

# Improving STD Prevention and Care through Partnerships Invitational Meeting Report



## Meeting Summary

AcademyHealth, in collaboration with the Centers for Disease Control and Prevention (CDC), the CDC Foundation and collaborative partners, hosted a meeting at the CDC Foundation in Atlanta, Georgia on April 27, 2023, to showcase the CDC Division of Sexually Transmitted Disease Prevention- (CDC DSTDP) funded work analyzing current trends in sexually transmitted disease (STD) testing and care delivery in the Medicaid program. This in-person meeting was designed and structured to share pertinent findings with and facilitate discussion among Centers for Medicare and Medicaid (CMS) Region 4 state Medicaid clinical leaders and quality experts. In addition, the meeting aimed to connect these state policy makers to their federal Medicaid and CDC DSTDP colleagues to help spur action. During this meeting there were facilitated peer discussions among Medicaid programs to identify opportunities for improving STD service delivery in the Medicaid program and strengthen partnerships with and within CMS Region 4.<sup>1</sup>

The following report provides an overview of the meeting's presentations along with a list of priority activities state Medicaid programs can explore to improve STD testing among their enrollee populations.

### Addressing the STI Epidemic thru the Medicaid Program

*Naomi Seiler, JD* of The George Washington University Department of Health Policy and Management provided a foundation for the overall meeting by sharing background on the increasing rates of bacterial STDs and the critical role Medicaid can serve in improving access to and care delivery for those most at-risk of infection. Ms. Seiler shared that as of December 2022, over 85 million Americans were enrolled in Medicaid, with another 7 million in the Children's Health Insurance Program (CHIP).<sup>2</sup> As the primary payer for family planning services for low-income women, Medicaid covers a disproportionate share of STD visits and nearly half of all births in the U.S. When looking at those eligible for Medicaid, there is significant overlap for those most at-risk for STDs. Medicaid serves a critical role in addressing this growing epidemic with those enrolled more likely to receive a sexual risk assessment and STD screening than people with private insurance. Furthermore, Medicaid serves a disproportionate share of minoritized populations, providing opportunities to narrow disparities and promote equitable access to STD care.

Ms. Seiler shared results from a landscape analysis she and fellow colleagues conducted to understand the barriers to and opportunities available to addressing STD testing and care delivery. Based on a literature review and multi-stakeholder interviews with Medicaid and public health officials, providers, and a Medicaid managed care organization (MCO), Seiler outlined several current challenges to STD testing and care along with potential opportunities for consideration to improve STD testing and care.<sup>3</sup>

**Reimbursement** There are several reimbursement challenges to STD testing and care, including STD provider inability to bill Medicaid or other third parties, non-coverage for multi-site testing, unclear guidelines on enrollees' ability to self-refer for STD services, and non-coverage for recommended partner treatment. In addition, there is a significant challenge with providing care to adolescents due to concerns about privacy and an overall limited knowledge about sexual health. States can explore innovative approaches to cover STD delivery, including creating state-specific coding and billing resources, and allowing coverage for same-day, multi-site testing.

**Performance Improvement** Noting there is only one bacterial STD-related HEDIS measure, Seiler shared that state Medicaid programs and their MCOs could implement plan and provider performance incentives, such as instituting their own reporting requirements, pay for performance, withholds, auto-enrollment preferences and performance improvement projects (PIPs). States could also consider approaches to incentivize providers.

**“The MCOs can do all kinds of creative things.... They could pay individually; they could pay more or less than the fee-for-service rate... They could do quality incentives with the providers and they can frequently do all those different kinds of methodologies.”**

**Medicaid and Family Planning Expansions** States could also leverage full Medicaid and/or Family Planning Expansions afforded by CMS. For states that expand Medicaid coverage to include adults up to 138% of the federal poverty level, more at-risk individuals, including young men previously unqualified for Medicaid, have an increased access to healthcare, including sexual health services. For states that leverage the Medicaid Family Planning Expansion, individuals otherwise ineligible for Medicaid or CHIP but meet the income eligibility level at or below that for pregnant women on Medicaid or CHIP, will have coverage for and increased access to family planning services, including STD testing and care.

