



Department of
Medicaid

Ohio Medicaid's Mom & Baby Bundle

January 9, 2020

Agenda

- Welcome and Introductions
- Program Overview & Q&A – 90 minutes
- Break – 10 minutes
- Small Group Discussions – 60 minutes
- Next Steps and Timeline – 15 minutes



Housekeeping

- We are broadcasting today's presentation via webinar and plan to record and post the recording.
- Slides are posted on the new Mom & Baby Bundle page on ODM's website.
- We have time reserved for questions from both the audience and webinar participants.
 - If you're here in person, please hold your questions until the end of the program overview.
 - Webinar participants can send questions via the chat feature at any time.





Department of
Medicaid



Opportunity for Every Ohio Kid



MIKE DEWINE
GOVERNOR OF OHIO

Children's Initiatives Goals



MIKE DEWINE
GOVERNOR
STATE OF OHIO

Executive Order 2019-02D

Creating the Governor's Children's Initiative

WHEREAS, Ohio's future depends on its children, yet nearly 1,000 Ohio babies did not live to see their first birthday in 2017; and

WHEREAS, more than half of all Ohio children are born into economically disadvantaged homes, and just 41 percent of children arrive at kindergarten with the essential language, social, and mathematical skills to be successful in school; and

WHEREAS, on the National Assessment of Educational Progress, just 24 percent of Ohio's economically disadvantaged fourth graders read at grade level, which research has shown to be a strong predictor of timely high school graduation and post-graduate success; and

WHEREAS, educational gaps can persist and grow over time, impacting a child's ability to live up to his or her God-given potential; and

WHEREAS, research conducted by the National Forum on Early Childhood Policy and Programs has shown that every dollar invested in high-quality early childhood programming yields up to nine dollars in future return; and

WHEREAS, Ohio's programming impacting children is split across multiple state agencies and lacks coordination and a clear point of accountability; and

WHEREAS, the Opportunity for Every Ohio Kid plan calls for a special position, reporting to the Governor, who works daily to improve the lives of Ohio's children;

NOW THEREFORE, I, Mike DeWine, Governor of the State of Ohio, by virtue of the authority vested in me by the Constitution and laws of this State do hereby order and direct that:

1. The Governor's Children's Initiative ("Initiative") is created in order to elevate the importance of children's programming in Ohio and drive improvements within the many state programs that serve children. The Initiative is charged to:

- a. Improve communication and coordination across all state agencies that provide services to Ohio's children.

Coordinate and align the state's **children's programming**

Advance **policy and innovation** in children's programming from birth to Kindergarten

Provide **support services** for all children and their families



MIKE DEWINE
GOVERNOR OF OHIO

Children's Initiatives Goals

- Triple families served by evidence-based home visiting.
- Ensure high-quality childcare settings for all children and expand access.
- Prevention education in every grade, every year.
- All children have access to a mental health professional in their school.
- Reform the foster care system.



