Ohio Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

Guidance for Managed Care Plans: **Provision of Enhanced Maternal Care Services**

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Background

Ohio Medicaid Managed Care Plan (MCP) maternal care programs are required to focus on the improvement of birth outcomes, the reduction of infant mortality, and optimizing health outcomes for women and their infants. Ohio Medicaid is committed to reliably driving improvements in these areas by encouraging innovative use of data and improvement science, including:

- Monthly provision of vital statistics data to MCPs for use in timely identification of and intervention with high risk women in need of enhanced maternal care;
- Geographically targeting birth outcome improvement efforts in areas of the state with the highest infant mortality rates [i.e., 9 Ohio Equity Institute communities[1] with special consideration also given to Appalachia ("priority communities")] by focusing on providing culturally competent[2] health care services within these areas;
- Integrating Quality Improvement (QI) science methods into performance improvement projects to more rapidly determine successful intervention strategies;
- Integrating eligibility and MCP specific information into mobile messaging applications, such as 'txt4baby', to improve patient engagement and connectivity to Care Management;
- Launching and continuously supporting the Ohio Perinatal Quality Collaborative (OPQC); and
- Advancing the science and implementation of evidence based care.

The MCPs are expected to use the above strategies in conjunction with investing in, and connecting women to, patient-centered medical homes (PCMHs); making arrangements with community partners; and performing expedited outreach to systematically address modifiable risk factors and obtain measurable improvements in birth outcomes over the next two years. These improvement efforts will be facilitated by the MCPs' active and direct participation in existing organized infant mortality/preterm birth prevention efforts, such as

1. ODM-endorsed Improvement Projects (e.g., Progesterone and Post-Partum Care);
2. Community-based efforts (e.g., Ohio Equity Institute communities, Cradle Cincinnati, CelebrateOne), and
3. State-level efforts (e.g., OPQC and the Ohio Collaborative to Prevent Infant Mortality (OCPIM).

[1] Butler County, Canton – Stark County, Cincinnati, Columbus, Cleveland – Cuyahoga County, Youngstown – Mahoning County, Dayton – Montgomery County, Toledo – Lucas County, and Summit County - Akron.

[2] Building cultural competency is one strategy for reducing disparities and achieving health equity. In culturally competent organizations, the importance of culture is recognized and incorporated at all levels, cross-cultural relations are assessed, dynamics resulting from cultural differences are recognized and attended to, cultural knowledge is expanded, and services are adapted to meet culturally unique needs. A culturally competent system also includes a mindfulness of how different patient populations' health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes intersect and influence one another. U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 4/11/2016]. Available from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

To assist with these ongoing efforts, ODM has developed guidance based on evidence-based practice (e.g., American College of Obstetricians and Gynecologists). This guidance is tailored to maternal risk level (as identified in the enhanced maternal care file) and to residence in priority communities, and outlines recommended services, communication, and care management supports that women of reproductive age and enrolled in a Medicaid MCP should receive.

ODM expects the MCPs to support the provider-patient relationship by arranging for timely receipt of evidence-based services, removing barriers to care (e.g., transportation, addressing social/safety aspects to care), establishing communication pathways across systems, and sharing data with/between providers.

The four maternal risk levels are as follows:

1. **All Women:** All women of reproductive age (15-44 years of age) receive a baseline of care. Each subsequent level builds upon this baseline. All women of reproductive age who reside in priority communities receive additional services.

2. **Chronic Conditions:** Women of reproductive age with chronic conditions need additional services.

3. **Medium Risk**: Women of reproductive age who had a previous pregnancy resulting in a poor outcome (such as stillbirth), delivered an infant weighing between 1500 grams and 2500 grams, delivered an infant between 32-1/7 and 36-6/7 weeks gestational age.

4. **High Risk:** Women of reproductive age who had a previous pregnancy that resulted in the birth of an infant weighing less than 1500 grams or an infant who was born prior at or before 32 weeks gestational age.