**Telehealth** There are also opportunities for improved provider access to STD care based on COVID-era flexibilities in telehealth. While it is still unknown whether certain telehealth provisions will remain, Medicaid programs acknowledge that this provision minimizes many barriers to care, including transportation limitations, lack of access to providers, overall as well as those that are culturally competent and LGBTQ+ friendly, and privacy concerns.

**Data Sharing** Leveraging enhanced data sharing among state agencies during the pandemic, states could explore existing or execute new data use agreements to gain a greater understanding of the population at-risk, current utilization of services and persistent gaps.

**Provider and Patient Education** State Medicaid programs and MCOs, in collaboration with state and local public health departments, can improve engagement with providers and patients by creating shared communications that message screening recommendations and information on how to access and find service providers.

**Future Focus** To message the importance of STD care among Medicaid enrollees, stakeholders should consider generating return on investment calculations for STD services. Researchers could also assist in measuring the impact of policy changes on STD service utilization.

## Trends in STD Screening and Prevalence among Medicaid Enrollees

This session showcased health services' work in measuring the testing and prevalence of STDs among the Medicaid population.

**Paul Lanier, PhD** of the University of North Carolina School of Social Work Sheps Center for Health Services provided an overview of the first multi-state project exploring trends in prenatal syphilis screening among Medicaid enrollees.<sup>4</sup> Modeled on the Medicaid Outcomes Distributed Research Network (MODRN)<sup>1</sup>, the STI Testing Among Medicaid Patients (STAMP) Project compared prenatal syphilis screening rates among six southern states (Georgia, Kentucky, Louisiana, North Carolina, South Carolina and Tennessee) using Medicaid administrative claims data from FY 2017-2018 and 2018-2019. Specifically, the project investigated the proportion of pregnant Medicaid enrollees that received syphilis testing at any time during pregnancy prior to delivery, along with those that received testing during the first trimester and those that received testing during the third trimester.

Overall, this study contributed significantly to the ability to calculate the STD testing rate for pregnant persons. Findings revealed substantial variation in state testing rates across the six states, ranging from 56% to 91%. These differences were also consistent across the two time periods and showed little improvement when compared to single state studies from two decades ago. For all states, testing among Medicaid enrollees was higher in the first trimester, ranging from 64% to 96%. Among sub-populations,

the project found younger age groups were associated with higher testing. Among specific Medicaid eligibility groups, disabled and children were more likely to receive tests than other eligible groups (i.e., short-term pregnancy, expansion, non-disabled). There was little pattern in testing rates by geographic region or race/ethnicity, but there was an observed trend in white patients having higher test rates in the first trimester and Black patients having higher rates in the third trimester.

**Lindsey Hammerslag, PhD** of the University of Kentucky, building on the STAMP study presented by Dr. Lanier, expounded on factors associated with prenatal syphilis screening and how linkage of STD surveillance data can improve completeness of patient history. The study examined prenatal syphilis screening at any time during pregnancy, during the first semester, or during the third semester in three states and looked at trends in demographic information, Medicaid coverage, and patient history.<sup>5</sup> One of the three states studied was able to establish a linkage between Medicaid claims data and STD surveillance data while the other two were not.

Dr. Hammerslag presented results that found gaps in prenatal screening, across states and dependent on prior STD, as well as screening variation by trimester with third trimester rates being the lowest in all three states. When comparing factors associated with screening at any time during pregnancy, there was no consistent effect of race nor ethnicity, while having a prior STD or having Medicaid benefits, either during the first trimester or pre-pregnancy, was associated with higher screening odds. For first trimester testing specifically, Non-Hispanic (NH) Black and Hispanic women had lower odds of screening as did enrollees with prior pregnancy. First trimester or pre-pregnancy Medicaid enrollment as well as prior STD or pelvic inflammatory disease (PID) were associated with higher first trimester screening odds. In the third trimester, Non-Hispanic (NH) Black women had higher odds of testing, as did women with prior STD or prior pregnancy. Pre-pregnancy, but not first semester, Medicaid benefits were associated with higher third trimester testing odds. As for the impacts of linking surveillance data to Medicaid data, the results were significant. In this study, less than half of women with a prior STD would have been identified as having an STD using Medicaid data alone and the proportion of women with prior STD captured by Medicaid data is higher for women with longer continuous Medicaid enrollment before pregnancy.

