

We have really through increased communication and an open invitation, increased the attendance at the fetal infant morbidity review sessions which occur multiple times a year in different regions of Texas. We had our Department of State Health Services present to our Medicaid managed care organization medical directors. We've actually had them do that a few times and really great when we get them to present. We've ensured education is included in the community Health worker training, which is owned by DSHS, but of course they work in a variety of settings.

There's been a grand rounds presentation. There's involvement of the Department of Family and Protective Services. We actually now have them in our interagency work group all the time. They've become a permanent addition. And then we also have upcoming the Texas Alliance for Innovation and Maternal Health Summit, which is going to include congenital syphilis that will occur before the end of the year.

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And so lastly, my advice for any other state Medicaid programs wishing to duplicate what we've done here in Texas is really just collaborate and communicate. So, focus on collaborative efforts on specific topics such as congenital syphilis. It's a great idea to create a plan together as well as brainstorm goals that you'd like to work on, and then decide what each agency can contribute to in achieving each of those individual goals. All of us I'm sure have done QI training where you learn how to write smart goals and so the T is for time. We want you to include dates for completion as well as just ongoing progress tracking towards your goals, and that's really a lot of what those report outs are during the quarterly. meetings. Ensure that there's communication between departments. I always suggest this set your meeting invites up for the year, get on someone's calendar. They will innately schedule other meetings around it if you've already tagged their calendar. Include stakeholders and program managers, allow lots of time for discussion in your agenda, don't pack it out, so it's just a talking you know present a lot and then you walk away, definitely make time for discussion. And then we always suggest seeking input from other states and that's why we're happy to present here today.

That was my last slide, so thank you.

[Lekisha Daniel-Robinson] Thank you, Miss Stauffer-Rocha. We will now hear from our Louisiana present presenters, dr. Herbert Twase, who is the Louisiana Department of Health Medical Program Manager along with dr. Kolynda Parker, Louisiana Department of Health, Medicaid Deputy Director and program Operations and compliance, quality improvements, and pharmacy.

[Herbert Twase] Yeah. Good afternoon. Can you hear me?

[Lekisha Daniel-Robinson] We can hear you well, thank you.

[Herbert Twase] Yeah, this is Herbert Twase. So, I'll be sharing with you, my colleague and I will be sharing with you what we're doing here in Louisiana.

Next slide, please.

So, in terms of the big picture, Louisiana consistently ranks at the. top for the highest STI rates. There is no current strategy to change the status quo. In terms of the long term STI consequences include the social stigma, psychosocial stress, prematurity, infertility, late diagnosis of cervical cancer. And in terms of the performance improvement background, I'll be sharing with you the timeline. In the fall of 2023,

Louisiana Department of Health together with our EQRO and the MCOs, we communicated to the MCOs that we'll be initiating a new performance improvement project. The topic includes addressing congenital syphilis through improved syphilis screening for healthy Louisiana enrollees. And late 2023 through early 2024, Louisiana Department of Health are our EQRO and the MCOs worked together to establish a charter for the performance improvement. And the performance improvement charter was finalized in March 2024 and signed by each of the six MCOs. The charter components include our project scope and design, performance indicators, measurement period, goals, and initial evidence-based improvement strategies.

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So, we selected seven indicators of those include the first indicators syphilis screening during the first pregnancy examination during weeks, 28 to 32 of pregnancy, screening at delivery, screening at any time during pregnancy or at delivery, screening during the 1st trimester, screening during the 1st trimester for all live births, and lastly screening during the 3rd trimester for all live births.

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So according to the baseline data that we got, as you can see, we are doing better on the syphilis screening at any time during pregnancy or at delivery, we are at 83.2 %. And there are some areas of improvement. We are doing poorly at syphilis screening during the first pregnancy examination, we had 34.2 % and also, we need there's an area of improvement also screening at delivery which we are at 0 %.