MIKE DEWINE
GOVERNOR OF OHIO

Cross Agency Leadership Team

Ohio

Department of
Developmental Disabilities

Ohio

Department of
Medicaid

Ohio

Department of
Education

Ohio

Department of
Mental Health &
Addiction Services

Ohio

Department of
Health

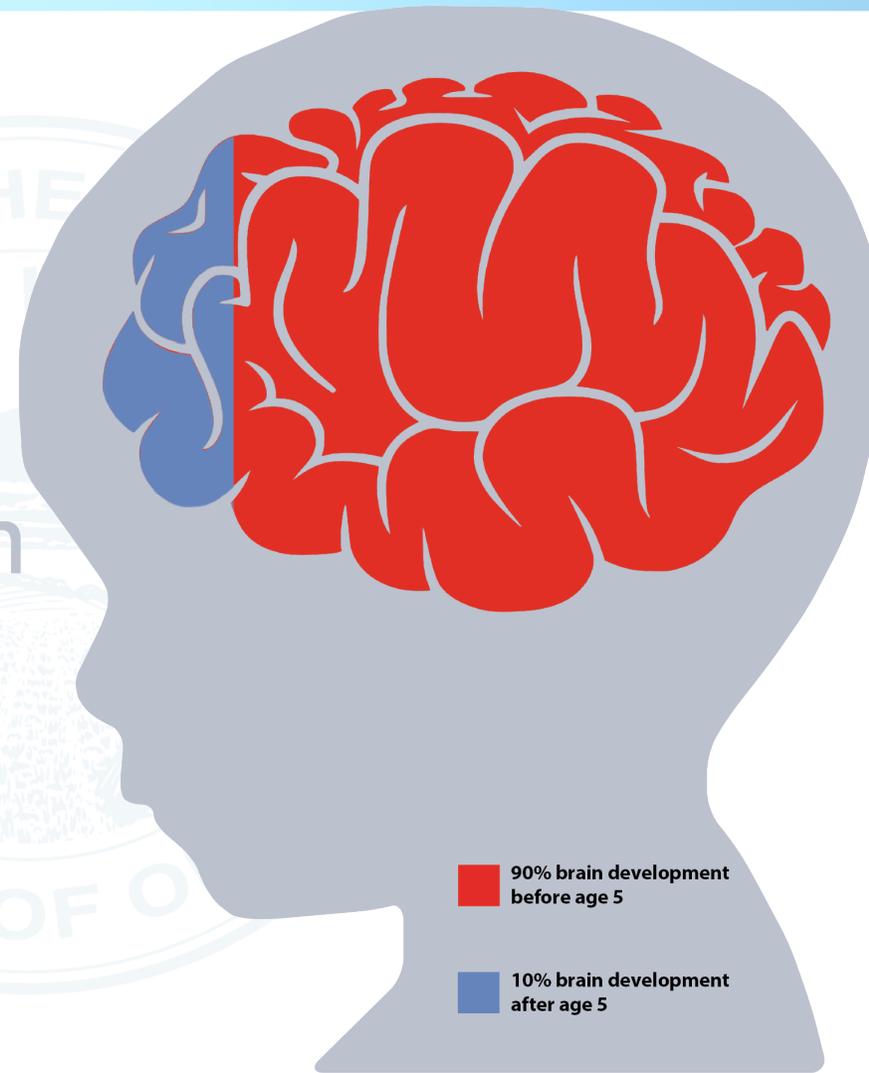
Ohio

Department of
Job & Family Services

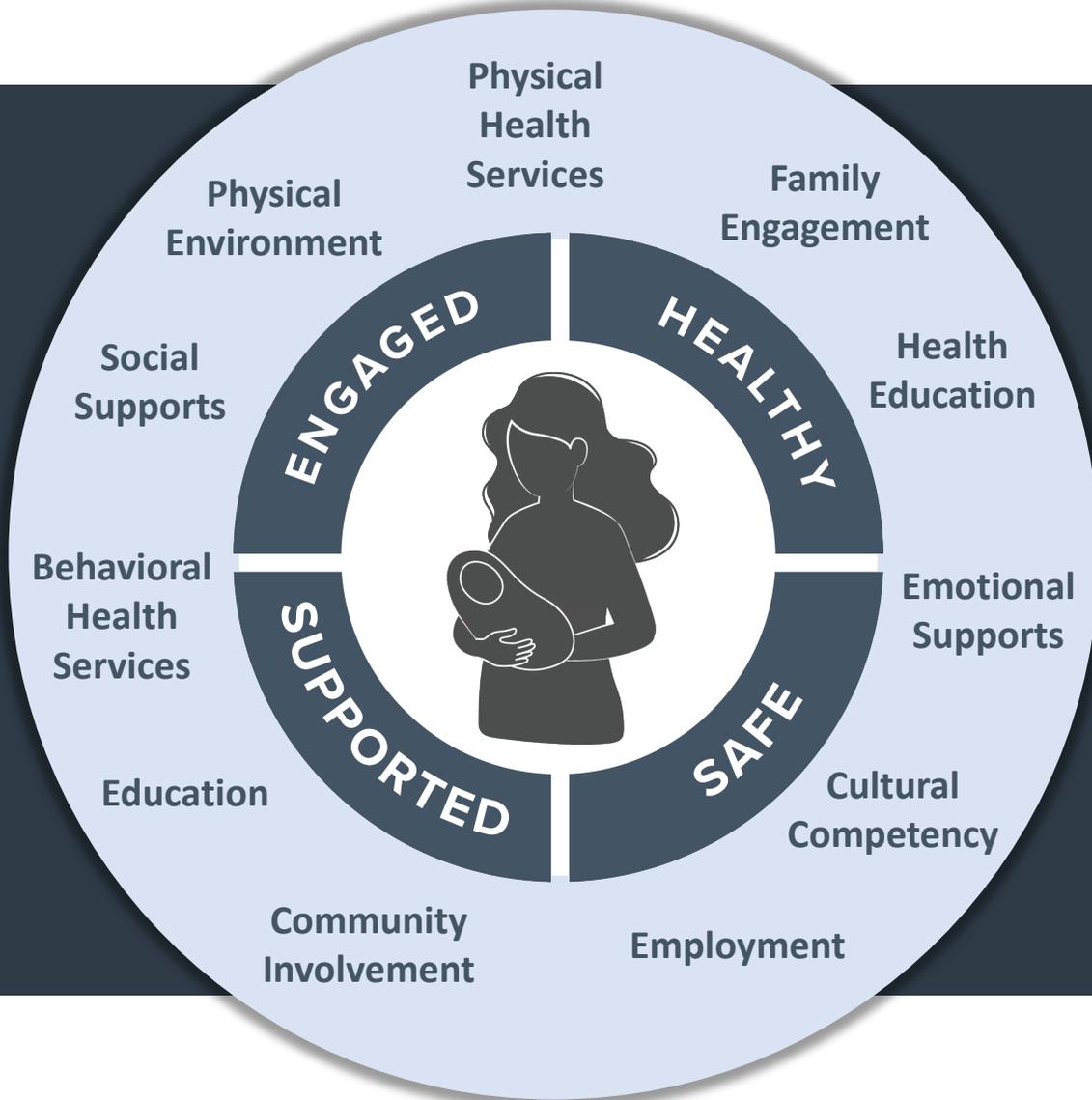


MIKE DEWINE
GOVERNOR OF OHIO

90%
of a child's brain
development
happens before
age 5



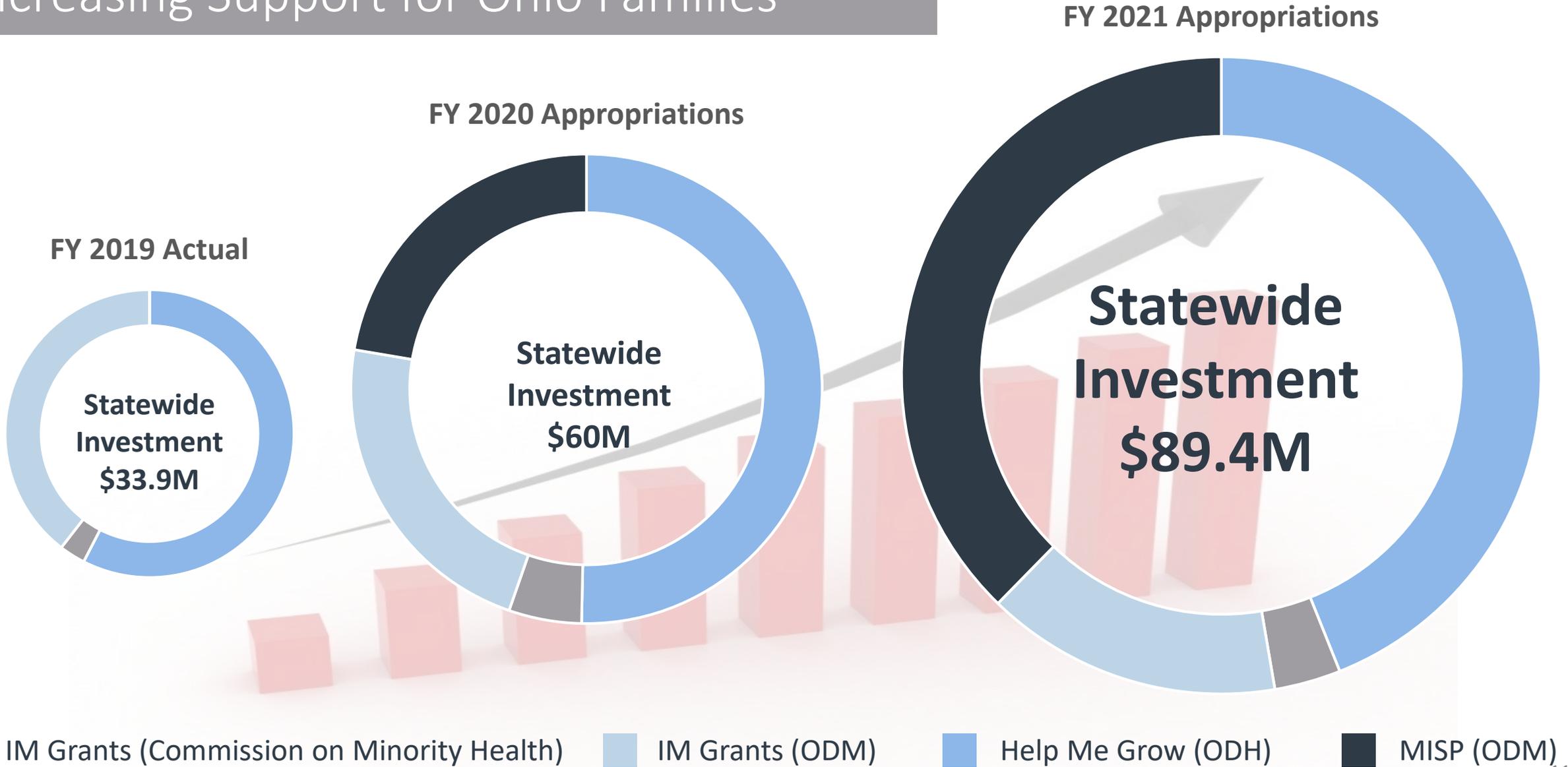
MIKE DEWINE
GOVERNOR OF OHIO



Coordinating Policy, Process and Practice

Integration of community-based services into the traditional healthcare system

Increasing Support for Ohio Families



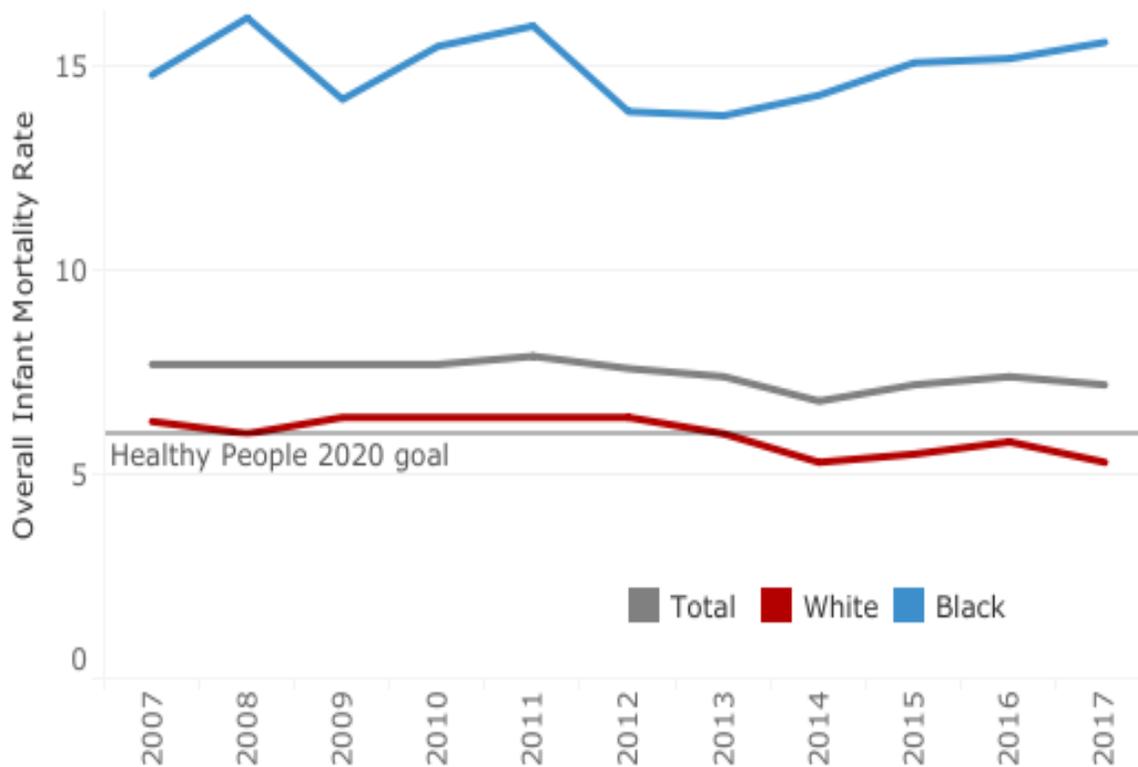


Department of
Medicaid



Ohio's Infant and Maternal Mortality Challenges

Infant Mortality By The Numbers

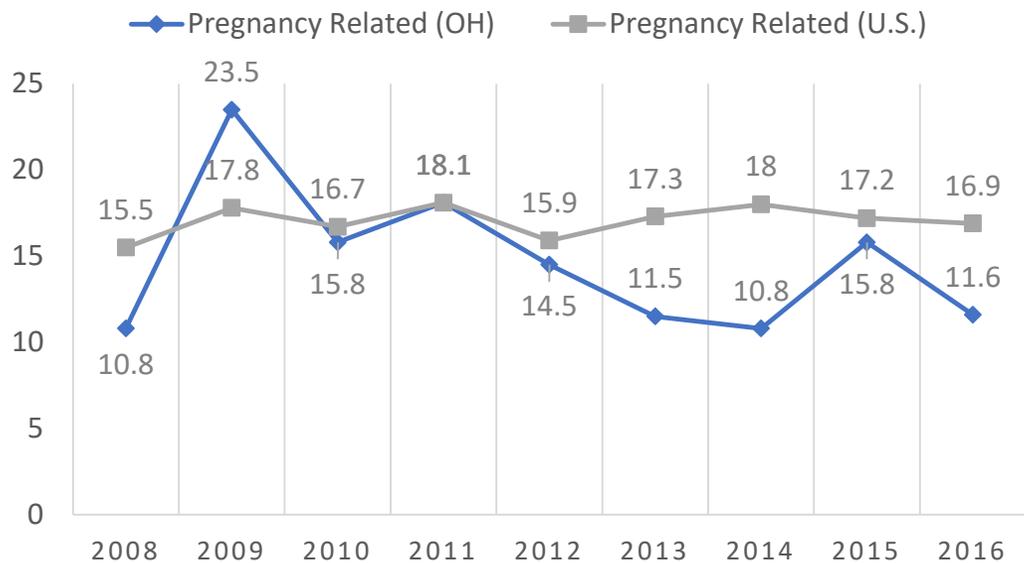


- In 2017, Ohio had its second-lowest infant mortality rate in a decade.
- Despite an overall decline, Ohio still has substantial disparities in survival of black and white infants.
- While we have early indicators that the infant mortality rates for black infants may be improving in select areas of the state, there is much work to be done.