**Elizabeth Crouch, PhD** of the University of South Carolina's Rural and Minority Health Research Center presented work conducted with colleagues exploring persistent racial, ethnic and urban/rural disparities in HIV and STDs in South Carolina.<sup>6</sup> Understanding STDs are disproportionately higher among minoritized and rural populations, Dr. Crouch and colleagues conducted a retrospective study, reviewing

1. Medicaid Outcomes Distributed Research Network. Accessed on May 25, 2023. <https://academyhealth.org/about/programs/medicaid-outcomes-distributed-research-network-modrn>

the most recent and complete South Carolina Medicaid administrative claims data between FY1 July 2019 to June 2020 and FY2 July 2020 to June 2021, to explore associations between chlamydia, gonorrhea, syphilis, HIV, race and ethnicity, and rurality among Medicaid enrollees in South Carolina. South Carolina presented a unique focus as it has nearly twice the number of Black and rural residents than the national averages and is among the top five states nationally with the highest incidence rates of STDs.

The study found Black enrollees were more likely to have chlamydia, gonorrhea, and HIV than white enrollees, and these associations were similarly true for other minority ethnic/racial groups when compared to non-Hispanic whites. Additionally, rural residents were more likely to have a claim associated with Chlamydia or Gonorrhea, but less likely to have a claim associated with Syphilis or HIV, when compared to their urban counterparts. This study suggested that additional contextual and structural factors, informed by social determinants of health, could help explain the disproportionate trends in STDs among minority ethnic and racial groups as well as lack of access to needed care delivery services in rural regions, and underscore the need for additional studies focused on these populations.

*Melinda Merrell, PhD* and her team at the University of South Carolina's Rural and Minority Health Research Center explored the current costs to Medicaid programs for STD screening and treatment for the three most common bacterial STDs and investigated if there are differences between expansion and non-expansion states. Dr. Merrell presented the results of the retrospective, cross-sectional study using South Carolina Medicaid claims data that found diagnosis and treatment of common bacterial STDs may have a considerable financial impact on state Medicaid programs, suggesting a continued focus on primary prevention coupled with increased access to STD screening services can reduce disease burden and may decrease overall costs.<sup>7</sup> Furthermore, the study highlighted opportunities to leverage partnerships between public health and health care entities, especially Medicaid managed care organizations.

## Role of Providers in Improving STD Screening and Access to Care

This session delved into topics related to the provider roll in enhancing STD care including the importance of leveraging various provider types, evidence supporting provider access increasing screening and care, and the promising impacts of Medicaid expansion.

*Dr. Lanier* provided findings from a second STAMP project exploring STD testing among Medicaid enrollees initiating Pre-Exposure Prophylaxis (PrEP) to help prevent contracting HIV to understand the likelihood of Medicaid enrollees to receive recommended STD

testing at specific intervals. Studying a cohort of enrollees who initiated PrEP within 2017-2018, the project explored Medicaid administrative claims data to determine what proportion had at least one STD test for syphilis or chlamydia/gonorrhea with three, six, and twelve months following the first PrEP prescription, and how many STD tests were performed per PrEP user by three, six, and twelve months following that first prescription.<sup>8</sup>

Overall, there was substantial variation between states and within Medicaid populations. Among the six-state study cohort of 990 Medicaid enrollees (22 per 100,000) who initiated PrEP in one year, there was variation across the states, ranging from 9.1 to 51.3 per 100,000. Similarly, STD testing prevalence within the three-, six-, and twelve-month periods of the PrEP prescription varied with tests the lowest at the recommended six-month post-prescription timeframe. Prevalence of STD tests also varied slightly for syphilis tests versus chlamydia/gonorrhea tests. Trends differed among sub-populations as well, with STD testing higher among non-Hispanic Blacks, females and urban residents compared to their relative PrEP initiator counterparts. These demographics of PrEP initiators also varied by a state's Medicaid expansion status. Testing also observed to increase with the age of the PrEP initiator.