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So, the initial improvement strategies provider-based interventions were incentivize contractor providers to submit a notification of pregnancy to the MCOs, second provider outreach and education on recommended timing of syphilis screening during pregnancy, first prenatal visit early third trimester and then at delivery, and then the last strategy provide education on methods for reducing the stigma of syphilis screening when delivering prenatal care. And I'll turn it over to my colleague Kolynda Parker. Thank you.

[Kolynda Parker, LDH] Thank you, Herbert.

Next slide.

So, Louisiana's current system is failing to control STI rates. Louisiana is consistently in the top three to four states with the highest STI rates. Barriers to success in our current practice includes stigma, especially in rural areas, as well as lack of convenience that's travel, again, especially in those rural areas. Low health literacy, a lack of understanding of excuse me, understanding of the risk, economic costs such

as loss of wages, childcare expenses, and asymptomatic infections which account for 60 to 70 % in the state of Louisiana.

Louisiana is exploring a comprehensive approach to STI reduction for the Louisiana women in our women in our state, and this is via at home testing. So, the focus is on the highest risk, highest burden population. Those are STIs in the 18 to 40 year old women, those who receive cervical cancer screening and 30 to 64 year old women and less than 50 % of Medicaid recipients are up to date as far as cervical cancer screening. We also want to mitigate barriers by having in-home specimen collection. There are certain diagnostic tests which are listed on your screen that can conducted, that can be conducted via a vaginal swab. HIV syphilis, hepatitis B and C can be collected by minimally invasive blood collection devices.

We also want to utilize technology for communication. In the state of Louisiana, we have a E platform an E platform called the Louisiana wallet, and we would like to link results and link follow up to this E platform device. And finally, we want to close the loop rapidly by connecting members to treatment and follow-up. within 24 hours utilizing telemedicine or in-person at health units, PCP, or an on-call provider.

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We conducted a survey about perceptions of the most important maternal health issues in the state of Louisiana. The half of those individuals surveyed identified a lack of comprehensive sexual education in schools, general lack of education or poor health literacy. The next highest included access to care again in those rural areas and others discuss a lack of transportation amongst other issues that are identified on the screen, which encompass social determinants of health of difficulty connecting, housing, and other factors. In addition, throughout the survey, many of the members brought up many of these additional concerns that were, that are also outlined on the screen as well. Some include SUD, that's also contributing to poor health outcome.

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Again, we would like to thank the members, thank the members of our team who's listed on the screen that assisted us with some of the data collection and some of the information that we presented. Thank you.

[Lekisha Daniel-Robinson] Thank you, and we're looking forward to the discussion. I do want to apologize for the audio issues today. We want the opportunity for all of our state panelists to share their activities. So, we're going to try once more for Dr. Watson with North Carolina Medicaid. Dr. Watson, you have the floor.

Dr. Watson, it seems we still maybe having some challenges with the audio for Dr. Watson, but we will note that her slide presentations will be available, presentation will be available as a part of the deck and will be posted.

[Brittany Watson] Can you hear me?

[Lekisha Daniel-Robinson] Yes, I can hear you. Can you hear us?

[Brittany Watson] Yes, I can hear you all.

[Lekisha Daniel-Robinson] Okay, great. All right. Let's go back to slide 14 for Dr. Watson, please.

[Brittany Watson] Excellent. Perfect. Thank you so much. I'm so excited to be able to present on behalf of North Carolina.

Next slide, please.

So, it's not immune to the congenital syphilis crisis or syphilis in general. From 2022 to 2023, we saw a 28 % increase in congenital syphilis cases and sadly preliminary data from 2024 shows that between January and June, there have been 38 cases and three stillbirths or neonatal deaths. North Carolina has experienced fighting syphilis like I mentioned, and as you can see by the graph on the left, we saw a spike in cases among men who have sex with men around 2015. And we deployed successful interventions targeting that population which curbed the increase. Yet rates among other populations Including women continue to climb, and we consider this to be a missed opportunity which we have learned from, and that brings us to the current crisis. MSM rates are decreasing as indicated by the arrow over 2022, but rates in other populations, including women are increasing. But we see a glimmer of hope that the curve is starting to bend, so we're not letting up off the gas this time.

