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.
Opportunity for Every Ohio Kid
Children’s Initiatives Goals

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
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.
Cross Agency Leadership Team

Ohio Department of Developmental Disabilities

Ohio Department of Education

Ohio Department of Health

Ohio Department of Medicaid

Ohio Department of Mental Health & Addiction Services

Ohio Department of Job & Family Services
90% of a child’s brain development happens before age 5
Coordinating Policy, Process and Practice

Integration of community-based services into the traditional healthcare system

Women’s Wellness Wheel™
Increasing Support for Ohio Families

- **FY 2019 Actual**: Statewide Investment $33.9M
- **FY 2020 Appropriations**: Statewide Investment $60M
- **FY 2021 Appropriations**: Statewide Investment $89.4M

Programs supported:
- IM Grants (Commission on Minority Health)
- IM Grants (ODM)
- Help Me Grow (ODH)
- MISP (ODM)
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.

Maternal Mortality By The Numbers

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

- 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.

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.
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
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

- Patient Identification
- Mom & Baby Bundle Entities
- Activities
- Payment Structure
- Outcome Reporting and Monitoring

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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.

INCREASING RISK FOR POOR BIRTH OUTCOMES

- 75%: All pregnant women and one year postpartum

- 25%: SUD, OUD, Medically Complex

- Lowest OOI septile, risk of pre-term birth, other SMI
25% of Medicaid Moms are at risk!

How can we identify them? Data can help!

- Low graduation rates
- High unemployment rates
- Previous poor birth outcome
- High risk of current poor birth outcome
- Racial and health equity disparities
- Asthma, Diabetes, Cardiac Conditions, etc.
- Depression, Substance Use Disorder, etc.
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

Continuous Eligibility

Routine Source of Primary Care

Patient Journey

*PRAF = Pregnancy Risk Assessment Form

Enter any time in pregnancy

Up to 1 year of postpartum care for mom & baby

Ongoing care and coordination of supports up to 1 year post-partum
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
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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

**ELIGIBLE PROVIDERS:**
- OB/GYNs practices
- FQHCs/RHCs
- Local Health Districts
- Hospital-based practices

**EXAMPLE ENTITIES:**
- Doulas
- Paralegals
- Community health workers
- Peer Supporters
- Lactation consultants

**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

**EXAMPLE ENTITIES:**
- 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
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
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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

- 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.

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

- 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.

- 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
- 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
- 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.

Relationship and Care Continuity
- Has a process to honor continuity in relationship with medical providers and 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
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- 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
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Community Integration
- 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.

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
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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.
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## Potential Quality Metrics

### LINKED TO PAYMENT - DRAFT
- C-Section Rate
- Community-Based Supports
- Follow-up Visits
- High Risk Composite
  - 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

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

Outcome Reporting and Monitoring
Annual Performance Monitoring
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 expected 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:

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