It was noted that the study's Medicaid expansion states suggesting higher rates of testing, but more assessments are needed. Furthermore, STD testing remains lower than what is clinically recommended, underscoring the need for Medicaid programs to focus on these populations, most served by Medicaid, and consider policies to incentivize testing to prevent and/or improve care delivery for STDs.

*Wiley Jenkins, PhD* from the Southern Illinois School of Medicine presented on the Illinois Project, a project aimed at improving access to primary care for persons who use drugs and have an STD in the Delta Region of southern Illinois. Beginning in 2023, the project is based upon the current ETHIC clinical trial addressing infectious disease risk associated with opioid misuse and drug injection in this region.

Dr. Jenkins shared preliminary data collected in two initial phases, from July 2018 to June 2019 and from August 2020 to April 2023, that indicated screening differences dependent on specimen type (urine, swab, or syphilis) by age, gender, and phase, and when combined with 2021 Chlamydia (CT), Gonorrhea (GC), and Syphilis (TP) case data from the state health department, showed significant differences in chlamydia and gonorrhea by age, sex, race, and residence. When compared against the Illinois Prescription Drug Monitoring Program (PDMP) data, results suggested having more providers has a positive impact on STD rates. Furthermore, Southern Illinois Healthcare's (SIH) electronic medical record (EMR)

data regarding STD diagnosis among patients with substance use diagnosis found potential association between infection risk and care engagement. Dr. Jenkins noted the Illinois project is exploring if a field-based STD diagnosis can be a leverage point to navigate people who use drugs (PWUD) into primary care and are in the process of developing supportive and motivational materials based upon preliminary data analyses.

Dr. Jenkins concluded with insurance implications for PWUD and STD, citing that patients with insurance more frequently report receiving care (and at routine venues), that the majority of insured individuals in the Rural Opioid Initiative July 2018 through June 2019 phase are Medicaid enrollees, and that those with Medicaid more frequently report accessing multiple substance use services. Furthermore, SIH data suggest lesser care engagement is associated with higher STD risk.

**Eric Mick, PhD** of the University of Massachusetts Chan Medical School reviewed the role of primary care providers in STD testing in the Massachusetts Medicaid and Children's Health Insurance Program (MassHealth) program. As background, over 60% of MassHealth's members are enrolled in accountable care organizations (ACOs) as part of an 1115 Demonstration Waiver. These ACOs incentivize quality care delivery among the primary care practices with value-based payments tied to cost and quality outcomes performance. While this ACO plan structure prioritizes comprehensive primary care, Dr. Mick notes that STD screening is not incentivized as STD screening and testing among Medicaid populations are largely provided outside of the primary care setting and these services do not require a primary care clinician (PCC) referral.

The study aimed to identify the annual prevalence of STD testing overall and within primary care settings, identify demographic, clinical, and social characteristics associated with STD testing, and assess the prevalence of STD testing among ACO members compared to those enrolled in other health plan types, such as a managed care organization (MCO) or a PCC Case Management Plan (PCCM). The study also applied a "Social Determinants of Health" model to assess medical morbidity, instable housing, and economic stress.

Reviewing managed-care-eligible members aged 0-64 years enrolled in a MassHealth managed care plan for at least six months during 2019, Dr. Mick and colleagues found the lowest prevalence of observed STD testing among MCOs and the highest prevalence among primary care ACOs. Roughly one in seven MassHealth members received any STD testing and testing was more prevalent among members with housing problems, greater medical morbidity, and residing in more socially stressed neighborhoods. It was also found that the primary care ACOs, structured to address population health, were more likely to test for STDs than other primary

care settings, suggesting that those health care delivery systems that are structured to address overall population health factors, may be best suited to incorporate STD screening in accordance with recommendations.

**Naomi Seiler**, in her second presentation, expounded on key findings and considerations from a study comprised of a literature review and key informant interviews exploring the role of community health workers (CHWs) in providing STD support services.<sup>9</sup> Ms. Seiler first elaborated on CHWs' unique positioning in the STD prevention field by highlighting their strength of gaining and leveraging trust, their potential to educate at a community level as opposed to just at an individual level, and their potential and ability to address social determinants of health.