<table>
<tr><th>Risk Indicator Level</th><th>Enhanced Maternal Care Service Standards</th><th>Additional Services for Women Residing in Priority Communities</th></tr>
<tr><td rowspan="3">All Women</td><td colspan="2">All women of reproductive age who are not pregnant should receive the following enhanced maternal care services:</td></tr>
<tr><td>At least one office visit per year is required for each of the following:
1. A reproductive health visit which shall include, at a minimum:
A. A physical exam, vaccination assessment, risk screening and counseling, and a folate assessment
B. A reproductive life plan, including the topics of intentionality, birth spacing, and family planning method.
2. A preventive health visit (e.g. adolescent well check or well-woman check).</td><td rowspan="2">All women of reproductive age who are not pregnant and reside within a priority community will have access to a community worker who will contact them and assist in removing barriers to receiving services referenced in 1, 2, and 3 (see left column).</td></tr>
<tr><td>At least two additional planned and facilitated office visits per year are required for:
3. Chronic condition management, including mental health and addiction challenges.</td></tr>
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Risk Indicator Level	Enhanced Maternal Care Service Standards	Additional Services for Women Residing in Priority Communities
	All pregnant women should receive the following enhanced maternal care services:	
	1. Direct services **A.** Routine prenatal visits with usual source of care; **B.** Enhanced prenatal education regarding: self-care and efficacy, breastfeeding, safe sleep, the importance of the post-partum visit, and patient-specific topics like diabetes and hypertension; **C.** Screening for tobacco and substance use (drugs and/or alcohol) with appropriate treatment facilitation, including counseling and medication-assisted treatment to prevent unexpected substance effects in the infant; and **D.** Completion of post-partum visit including meeting key content criteria. **2.** Communication and support services offered by the MCP. **A.** Directly communicating with clinicians providing care for the woman; **B.** Enrollment of women into program that use mobile messaging applications, such as 'txt4baby', and adding this option to other methods of outreach and communication; **C.** Facilitation of addressing patient needs across agencies and social systems, and removing barriers to the timely receipt of evidence-based care including that received through the Centering Model and/or through maternity medical homes; **D.** Facilitation of addressing patient needs across agencies and social systems, and removing barriers to the timely receipt of evidence-based care including that received through the Centering Model and/or through maternity medical homes; **E.** Culturally competent care management and coordination; and **F.** Development of a plan to mitigate social determinants of health.	**During Pregnancy:** Pregnant women residing within priority communities will have access to a package of services, including, at minimum: **1.** Enhanced prenatal services occurring in conjunction with a community worker through centering programs and/or maternity medical homes that result in the equivalent of two additional prenatal visits with ACOG standard content; and **2.** Reproductive health discussion and planning. **After Pregnancy:** Women residing in priority communities should also receive additional services, including: **1.** Monitoring of health and well-being over time through the receipt of at least quarterly health care visits with a usual and consistent source of care; and **2.** Education including information on parenting and the first year of infant life (which may be accomplished through a centering parenting program).

<table>
<tr><th>Risk Indicator Level</th><th>Enhanced Maternal Care Service Standards</th><th>Additional Services for Women Residing in Priority Communities</th></tr>
<tr><td rowspan="4">Chronic Condition</td><td colspan="2">Pregnant women who have a chronic condition should also receive the following enhanced maternal care services:</td></tr>
<tr><td>1. Dating and mid-pregnancy ultrasound;
2. Effective treatment of chronic conditions – including nutrition classes, medication and care adherence, coordinating between OB and specialist(s) or primary care clinicians managing chronic conditions;
3. Delivery at an appropriate facility (i.e., the highest level specialty and expertise based on the risk level of the mother and baby); and
4. Completion of post-partum visit including meeting key content criteria, including ongoing care and improvement of the chronic condition.</td><td>They should be enrolled in a medium, high, or intensive level of care management.

The MCP is expected to:
1. Standardize and incentivize the timely assessment of pregnancy risk factors and the need for the MCP to provide care management services;
2. Share pertinent MCP information & findings with the woman’s physical and mental health providers;
3. Communicate with providers, patients and the family, as frequently as needed, to develop a mutually acceptable care plan;
4. Assist with patient engagement & shared decision-making efforts; and
5. Help coordinate community resources.

Note: These items may be achieved through building the capacity of and using a variety of community based resources, community workers, centering programs, home visit program, or maternal care homes.</td></tr>
<tr><td colspan="2">For of reproductive age who are not pregnant but have a chronic condition, enhanced maternal services also include:</td></tr>
<tr><td colspan="2">A visit with the primary managing clinician between 2-4 times per year (See “All Women” on page 4).</td></tr>
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Risk Indicator Level	Enhanced Maternal Care Service Standards	Additional Services for Women Residing in Priority Communities
<u>Medium Risk</u> Women who: • Delivered an infant with a birth weight of 1500-2500 grams; **and/or** Delivered an infant between 32-1/7 and 36-6/7 weeks gestational age; **and/or** • Other prior poor outcome (such as stillbirth).	**Pregnant women and assigned a medium risk indicator should also receive the following enhanced maternal care services:**	
	1. Two trans-vaginal ultrasounds performed to: **A.** Date the pregnancy, and **B.** Confirm cervical length; **2.** One extra scan to screen for a major anomaly **3.** Screened for progesterone therapy, as clinically directed, either through weekly visits for injection or daily vaginal administration; **4.** Prenatal visits per clinician recommendations; **5.** Effective treatment of chronic conditions, including the coordination of care between the obstetrician and the specialist(s) managing conditions; **6.** Delivery at an appropriate facility; and **7.** Completion of the post-partum visit which includes an inter-conception health plan and other key content (safe spacing, screening for postpartum depression and gestational diabetes, breastfeeding).	All pregnant women in priority communities should be assigned to a high level of care management.