Source: 2017 Ohio Infant Mortality Report – Final. Ohio Department of Health 2019, <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/infant-and-fetal-mortality/reports/2017-ohio-infant-mortality-report-final>. Accessed on 11/19/19

Maternal Mortality By The Numbers

OHIO AND U.S. PREGNANCY-RELATED MORTALITY RATIOS (2008-2016)



Source: A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, Ohio Department of Health 2019, <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/pregnancy-associated-mortality-review/resources/pregnancy-associated-deaths-ohio-2008-2016>. Accessed on 11/19/19

- Maternal Mortality in the United States has steadily increased from 7.2 deaths per 100,000 live births in 1987 to 17.2 deaths per 100,000 live births in 2015.¹
- Women died from pregnancy-related causes in Ohio at a ratio of 14.7 per 100,000 live births from 2008 through 2016.
- **Leading causes of death related to pregnancy in Ohio were cardiovascular and coronary conditions**, followed by infections, hemorrhage, pre-eclampsia and eclampsia, and cardiomyopathy.
- Over half of deaths were thought to be **preventable** (among deaths occurring from 2012 through 2016).
- **Black women died at a rate more than 2.5 times that of white women in 2016.**

¹ Pregnancy Mortality Surveillance System. Trends in Pregnancy-Related Deaths. <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>. Accessed on 12/9/19)



ODM's Learnings and Opportunities from Ongoing Efforts

Infant Mortality Racial Disparity Reduction Efforts



- In 2016, Medicaid and the Managed Care Plans started funding Infant Mortality efforts through Community Based Organizations (CBOs) in Ohio's Counties with the highest racial disparities in infant mortality rates
- Current funding totals approximately \$26 M for 2020-2021.
- Communities' coordinated efforts included at least one of three evidence-based interventions:
 - Home Visiting
 - Centering Pregnancy
 - Community Health Workers
- There are early signs that these interventions are working.

Key Infant Mortality Community Learnings



In communities with Medicaid Managed Care-funded Infant Mortality Grants, women expressed the following key barriers to improving their pregnancy and health outcomes:

- ✓ Lack of Trust of the Health Care System
- ✓ Lack of Provider Empathy
- ✓ Lack of Effective Communication from Providers
- ✓ Lack of Social Supports
- ✓ Lack of Community Resources
- ✓ Lack of Medicaid Coverage of Alternative Providers and Services

What we heard...



“Just be there for me; for my health and my baby’s health. Don’t be so judgmental and make me feel like I’m not a person...”

What we heard...



“Just because someone doesn’t have the same type of insurance or they live in a different neighborhood than another patient...doesn’t mean that we should discount that patient or cut their needs short. We need to provide the same type of quality care for everyone.”

Medicaid's Comprehensive Maternal & Infant Support Program



- Launching a new **Mom & Baby Bundle** model of care that commits to expanding relationships between clinicians and communities
- Developing reimbursement for **nurse home visiting** services
- Investing in community efforts focused on **reducing the racial disparity** in African American infant outcomes through Managed Care
- Developing a **mom and baby dyad** model of care that supports mother and infant co-location when infants have neonatal abstinence syndrome and moms have substance use disorder
- Pursuing of CMS approval for **continuous 12-month Medicaid eligibility for postpartum women with substance use disorders**
- Refining the **perinatal episode of care** to account for tiering of risk ²⁰

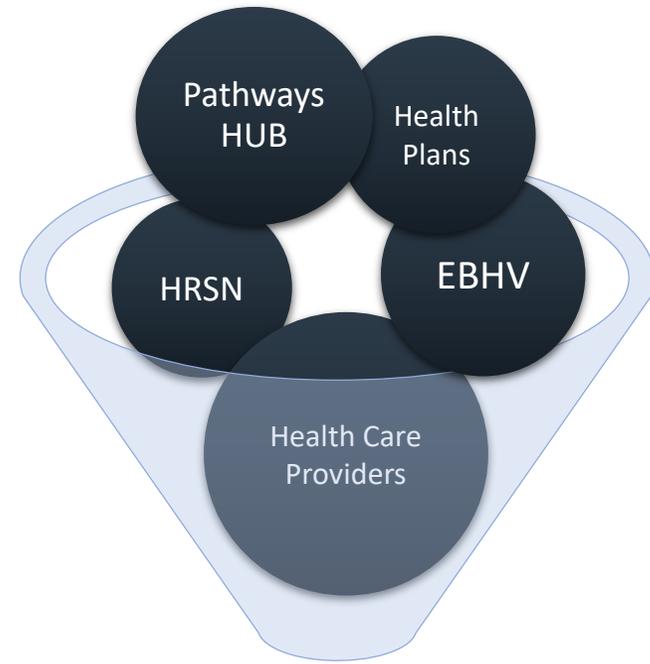
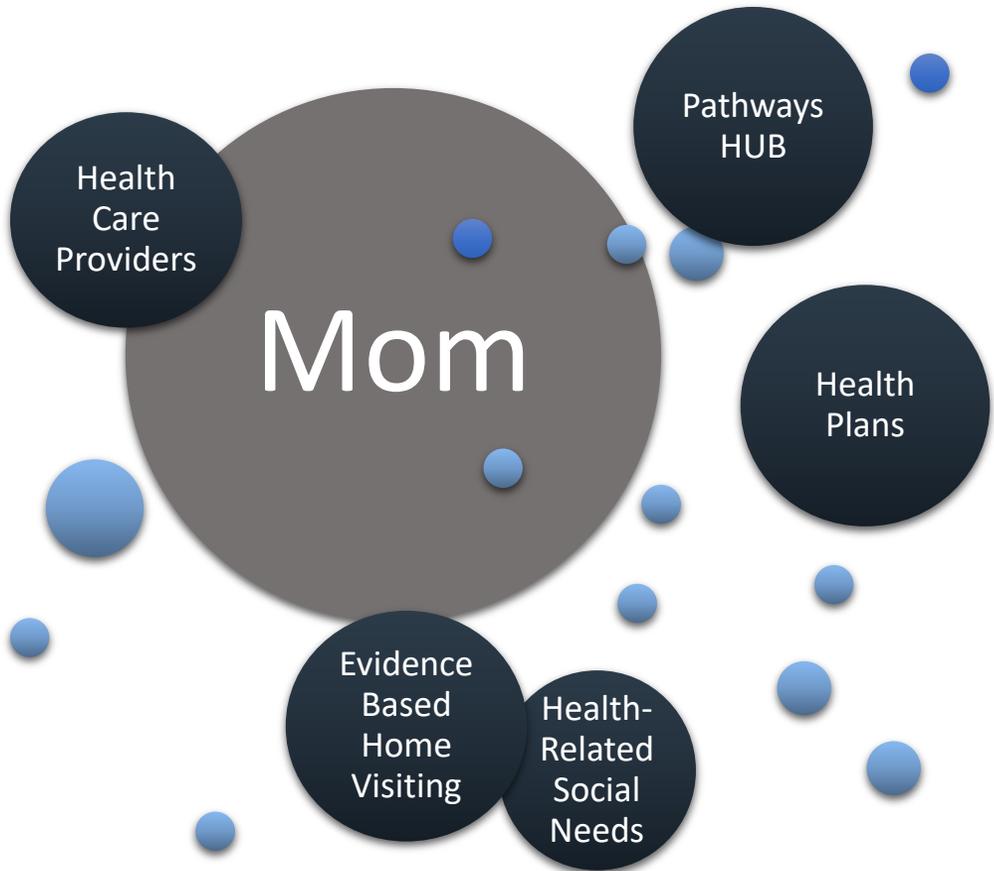


Department of
Medicaid

A photograph of four diverse babies sitting on a white reflective surface. From left to right: a baby with dark hair, a baby with light skin and blue eyes, a baby with dark skin and curly hair, and a baby with light skin and dark hair. A red banner is overlaid across the middle of the image, containing the text "Mom & Baby Bundle".