Given there are not many CHWs currently working in the field, Ms. Seiler went on to explain how Medicaid payment may help support a sustainable CHW workforce. The project findings suggest identifying existing Medicaid payment models for CHWs by state, determining if CHWs working in the STD field can benefit from such models, and ensuring STDs providers and CHWs can continue to contribute to the discussion of Medicaid payment models for CHWs as considerations for strengthening the CHW workforce.

Ms. Seiler concluded by suggesting that, with health department support, Disease Intervention Specialists (DIS) and CHWs could use their complementary skills, training, and connections to support each other's work and bridge gaps in the STD field.

## Exploring Policy and Payment Levers to Affect Change

This session explores various supportive Medicaid policy and delivery system payment levers states could consider to improve access to and treatment for STD services.

**Naomi Seiler**, in her third and final presentation, offered key findings from two projects in collaboration with her colleagues, on STDs and Medicaid.<sup>10</sup> One project explored challenges and opportunities for addressing congenital syphilis through the Medicaid program by focusing on seven southern states: Alabama, Georgia, Kentucky, Louisiana, North Carolina, South Carolina, and Tennessee.<sup>11</sup> Ms. Seiler elaborated on key federal and state level challenges uncovered including that risk-based national recommendations for third trimester syphilis screening may inhibit the development of incentives or performance measures, that pregnant people who are immigrants often have limited access to Medicaid coverage, that Medicaid reimbursement features like including bundled payments may obscure screening rates, and that failure to expand Medicaid delays prenatal care, potentially hindering syphilis screening.

Ms. Seiler presented several opportunities for congenital syphilis prevention via recommendations at various governmental and jurisdiction levels. Some key recommendations include presenting the cost of treating congenital syphilis in an infant to Medicaid agencies and MCOs to persuade them to invest more in prevention, revising guidelines to promote routine third trimester testing or offer more specific criteria for when a community should be considered high risk, having state public health authorities convene discussions with Medicaid and commercial payers in the state to develop a standardized approach to reimbursing third trimester syphilis screening with no cost sharing, have state policymakers leverage the Medicaid family planning expansions to support male partner coverage and continuity of care for women, and for Medicaid programs and MCOs to explore the use of plan and/or provider incentive models for congenital syphilis prevention.

Ms. Seiler's second project explored the relationships between social determinants of health (SDOH) and STD risk.<sup>12</sup> Preliminary findings and observations found that states have broad flexibilities and CMS' support to address SDOH, state Medicaid and other experts rarely prioritize SDOH and STDs but do address social determinants related to SDOH (e.g., housing, food insecurity, transportation), and although there are data analysis challenges, health plans and providers frequently utilize screening tools for SDOH.

**Melinda Merrell** of the University of South Carolina provided findings from a quality improvement initiative implemented in four rural South Carolina primary care clinics to improve STD services.<sup>13</sup> Dr. Merrell and colleagues Quality Improvement (QI) study aimed to reduce STD prevalence among state residents by both identifying areas of high need of STD services (i.e., areas with high disease risk and accessible healthcare services) within rural communities and assessing overall awareness and availability of STD and HIV services among the four rural counties primary care clinics, particularly for those deemed highest at-risk.

Staff identified four counties with high needs based on overlapping risk data in combination with available STD and HIV services, and then engaged primary care clinics within the counties to understand their current STD and HIV testing and treatment practices. Findings revealed that clinic staff could benefit from STD/HIV services education and training, including orientation on call to action, clinical guidance, needs for special populations and considerations with respect to management of practices. It was additionally noted that clinics needed QI education resources to support the study's QI initiative. Overall, this study underscored the need for state public health and Medicaid programs to consider resource allocation as it relates to supporting rural health communities in providing equitable, high-quality, patient-centered care, especially for special populations particularly higher at-risk. This includes targeting rural

primary care practices as valuable STD/HIV service providers, with special priority given to addressing cultural issues and persistent stigmas related to sexual health.

**Arlene Ash, PhD** of the MassHealth Consulting Team at the University of Massachusetts Chan Medical School, presented on the merits and challenges of a bundled payment for STD care. Recognizing that existing data provide insights into what clinical services are paid for and to whom, but little into what was needed, Dr. Ash explored risk-adjusted models to guide larger payments to providers whose patient panels require more care as well as provide fair and effective quality assessments that compare services rendered to (model-predicted) estimates of needed services.