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So congenital syphilis is seen across the state, and the cause of this crisis in North Carolina is multifactorial. The vast majority of cases in 2023 were diagnosed in individuals who were asymptomatic, and about a third of the cases were linked to individuals with no prenatal care. And of those who did have prenatal care, many accessed care late, meaning in the second or third trimester. We also noticed that substance use is a significant contributing factor in our state.

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So, what are we doing in North Carolina? Congenital syphilis is a part of the North Carolina Department of Health and Human Services strategic plan and highlighting this as a part of the department's priorities emphasizes its importance and helps mobilize people and resources across divisions to strategize and combat this crisis from various angles. And there's been a huge push to increase awareness about syphilis and congenital syphilis in the community. Awareness campaigns have targeted providers, lay community members and beneficiaries. The department has launched media campaigns, pushed out health alerts, and launched a provider webpage with resources.

We've also worked to build new and foster existing partnerships. For example, North Carolina hosted a southeastern congenital syphilis Summit back in October of 2023 where public health and public payers, including managed care plans across the southeast, participated in a collaborative summit where information was shared and ideas were generated. And in December of 2023, the North Carolina Division of Public Health and NC Medicaid released a joint statement that highlighted the importance of syphilis testing three times in pregnancy for every birthing person and emphasize avoiding discharging newborns without the results of delivery syphilis screening being known. Both of which are state law in North Carolina. The statement also included recommendations on how hospitals could achieve that second point.

We continue to work with our public health partners regularly, which includes engaging in a quarterly congenital syphilis review boards that reviews current data and interventions. And in February of 2024, we increased the reimbursement rate for Bicillin through the physician administered drug program, which hadn't been updated since 2012. North Carolina has added coverage for extencilline and lentocillin both imported drugs allowed for use during a Bicillin shortage. We've also increase access to point of care testing. And lastly, as of September we began covering condoms and spermicides.

Next slide please.

So, in terms of impact, we've seen an increase in syphilis testing. We look and compare to quarter one of 2023 to quarter one of 2024, and we saw a 17 % increase. Our public health data shows that by testing and treating, we prevented 71 % of congenital syphilis cases in 2023. And the division of public health monitors traffic on external facing webpages in both Spanish and English. But most of our 2024 interventions don't have impact data quite yet. We have not received any claims for any imported drugs and we don't have data on point of care testing quite yet.

Next slide please.

So, what have we learned along this journey? First, partnerships are key, partnerships within the state and partnerships across state lines. Second, data is also important. In North Carolina, we've worked to establish data sharing agreements so that we can work together with the most comprehensive information possible. And finally state plan amendment. North Carolina did not initially have SPA authority to cover prescribed drugs during a shortage, therefore, 100 % state dollars would have been used to cover those imported drugs. With this newly obtained SPA authority, the state can claim FMAP for imported drugs and we recommend that states considered obtaining the SPA authority if they don't already have it as it could be needed in other drug shortages in the future.

This concludes my presentation. Thank you all for listening. I'm sorry for the audio issues and we're excited to share what we're doing to address congenital syphilis in North Carolina. I'll pass it back to Lekisha.

[Lekisha Daniel-Robinson] Great. Thank you so much. I'm so glad that you were able to make it to the presentation in order for everyone to hear it. We'll now turn to the question and discussion portion of the webinar, and there have been some questions coming in through the course of the presentation, so I'll just jump in with the first one.

This one is specific to Texas. We have been working with Texas titled Ten. I'm sorry, not Texas, but we've been working with title Ten clinics in six states to incorporate syphilis point of care testing with each pregnancy test performed. There are some clinics that want to test but no longer consider Medicaid providers where they can get reimbursement for sustainable testing. Any thoughts on how to fund testing for Organizations that may not be, providers?

I'm not sure that we can answer that one, if there's a challenge because of the challenges within Texas Medicaid, but miss Rocha, would you like to say anything to that?