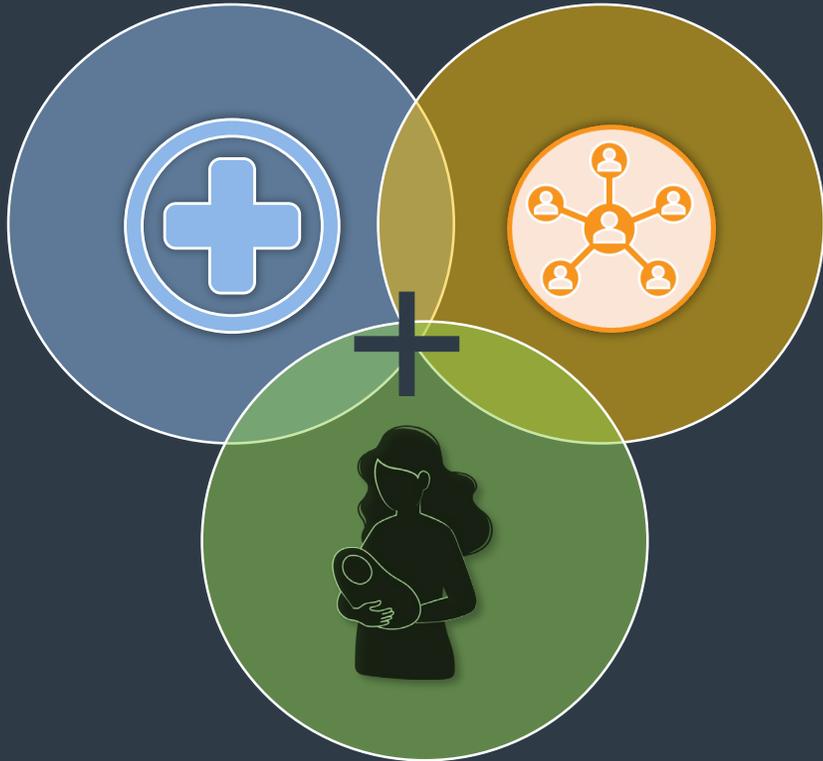
Mom & Baby Bundle

Current State vs. Role of Mom & Baby Bundle



Mom & Baby Bundle:
Integrated and
Connected Care

Mom & Baby Bundle Brings Health Systems and Communities Together to Support Pregnant Women and Infants to Improve Outcomes and Improve Equity



Integrate medical and community-based services through “coordinating” and “partnering” entities



Require provider cultural competence training and reduce implicit bias



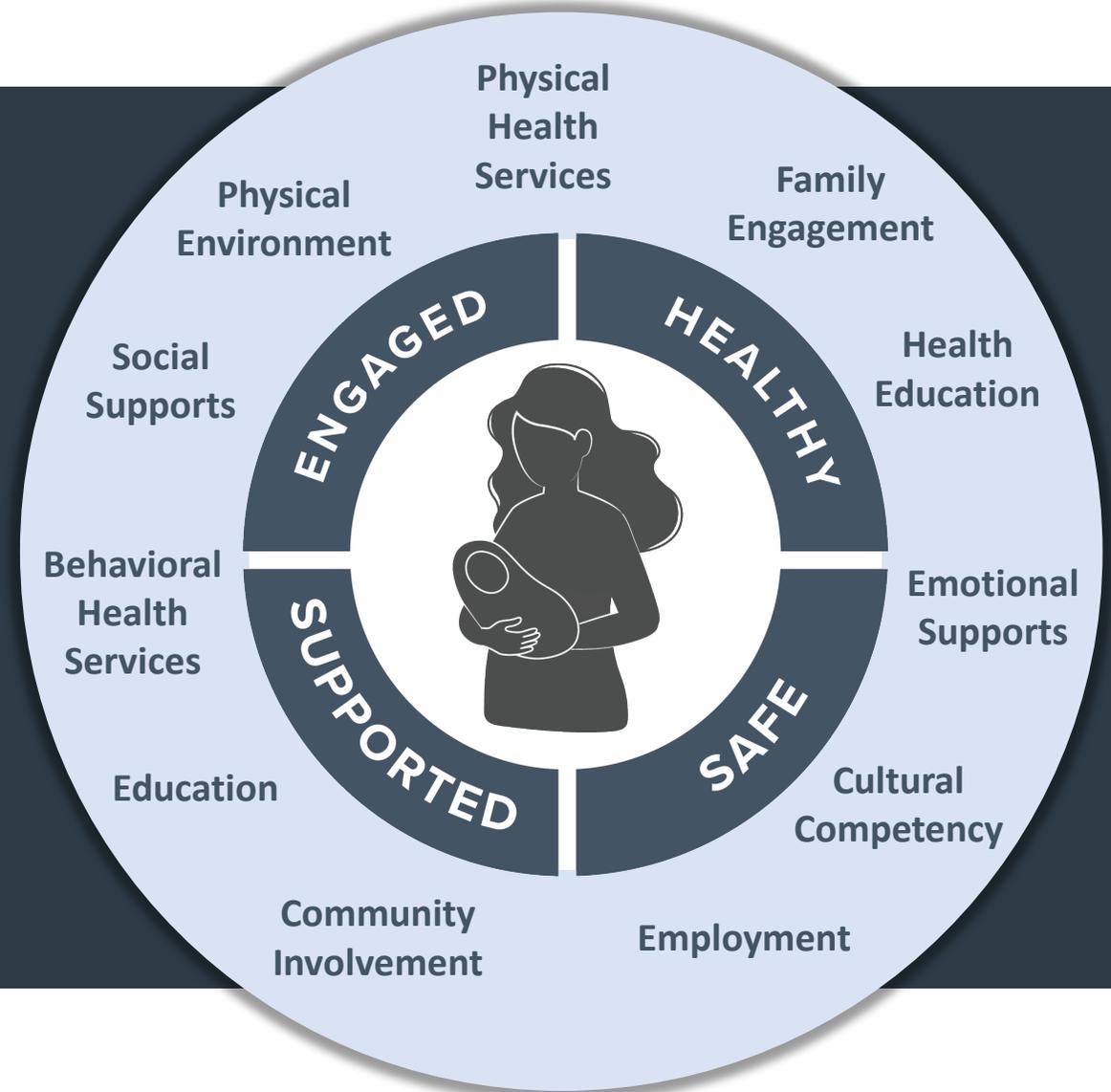
Measure and improve patient experiences



Improve statewide maternal and infant outcomes while decreasing racial disparities

Ohio Medicaid's Coordination of Clinical and Community-Based Supports and Resources

Mom & Baby Bundle creates strong incentives to integrate community-based and non-traditional services into the traditional healthcare system