Risk Indicator Level	Enhanced Maternal Care Service Standards	Additional Services Standards for Women Residing in Priority Communities
	Pregnant women who are assigned a high risk indicator should also receive the following enhanced maternal care services:	
<u>Highest Risk</u> This level of risk is appropriate for women who: • Delivered an infant weighing less than 1500 grams; **and/or** • Delivered an infant at or before 32 weeks gestational age	**1.** Two trans-vaginal ultrasounds performed to: **A.** Date the pregnancy, and **B.** Confirm cervical length; **2.** One extra scan to screen for a major anomaly **3.** The receipt of progesterone therapy, as clinically directed, either through weekly visits for injection or daily vaginal administration; **4.** Prenatal visits per clinician recommendations; **5.** Enhanced prenatal education including: self-care &efficacy, breastfeeding, safe sleep, importance of post-partum visit and inter-conception care, the mitigation of social determinants of health and healthcare barriers, as well as patient-specific topics; **6.** Face-to-face care management which is culturally competent and at a frequency reflecting need; **7.** Effective treatment of chronic conditions, including the coordination of care between the obstetrician and the specialist(s) managing conditions; **8.** Delivery at an appropriate facility; and **9.** Completion of the post-partum visit which includes an inter-conception health plan and other key content.	All pregnant women in the priority communities should be enrolled in the intensive/high level of care management. For this group of women, MCPs are expected to: **1.** Include the entire package of services; **2.** Share pertinent MCP information & findings with the woman's physical and mental health providers; **3.** Communicate with providers, patients and the family, as frequently as needed, to develop a mutually acceptable care plan; **4.** Provide support for education, childcare, employment, & personal health choices through building community worker capacity or through the use of other models, such as maternal health homes, home visits, or centering. Additional topics may include: **A.** Timeliness & frequency of prenatal care; **B.** Tobacco/drug cessation; **C.** Vitamins & adequate nutrition and exercise; **D.** Efforts towards reaching ideal weight; **E.** Education & shared decision making; **F.** Safe sleep; **G.** Breastfeeding; **H.** Depression;, **I.** Parenting education; **J.** Family support; **K.** Antenatal steroids; **L.** Progesterone therapy as appropriate; and; **M.** Post-partum ACOG content & evidence-based care through the infant's first birthday.

Appendix A: Evaluation of New Framework

The Ohio Department of Medicaid uses a number of measures to assess the success of MCP performance in a number of program areas, including maternal care. Evaluation includes MCP efforts to improve birth outcomes, reduce infant mortality, and optimize health outcomes for the woman and infant. Sources for these measures include:

- MCP-reported, audited HEDIS data;
- Ohio vital statistics birth and death certificate data;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) data; and
- Indicators developed by the Agency for Healthcare Research and Quality (AHRQ).

These measures align with a number of existing initiatives to improve the health of women and infants, including perinatal episode and the Ohio Equity Institute community initiatives.

The establishment of Quality Measures and Standards in this Appendix is not intended to limit the assessment of other indicators of performance for quality improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

A list of current measures being used to assess performance can be found in the table below.

Measure	Data Source	Initiative
Adolescent Well Check Visits	Claims	Infant Mortality Score Card Medicaid Managed Care Performance Standards
Prenatal Care During First Trimester	Claims	Maternal & Infant Health Dashboard
Postpartum Care	Claims	Infant Mortality Score Card Medicaid Managed Care Performance Measures Maternal & Infant Health Dashboard
Progesterone Initiation Rate Among All Women	Claims & Vital Statistics	Infant Mortality Score Card Maternal & Infant Health Dashboard
Percent of Live Births Weighing Less Than 2,500 Grams	Claims; Vital Statistics; CHIPRA	Infant Mortality Score Card Medicaid Managed Care Performance Measures
Preterm Birth Rate/1000 births	Vital Statistics	Infant Mortality Score Card
Infant Mortality (Rate/1000)	Vital Statistics	Infant Mortality Score Card