Dr. Ash suggested using existing, imperfect data to calculate the Primary Care Activity Level (PCAL) outcome, then building a model to predict this outcome from patient characteristics, which can address existing problems such as fee-for-service (FFS) payments to primary care providers (PCPs) being inadequate to support comprehensive care as well as existing procedure codes and bills missing some rendered services.

Dr. Ash concluded by applying the PCAL to STD care, calling for the identification of data relating to STD care via exploring ICD-CM codes that capture STD, STD risk factors and STD-related care as well as relevant neighborhood-level variables that characterize social determinants of health and thus STD-risk, such as medical morbidity, instable housing, and economic stress, the construction of an STD-care outcome based on current use, and the creation of a model to predict the STD-care outcome.

## Lessons Learned in the Adoption of a Congenital Syphilis Measure in South Carolina

**Ana Lopez-De Fede, PhD** of the University of South Carolina shared important learnings gained while implementing QI goals to increase STD and prenatal syphilis screenings among pregnant women in the South Carolina Birth Outcomes Initiative (SC BOI). First, Dr. Lopez-De Fede outlined key steps that are instrumental in successful quality improvement initiatives, including understanding who the important stakeholders to engage with at every step in the QI process, knowing what the current statistics are so that one can accurately establish goals and measure and report on intended progress. She then shared insights gained from implementing a quality measure in the SC BOI. It was understood that Medicaid is the payor for approximately 60% of all births and that the rate of congenital syphilis is continuing to increase in SC, contributing a substantial cost burden to the Medicaid programs. As such, there was a natural cost benefit to understanding gaps in STD testing and treatment and establishing a goal to increase STD screening.

Initial review of Medicaid STD screening trends in South Carolina between 2017 and 2021 revealed significant predictors for screening prevalence, such as, having a prior STD or prior pregnancy, being continuously enrolled in Medicaid, being younger in age and being white. Conversely, adults with disabilities were less likely to get screened. Recognizing that the CMS quality measurement development process is a lengthy, multi-year process, Dr. Lopez-De Fede emphasized the opportunity state Medicaid programs must establish or support their own QI initiatives, urging states to not wait for CMS quality measurement approval, but considering aligning with their goals. The SC BOI established a QI goal to increase STD screening among first and third trimesters to 70% and increase prenatal syphilis testing in the third trimester to 20%. Adoption of this measure provided additional considerations to improve QI progress, including engaging various provider types to limit burden and ensure buy-in for reporting, enable reporting at different health system levels to capture other areas for impact, and incentivize reimbursement taking care to align those Medicaid and commercial payer policies and processes.

## Marking the Path – Identifying and Prioritizing a Roadmap for State Action

Following presentations, state Medicaid clinical and quality leaders, along with their public university colleagues were organized into break out groups to reflect on the day's presentation findings on STD prevalence, treatment trends, and Medicaid levers and consider a roadmap toward improving STD detection and treatment among their own Medicaid populations. Specifically, state policy-makers and their peers were charged with identifying strategies or actions for improving delivery of STD services for at-risk Medicaid enrollees, including how to best identify and build sustainable partnerships across agencies and within their communities to further these efforts. States were provided with an action plan template (see Appendix) that enabled states to identify objectives and chart steps that they could follow to fulfill the objectives.

In addition to the general objective to improve collaboration among Medicaid and public health program to improve recommended STD screening overall, participants also considered focusing on specific populations of interest or priority for their programs, such as pregnant Medicaid enrollees, where efforts to increase recommended STD screening could be readily aligned with existing measures to improve access and quality of prenatal care. To achieve these more immediate objectives, states identified the following discreet strategies states could consider employing:

- *Leverage academic detailing tests and MCO visits to provider practices* to increase provider awareness of current guidelines.
- *Utilize case management to educate members*, by applying a nurse case management model, *and, if needed, link them to behavioral health care resources* to address any underlying issues.
- *Increase provider treatment effectiveness for STDs through initiation of a provider hotline* to answer questions about STD treatment, and implementation of an ECHO-based education program with CME incentives for participation and completion.
- *Utilize community health workers, doulas or other peer support providers, who can provide culturally concordant support and/or lived experience* to provide STD education.
- *Detect and treat congenital syphilis as early as possible during pregnancy* by applying prenatal visit incentives (i.e., monetary for visits or completion of online Notice of Pregnancy form, supplies), expanding pharmacist involvement as an additional mode of early communication with pregnant women, and removing or preventing required prior authorization.
- *Disseminate March of Dimes report cards to state leaders* as a potential way to publicize current trends in STDs, specifically alarming increasing rates of congenital syphilis.
- *Calculate and message the economic impact of the neonatal intensive care unit (NICU) to Medicaid*, acknowledging that congenital syphilis, while not the only contributor, is a major factor.
- *Orient messaging to policy leaders around maternal and family health to alleviate any stigma* and concerns around STDs and sexual health.
- *Leverage nurse strike teams* as an avenue for reaching people involved with justice and STD services and care.
- *Leverage existing or explore adoption of Family Planning Expansion Medicaid waiver* to include PrEP services.
- *Explore interagency agreements*, including memorandum of understandings or data use agreements, *to enable data matching of Medicaid administrative claims with surveillance data* to understand true rate of congenital syphilis and identify missed surveillance.
- *Explore best practices in linking race and ethnicity data* in Medicaid administrative claims with birth certificate data.
- *Develop a formal PrEP Access-to-Needs Metric* to enable states to measure availability and uptake of essential STD screening and treatment services.
- *Map sexual health service locations by provider type* to inform gaps in care and design/deliver STD screening training and education services.

## Moving Forward

This meeting brought together a myriad of stakeholders to address a topic of utmost importance. True to the meeting's objective, we hope that these discussions inspire collaborative actions among Medicaid and public health programs aimed at increasing and improving STD testing and care delivery in the Medicaid program and beyond.

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## Appendix

### Action Plan: Medicaid Strategies to Improve STD Service Delivery for Enrollees

#### Exercise Aim

The aim of this exercise is to help you identify strategies, and key partnerships, and to outline initial and subsequent steps your Medicaid program can take to improve STD service delivery for your Medicaid population.

#### Step-by-Step Guide

##### Step One: Identify the baseline of STD services being provided by your Medicaid program.

1. What does access to screening and follow-up STD services currently look like for our Medicaid enrollee population in our state?
  - a. What do we know, and how—or how “well”—do we know it (e.g., data vs. anecdote)?
  - b. What do we need to know—and who may have this and where might we find this information (facilitators and resources)?
  - c. Is there one specific STD or STD service in your state that you believe requires particular attention?

##### Step Two: Identify if your Medicaid policies and procedures are adequately responsive to addressing STDs among your Medicaid population.

1. What are your reimbursement policies? Do your FFS and/or MCO plans reimburse for multisite testing?
2. Do your plans permit self-referral for STD services? Even out-of-network? Do they reimburse for this self-referral?
3. Do your plans permit nontraditional reimbursement for STD services? (e.g., clinic walk-ins)

4. What privacy policies do your plans have to ensure protection of patient information regarding ‘sensitive services’? How are these applied for adolescents?
5. Do your plans provide telehealth-based/facilitated STD services? Are these adequate (e.g., easily accessible, privacy protected)?
6. Do you know your rates of prenatal syphilis testing? By trimester? How do your plans reimburse providers and facilities for prenatal care?

##### Step Three: Identify the specific barriers and/or facilitators to these policies that are influencing the adequacy of STD service delivery. How is your program addressing these barriers and/or facilitators?

1. What are barriers or facilitators that are influencing your policies above?
2. How are we addressing these barriers or facilitators (if at all)?

##### Step Four: Consider strategies that you could employ, and key persons to engage with, to remove these barriers and improve STD service delivery.

1. What would it take to implement the ideas shared in response to addressing existing barriers or bolstering facilitators?
2. Can your Medicaid program leverage existing performance measurement or outcomes measures to monitor and incentivize plan/provider performance?
3. Can your Medicaid program foster and strengthen internal/external partnerships to improve the delivery of services? Enhance engagement with providers and patients?