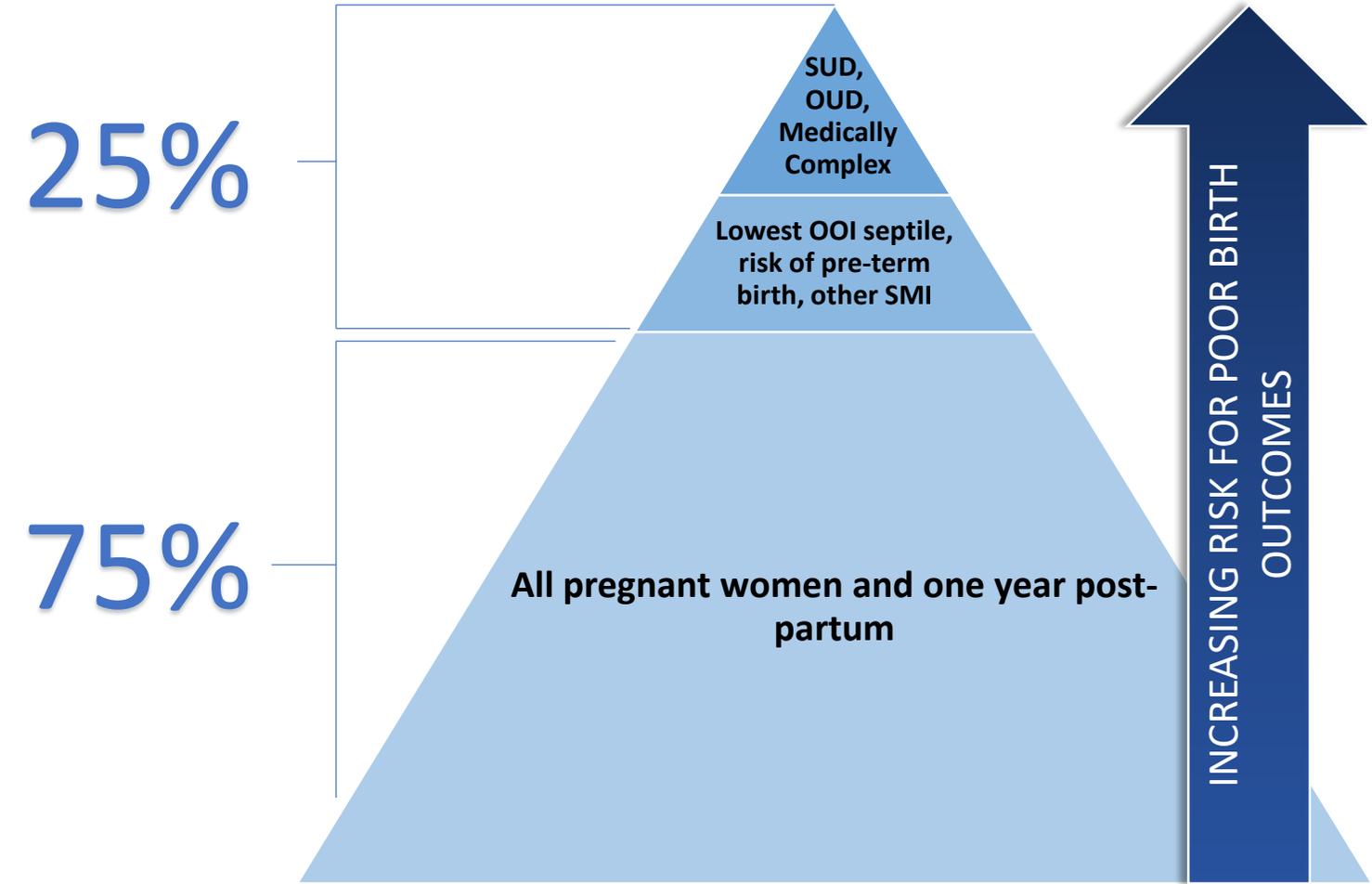


Components of Mom & Baby Bundle

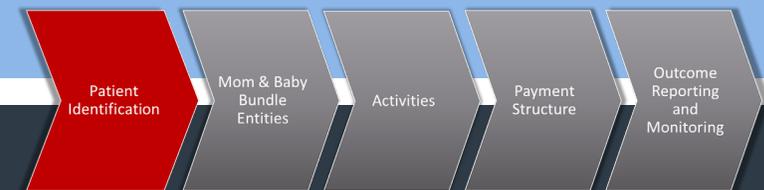




Medicaid covers 52% of Ohio's Births (that's almost 70,000 births each year)



- All pregnant and postpartum women in the Medicaid program should be offered the opportunity to receive integrated, culturally competent, longitudinal care from a team of providers and community partners they trust
- All pregnant and postpartum women will be “risk stratified” to determine the level of extra intervention they may need to have the best experience and outcomes



Identifying High-Risk Women

25% of Medicaid Moms are at risk!

How can we identify them? Data can help!



Fewer Neighborhood Opportunities

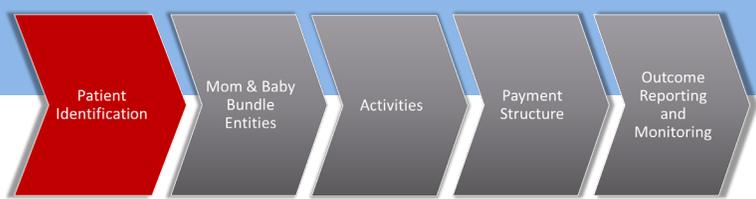
- Low graduation rates
- High unemployment rates

Higher Risk of Poor Birth Outcomes

- Previous poor birth outcome
- High risk of current poor birth outcome
- Racial and health equity disparities

Physical & Mental Health Chronic Conditions

- Asthma, Diabetes, Cardiac Conditions, etc.
- Depression, Substance Use Disorder, etc.



Patient Journey

← **Continuous Eligibility** →



Enter any time in pregnancy

Patient Identification

- "No Wrong Door"**
- Notification of Pregnancy or PRAF*
 - OBs, Hospitals, FQHCs, Emergency Department, PCPs, etc.

Risk Tiering and Attribution

- Completed by ODM
- Algorithm defined by state based on claims, vital stats, PRAF data, etc.
- Determine risk tiering for each woman who is pregnant
- Attribute to provider based on algorithm defined by the state

Planning and Engagement

- Informed Consent
- PRAF completed, if applicable
- Provider identifies Mom & Baby Bundle options based on patient risk assessment and provides choice to woman
- Provider links to selected partnering entities, PRAF sent to Help Me Grow Central Intake
- Can be performed at any prenatal appointment

Team-Based Care

- Provider coordinates ongoing health care and community supports
- Uses a family-centered approach to deliver customized interventions to the patient and her family
- Routine, planned multidirectional communication with the team, including the patient, OB, PCP, and pediatrician
- Continued care and coordination of supports up to 1 year post-partum