[Emily Rocha] I think if there's anyone experiencing any challenges with becoming a Medicaid provider, we definitely have staff who can help walk people through that program. So, that would probably be my best suggestion again without any really knowing the specifics of these individual cases, but we definitely have a, have staff who can help with the paperwork needed to become a Medicaid provider.

[Lekisha Daniel-Robinson] Okay, thank you. The next question, how are Medicaid programs handling billing for at-home testing? Are there any special reimbursement codes needed for them or is it, you know, is the billing code the same regardless of whether it's at-home versus clinic setting testing? Maybe we can start with North Carolina, I know you mentioned it. Or any other state, want to jump in with that one?

[Kolynda Parker, LDH] This is the state of Louisiana. Right now, because this we're implementing a pilot program, currently there are provider incentive payments to cover the cost of some of these kits. However, you know, we want to, we're looking at incentivizing the recipients through the managed care organizations with the home testing kits. But right now, there there's not a specific code for this home, this at home testing or collection for this test. But again, this is pilot for us and we're looking at, incentivizing, these, these tests and collection kits.

[Lekisha Daniel-Robinson] Okay. Great. Thank you for that. Any other states before we move on to another question?

This one then is for Dr. Lee. Does CMS plan on adding a core metric to measure congenital syphilis screening and treatment three times during pregnancy? This

could be a sub measure to the prenatal and postpartum care measure that exists on the set currently.

[Jessica Lee] Thank you for that terrific question. There is a process for core set measure submission and an evaluation and recommendation process that's done through a work group and I can paste into the chat some information about that and that's the process for selecting core set measures. One thing that's important to know is that core set measures do have to be feasible for state reporting, and so looking at state feasibility and prior testing experience is an important part of the consideration, but I'll include the information about how measures get onto the Core Set.

[Lekisha Daniel-Robinson] Great. Let's go to another question. What strategies did Alaska use to connect with homeless Individuals. Do we still have Dr. Ohlsen or Dr. Lawrence?

[Elizabeth Ohlsen] This is Liz, can you hear me? Great. We work very closely with many local tribal and community partners. There are community coalitions that, work with homeless service providers and other organizations, and. We have tried to partner directly with them. We know that one of the places that people who are experiencing homelessness have [lost audio]. So that's really been our, our key group of trusted partners. We've also partnered with local clinics in some of our bigger areas to offer testing directly at shelters.

[Lekisha Daniel-Robinson]

Okay, great, thank you. For, Dr. Fish, what would you recommend as the first or easiest step to get started?

[Douglas Fish] The first or easiest step, well, and thank you for the question. I would say that working closely for, I'm speaking for the Medicaid program, right? So, work closely with your public health colleagues and they can apprise you of the data, the current state. And just make sure that you're aligned on messaging. And then on the Medicaid side we can develop policies just to make sure there was a question about frequency of testing and those testing limits are really set by the states. So, we wanted to ensure that when we, you know, we're implementing this law that there were no barriers in the in the reimbursement processes on the Medicaid side that would, impede, you know, provider's abilities to be paid. So, you know, people need to be screened for syphilis as many times this is clinically appropriate and we didn't want to have any barriers to that. So, I would just say I think in summary, that close collaboration with, with public health. Thank you.

[Lekisha Daniel-Robinson] Great. Thank you. Let's go to our next slide. We had a bit of audio challenges earlier, but I wanted to note a couple of things. One, registrants will receive a notification when the slide deck is available, has been posted on the CMS website on the Medicaid.gov website. But I wanted to thank all of our state

presenters today for their very insightful presentations and recommendations for how states can really engage on this topic. And stem the tide of the growing rate of transmission of syphilis.

So, with that, we'd like to close the webinar. We'd ask you to complete the evaluation as you exit, and if there are any questions, please submit them to MedicaidCHIPQI@CMS.hhs.gov.

Thank you so much.

[Douglas Fish] Thank you.