Note: Consider who would need to be onboard/engaged internally? What would be the “ask” for them and their incentive to respond? What would they want to know/see?; Who would need to be onboard/engaged externally? What would be the “ask” for them and their incentive to respond? What would they want to know/see?

## EXAMPLE

### Definition of Terms

**Timeline:** Please specify number of months needed for completion, not to exceed 12 months.

**Responsible Person, State Agency/Department, and External Organization:** Please list both internal and external staff who will have lead responsibility for the activity/activities.

**Facilitators:** Please list additional persons or resources that can facilitate the progress of this goal.

Objective 1: Please write your goal here.  For example: Increase the proportion of pregnant Medicaid enrollees who receive recommended STD screening	Timeline	Responsible Person, State Agency/Dept, Organization	Facilitator(s)	Critical Resources and/or Information Needs	How will Progress be Measured?
<b>Strategy 1:</b> Improve provider awareness of CDC guidelines for STD testing.		Health Department (HD)/ MMD/MCO(s)		CDC STD Treatment Guidelines (2021)	
Action Step 1: Develop new and/or disseminate existing STC practice guidance and tools via existing channels for communicating with contracted/network providers (e.g., Provider newsletters or policy bulletins)		MCOs and Medicaid			# of Medicaid Providers Receiving email/ mailing on CDC STD Treatment Guidelines
Action Step 2: Attend and present at state chapter of a provider association, such as the American College of Obstetricians and Gynecologists (ACOG) meetings		HD		Calendar of State ACOG Engagements	# of meetings at which a presentation on STD treatment guidance was delivered
Strategy 2: Support appropriate submission and prompt payment for telehealth-facilitated services related to STD testing		Medicaid/MCOs		CMS National Correct Coding Initiative	Increase in # of claims for telehealth-facilitated testing
Action Step 1: Review current Medicaid telehealth policies to understand covered STD services and providers		Medicaid/MCO(s)	Medicaid		Compiled list of policies and practices
Action Step 2: Develop and disseminate detailed coding guidance for providers to use when submitting claims for telehealth facilitated testing for STDs		Medicaid/MCOs		Coding Document/Issue Brief on Coding	# of providers that receive a copy of the Coding Guidance

**Barriers/Challenges associated with achieving this objective:**

**State:**

**Medicaid Representative:**

Objective 1: Please write your goal here.	Timeline	Responsible Person, State Agency/Dept, Organization	Facilitator(s)	Critical Resources and/or Information Needs	How will Progress be Measured?
<b>Strategy 1:</b>					
Action Step 1:					
Action Step 2:					
Strategy 2:					
Action Step 1:					
Action Step 2:					
<b>Strategy 3:</b>					
Action Step 1:					
Action Step 2:					
<b>Barriers/Challenges associated with achieving this objective:</b>					

Objective 2: Please write your goal here.	Timeline	Responsible Person, State Agency/Dept, Organization	Facilitator(s)	Critical Resources and/or Information Needs	How will Progress be Measured?
<b>Strategy 1:</b>					
Action Step 1:					
Action Step 2:					
<b>Strategy 2:</b>					
Action Step 1:					
Action Step 2:					
<b>Barriers/Challenges associated with achieving this objective:</b>					

## Endnotes

- 1 For the purposes of this report STI and STD were interchangeable in titles.
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- 9 A working paper is forthcoming.
- 10 Seiler, N., Heyison, C., Organick-Lee, P., Karacuschansky, A., Dwyer, G., Osei, A., Stoll, H., & Horton, K., “Congenital Syphilis in the Medicaid Program: Assessing Challenges and Opportunities Through the Experiences of Seven Southern States,” *Health Policy and Management Informal Communications*, 2023.
- 11 Seiler, N., Pearson W.S., Bachmann L.H., Heyison C., Organick-Lee P., Karacuschansky A., Dwyer G., Osei A., Stoll H., & Horton K., “Congenital Syphilis in the Medicaid Program: Assessing Challenges and Opportunities Through the Experiences of Seven Southern States,” *Womens Health Issues*, S1049-3867(22)00178-5, January 24, 2023.
- 12 A working paper is forthcoming.
- 13 A working paper is forthcoming.