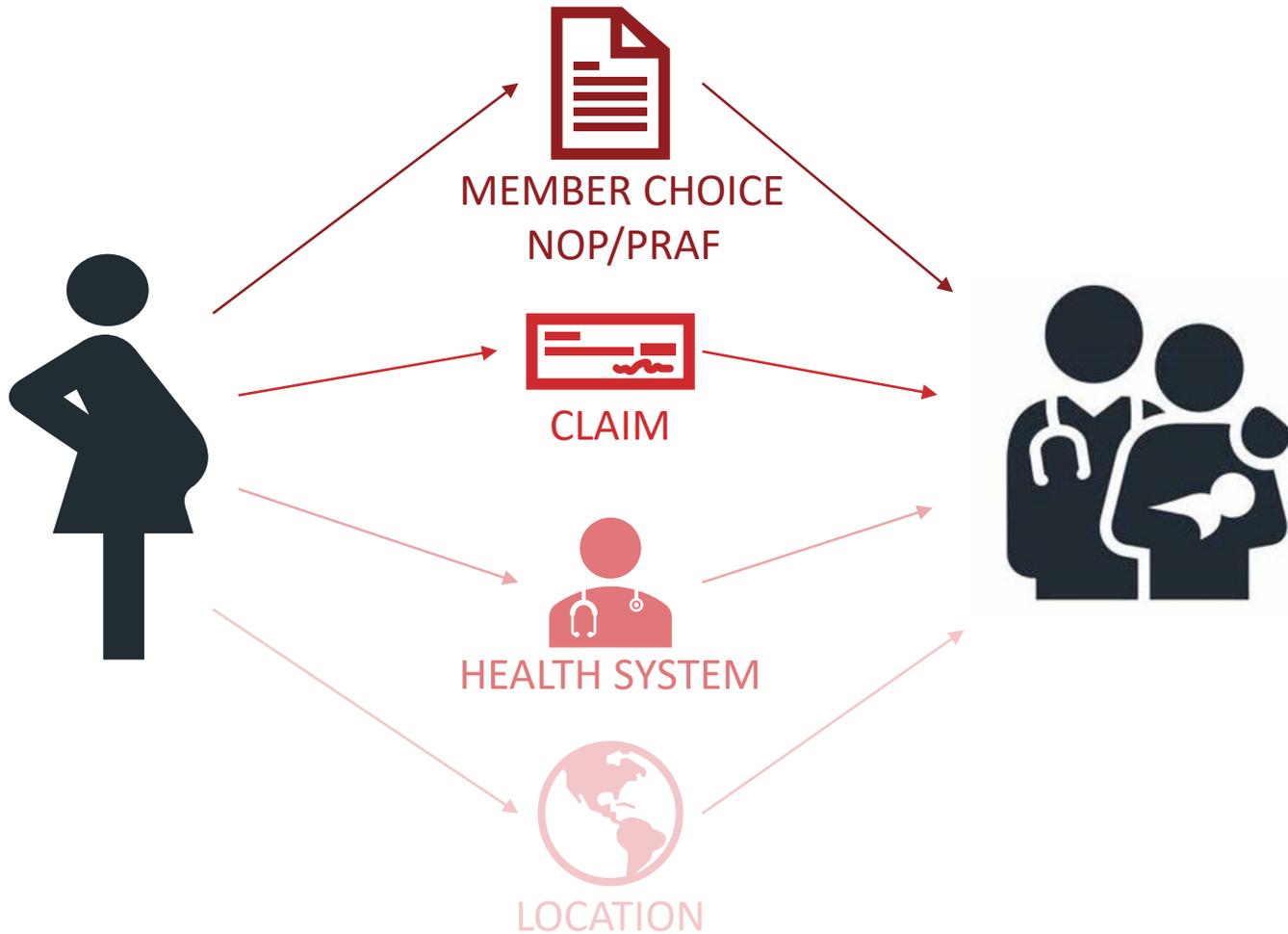


Up to 1 year of postpartum care for mom & baby

← **Routine Source of Primary Care** →

*PRAF = Pregnancy Risk Assessment Form

Mom & Baby Bundle Attribution

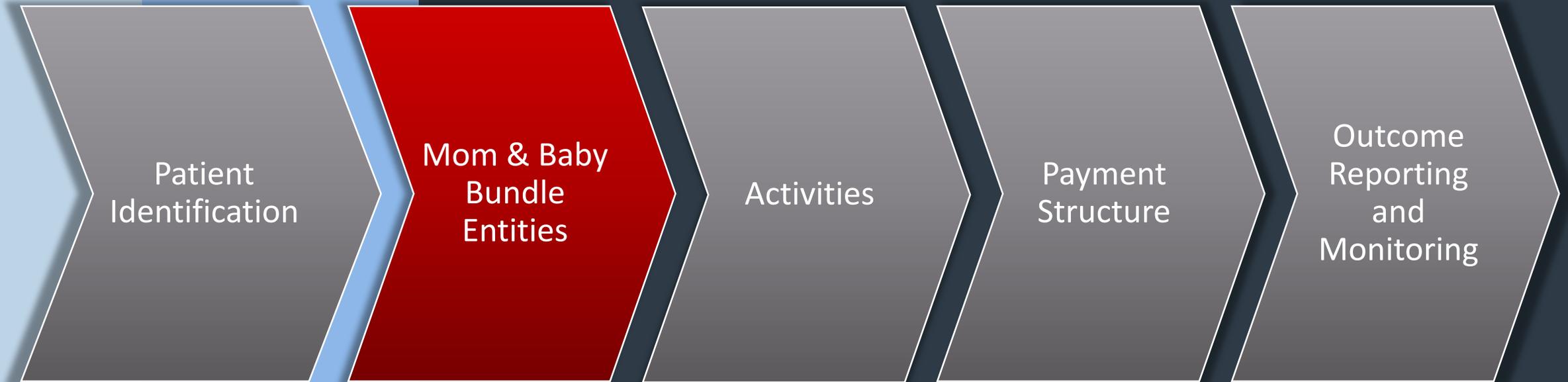


All pregnant/post-partum women will be attributed to an OB provider entity

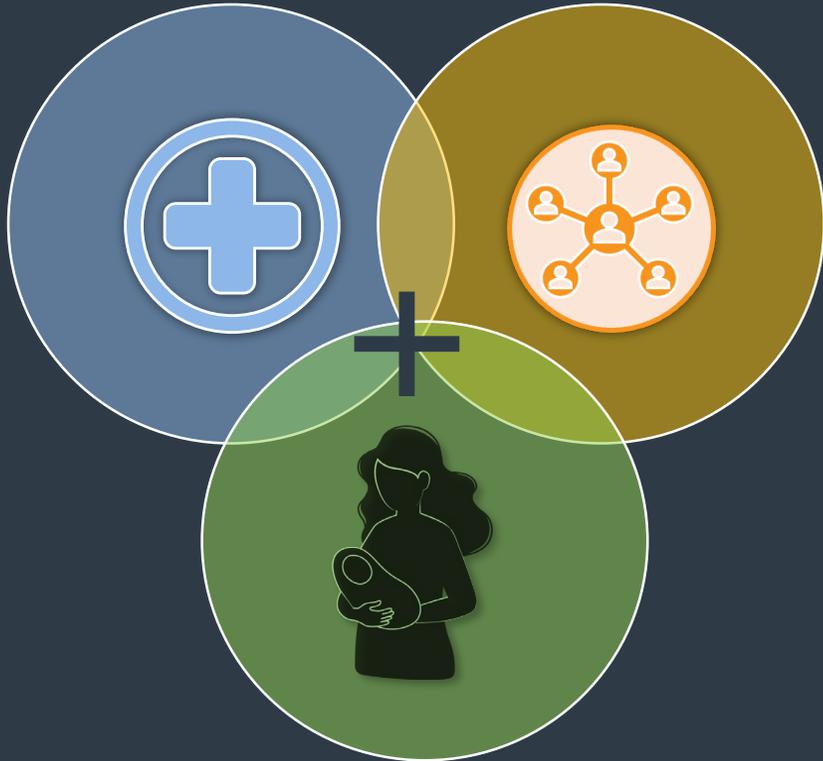
1. Member choice indicated on Notification of Pregnancy (NOP) / Pregnancy Risk Assessment Form (PRAF) sent by providers
2. Pregnancy-related claims
3. Health system relationships
4. Geography

Attribution will be updated monthly

Components of Mom & Baby Bundle



Mom & Baby Bundle Brings Health Systems and Communities Together to Support Pregnant Women and Infants to Improve Outcomes and Improve Equity



Integrate medical and community-based services through “coordinating” and “partnering” entities



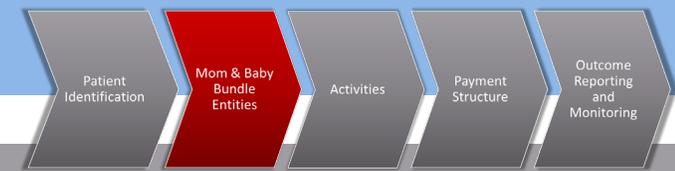
Require provider cultural competence training and reduce implicit bias



Measure and improve patient experiences



Improve statewide maternal and infant outcomes while decreasing racial disparities



Coordinating Entities (CEs) + **Partnering Entities (PEs)**

CRITERIA:

- Current Medicaid providers of prenatal & postpartum care
- Sufficient capacity to coordinate holistic patient needs
- Opportunity for systematic improvement in better patient approaches and outcomes
- Ability to exchange and use electronic data from variety of sources



CRITERIA:

- Trusted by women
- Proven improvement in patient engagement and support
- Ability to customize care for women, babies and their families
- Opportunities to coordinate non-medical care to optimize patient outcomes

ELIGIBLE PROVIDERS:

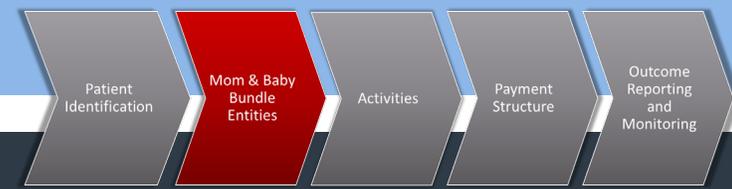
- ✓ OB/GYNs practices
- ✓ FQHCs/RHCs
- ✓ Local Health Districts
- ✓ Hospital-based practices

EXAMPLE ENTITIES:

- ✓ Doulas
- ✓ Paralegals
- ✓ Community health workers
- ✓ Peer Supporters
- ✓ Lactation consultants
- ✓ Home Visitors
- ✓ Navigators
- ✓ Pathways Community HUBs
- ✓ Public health nurses
- ✓ Other community supports

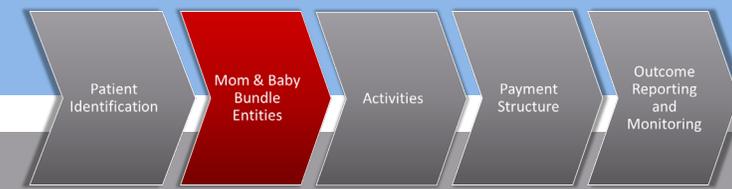


How do Providers become a Coordinating Entity?



PROCESS:

1. Meet eligibility criteria
2. Submit an application with attestation to ODM
3. Enroll as a Mom & Baby Bundle Coordinating Entity
4. Perform activity requirements, submit annual attestation and achieve outcomes



What are the requirements to receive and maintain CE status?

To become a CE, you must:

- Be a current Medicaid provider: Professional Medical Group, Hospital, FQHC/RHC, or Clinic
- Serve a minimum number of attributed Medicaid women under same tax ID
- Submit an application and attestation to the Ohio Department of Medicaid

To be approved as a CE, you must attest to meet the following by enrollment:

- Demonstrate commitment to physical and behavioral health integration
- Assure completion of cultural competency training requirements
- Establish (or adapt) a patient and family advisory council
- Participate in learning activities
- Review reports provided by ODM
- Have the following on staff/contract: a practitioner with prescribing authority, a RN/LPN, and a case manager
- Perform activity requirements
- Have contracts / arrangements with partnering entities to assist with meeting activity requirements
- Use an EHR; have ability to share & use electronic data with multiple sources



How will Partnering Entities participate?



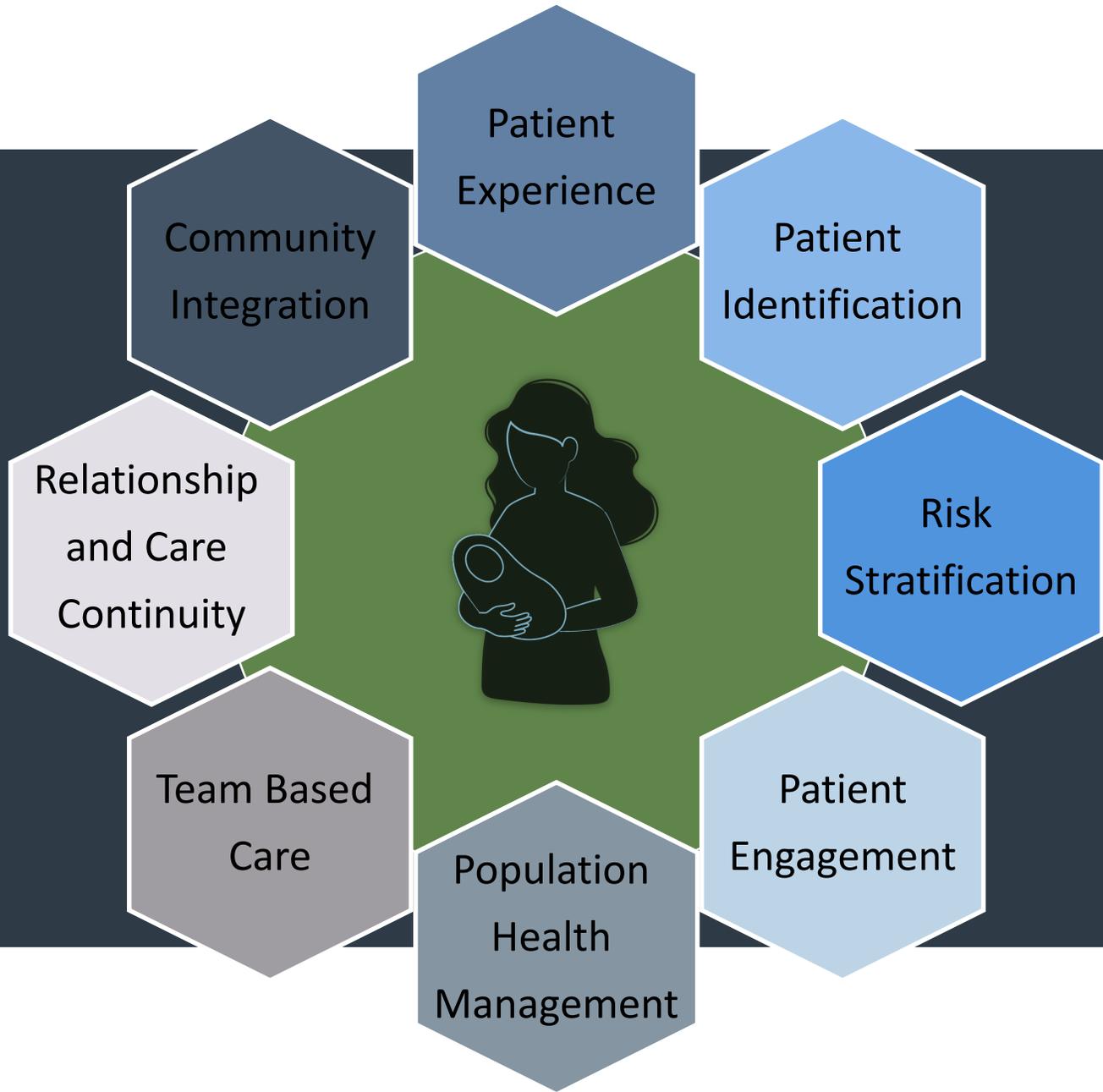
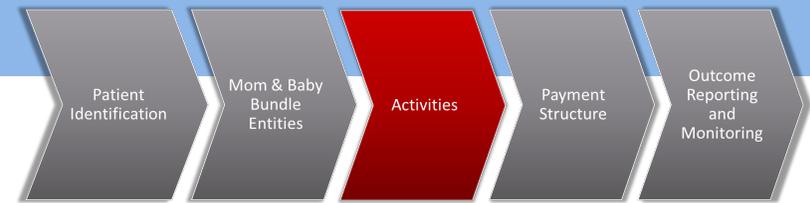
Creativity is needed to build relationships and deliver supports that meet the unique needs of women served by each CE.

SOME EXAMPLES:

- Public health nurses partner with CEs to deliver in-home post-partum visits to women and babies
- Community Pathway HUBS partner with CEs to engage women in meeting their health-related social needs (i.e. accessing SNAP, WIC, housing) before and after birth
- Legal Aid entries partners with CE to assist women and infants with housing-related and other legal challenges
- Navigators partner with CEs to ensure women begin and stay engaged in longer-term evidence-based home visiting services
- Doulas partner with CEs to deliver prenatal, labor, and post-partum supports
- Child care providers partner with CEs to ensure women can participate in weekly group pregnancy and parenting programs
- Community health workers partner with CEs to identify and engage attributed women in perinatal care

Components of Mom & Baby Bundle

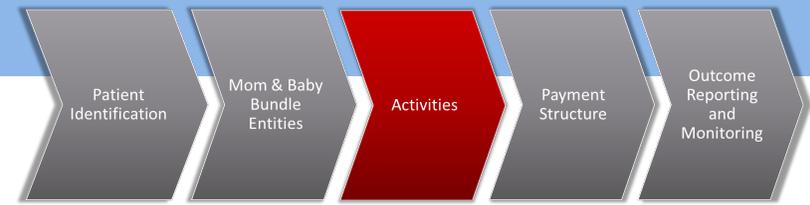




Activity Requirements

Coordinating Entities will receive a prospective per-member, per-month (PMPM) payment for each attributed patient to perform activity requirements as needed.

Coordinating Entities must collaborate with Partnering Entities to successfully perform the activity requirements



Activity Requirements

Patient Identification

- Identifies eligible women using ODM attribution files and the pregnancy risk assessment form (PRAF)
- Has a process to accept referrals from multiple sources; assures a PRAF is submitted for every pregnant woman.

Risk Stratification

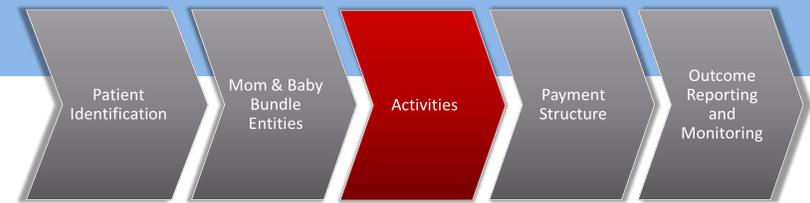
- Uses risk stratification information from multiple sources including, but not limited to, payers, PRAF, screening tools, electronic health records, and patient history

Patient Engagement

- Engages patients early in their care and encourages them to be active participants in care delivery
- Delivers services in a manner that meets the social, cultural, and linguistic needs of the women
- Assures appropriate consents are in place to support full exchange of information
- Educates women about program participation benefits including services available through community partner entities.

Population Health Management

- Identifies women in need of medical, behavioral, or community support services and implements an ongoing multifaceted outreach effort to connect the patient to needed services and supports
- Practice has a planned strategy to improve population health



Activity Requirements

Team Based Care

- Defines care team members (incl. OBs, primary care, and pediatricians), roles, and responsibilities
- Establishes care team meetings and planned, formal communication among team members
- Has active relationships with other health providers and partnering entities based on patient population needs
- Tracks and follows up on referrals to medical, behavioral health and community services; ensures no gaps in care

Relationship and Care Continuity

- Has a process to honor continuity in relationship with medical providers and h partnering entities
- Plans for transition of patients to appropriate providers and resources as move through the care continuum.
- Ensures warm hand-offs are made to primary care for mom and pediatric primary care for baby

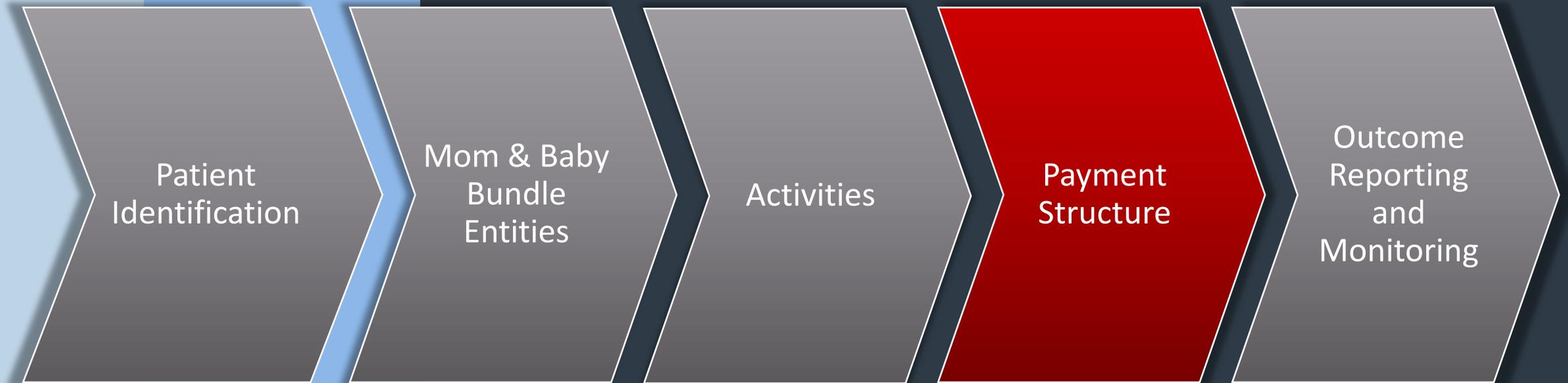
Community Integration

- Prioritized the use of partnering entities for the provision of Mom & Baby Bundle activities
- Has a documented community engagement plan involving women served; regularly meets with key local stakeholders to collaborate on shared goals of improving maternal and infant outcomes
- Tracks documented, assessed community needs and local entities that can help patients meet those needs.

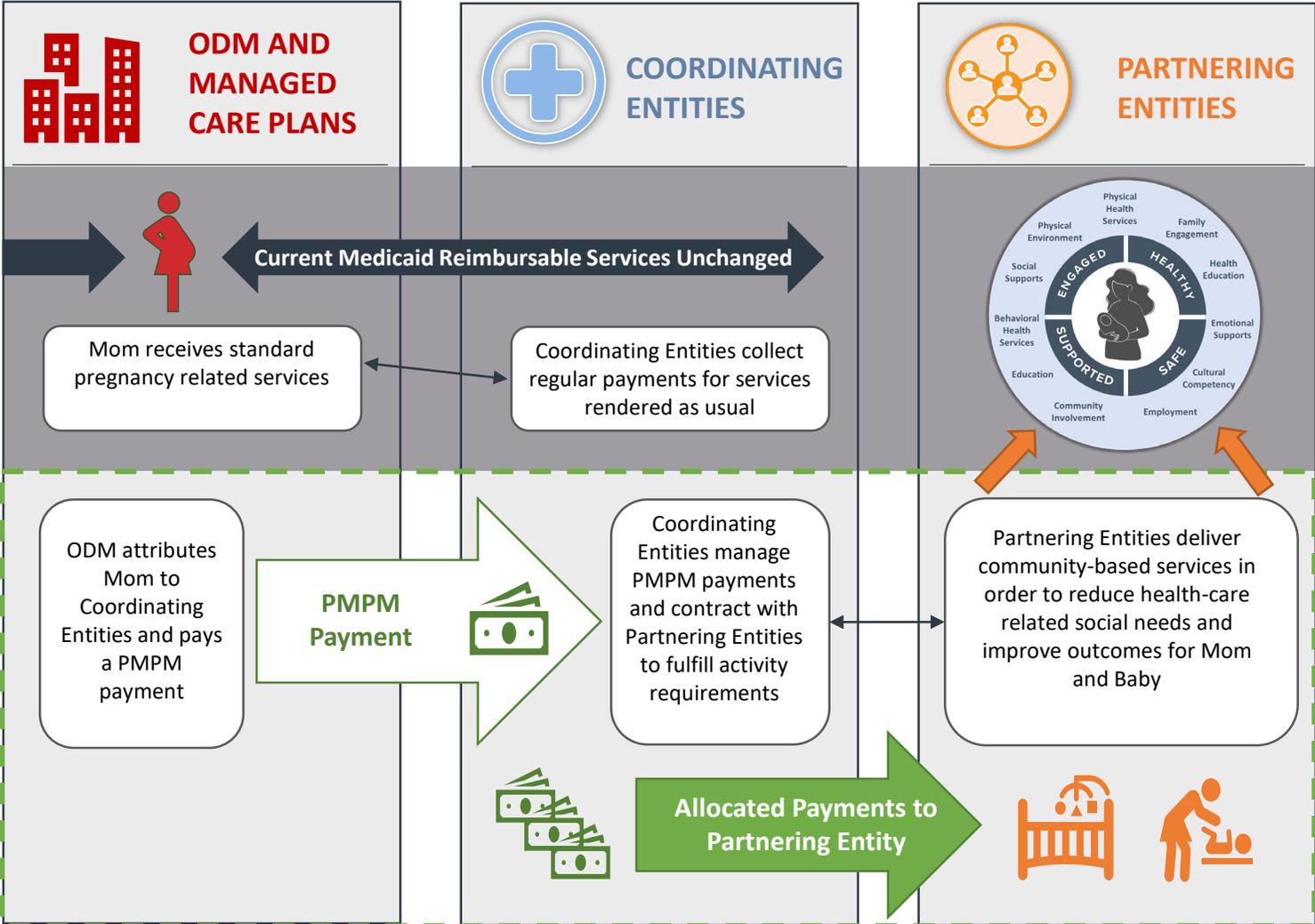
Patient Experience

- Assesses its approach to improving the patient experience at least once annually through quantitative and qualitative means covering topics such as access to care, cultural competence, holistic care, etc.
- Identifies and acts on improvement opportunities to better the patient experience and reduce disparities
- Feeds information back to the patient, partnering entities, patient and family advisory council, ODM, and MCPs.

Components of Mom & Baby Bundle



Mom & Baby Bundle Reimbursement Flow

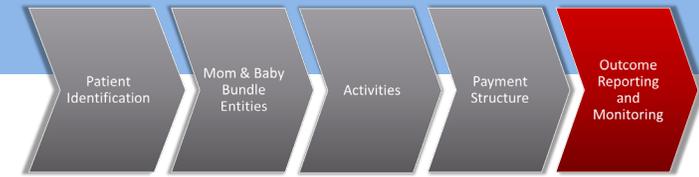


Coordinating entities are held accountable for meeting the activity requirements, which can only be completed with the help of the partnering entities.

This promotes connection between providers of medical and community-based services.

Components of Mom & Baby Bundle





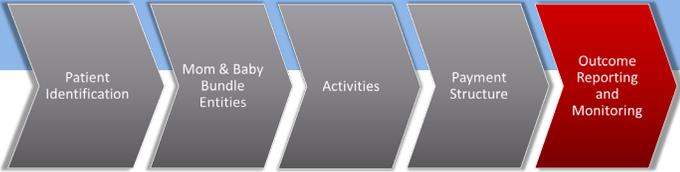
Potential Quality Metrics

LINKED TO PAYMENT - DRAFT

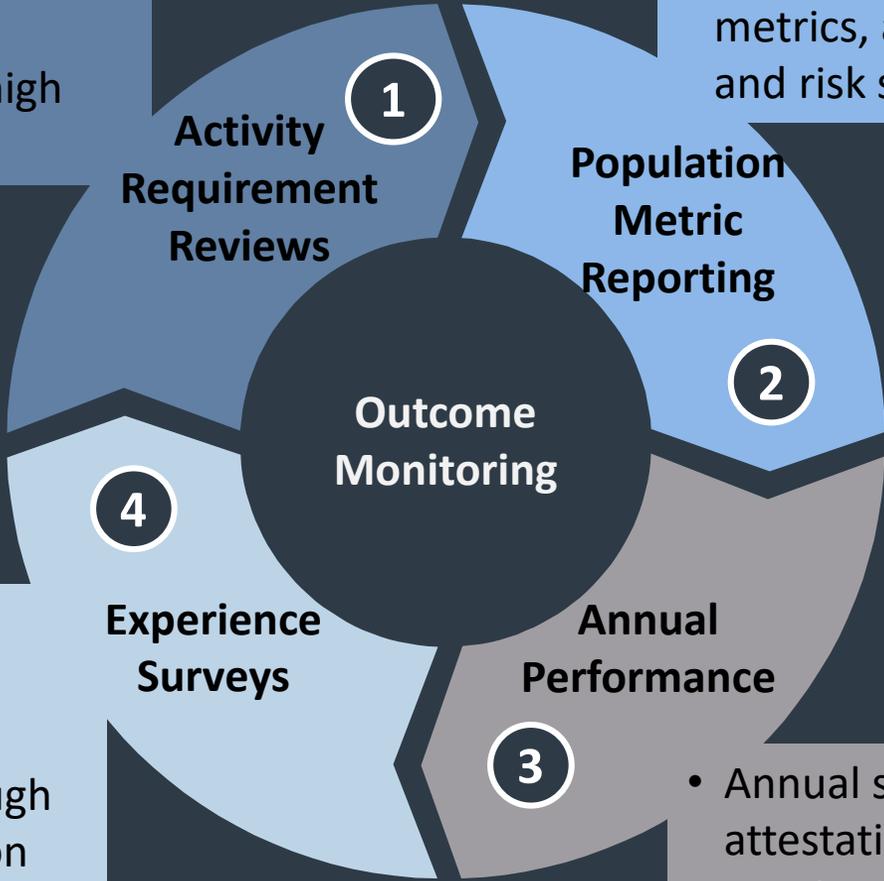
C-Section Rate
Community-Based Supports
Follow-up Visits
High Risk Composite
<ul style="list-style-type: none"> Behavioral Services Progesterone Administration New Opioids Fill Rate SUD Treatment
HIV Screening

INFORMATION ONLY - DRAFT

Breastfeeding at discharge
Breastfeeding at 6 months
Depression Screening
Enrolled in Evidence-Based Home Visiting
Enrolled in WIC
Hepatitis B screening
Low-birth Weight
Pre-term Birth
Primary Care Visits for Mom
Primary Care Visits for Baby
Tdap and Flu Vaccine
Tobacco Cessation



- Desk review for all practices
- On-site reviews for high and low performers



- Quarterly reporting on quality and efficiency metrics, as well as population composition and risk shifts

Outcome Reporting and Monitoring

Annual Performance Monitoring

- Real-world assessments of performance as determined through patient satisfaction

- Annual synthesis of all aspects of performance, re-attestation to commit to continuing to meet requirements



Questions & Discussion

A photograph of four diverse babies sitting on a white reflective surface. From left to right: a baby with dark hair, a baby with light skin and blue eyes, a baby with dark skin and curly hair, and a baby with light skin and dark hair. They are all looking towards the camera. A red banner with white text is overlaid across the middle of the image.

Break – 10 Minutes
Small Group Discussions

Small Group Discussions – Sample Questions

- From the lens of a potential participant in the Mom & Baby Bundle, what do women need from this model that has/has not already discussed here today?
- As a Coordinating Entity, what should be added/changed to ensure the model has the desired impacts to improve health outcomes and reduce disparities?
- How does ODM ensure accountability and value with this new model?
- As a Partnering Entity, do you have what you need to form relationships with CEs participating in the model?



Next Steps & Timeline

Next Steps

- **Timeline: Mom & Baby Bundle is expect to begin by the end of 2020**
- There will be many more opportunities to provide input into the design:
 - A follow up survey will be sent to participants to solicit additional feedback
 - ODM will schedule Clinical Advisory Groups in the near future to explore:
 - Specific design elements: activity requirements, leveraging PRAF and NOP data, risk tiering, outcome metrics
 - Training and technical assistance needs for PEs and CEs
- ODM will hold additional stakeholder engagement re: other components of the Maternal and Infant Support Program
 - Nurse home visiting
 - Mom / baby dyad
- Please sign up for our email list on the Mom & Baby webpage

Thank you

For more information, contact:

MISP@medicaid.ohio.gov