Ohio | Department of Medicaid

Ohio Medicaid's Mom & Baby Bundle

Community Advisory Group Meeting

January 29, 2020

Agenda

- Welcome and Introductions
- Patient Example Journey
- Cultural Competency Requirements
- Activity Requirements
- Next Steps

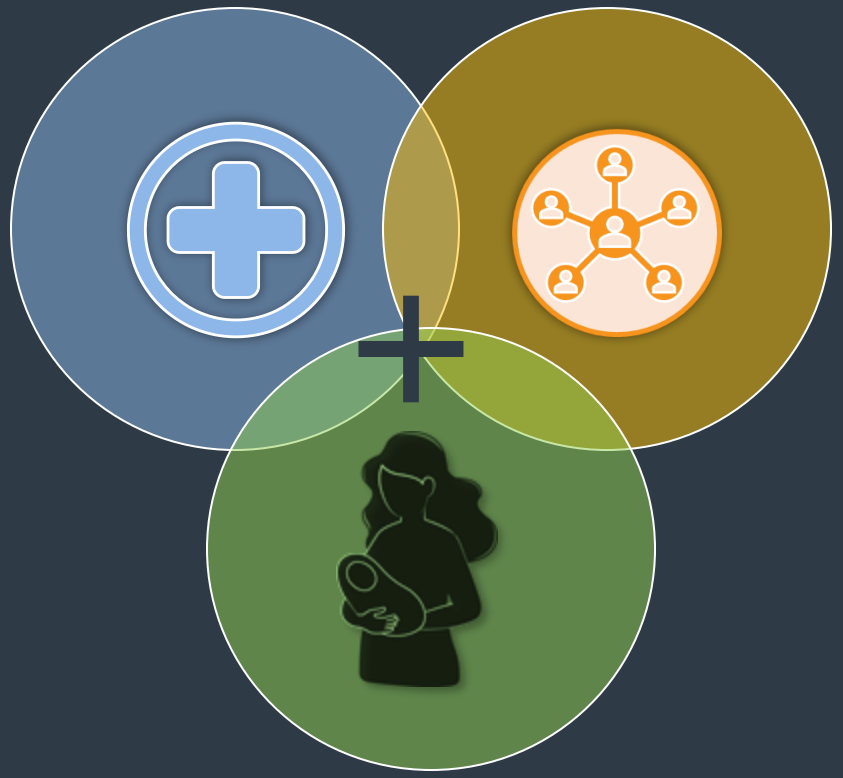
Housekeeping

- 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.
  - https://medicaid.ohio.gov/INITIATIVES/Maternal-and-Infant-Support/Mom-Baby-Bundle

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 Brings Health Systems and Communities Together to Support Pregnant Women and Infants to Improve Outcomes and Improve Equity



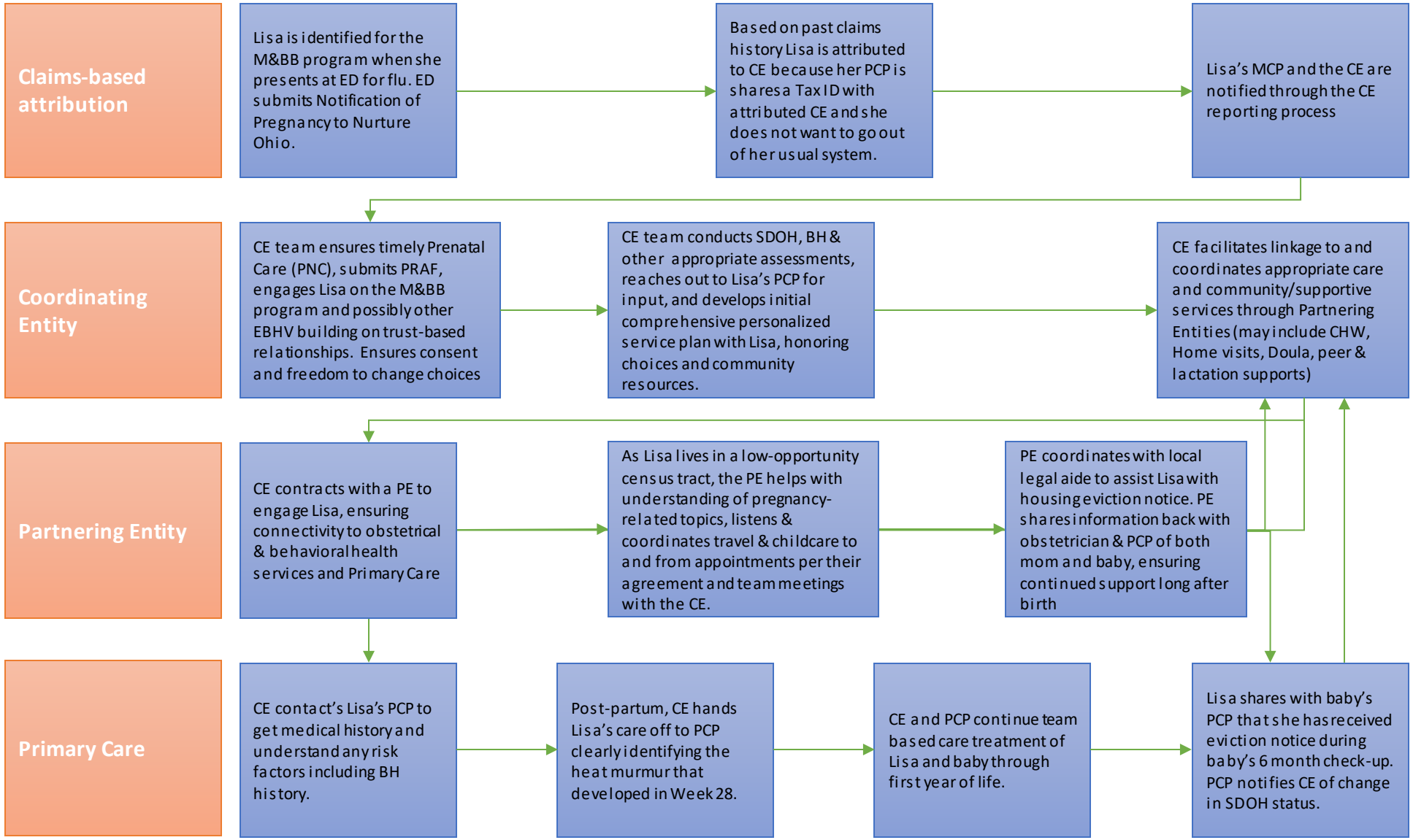
- **Integrate medical and community-based services through "coordinating" and "partnering" entities**
- **Require provider cultural competence training and reduce implicit bias**
- **Measure and improve patient experiences**
- **Improve statewide maternal and infant outcomes while decreasing racial disparities**

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

Women's Wellness Wheel ™

Hypothetical Patient Scenario: Low Opportunity Index Resident



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

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:

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

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

Cultural Competence Requirements - CEs

What we proposed	What we heard from stakeholders	What we revised
• Assure all clinical and professional staff who interact with patients must complete cultural competency training within 6 months of enrollment and on annual basis (deemed acceptable by ODM)* • Assure that new employees complete within 90 days of start date • Verify that PEs that interact with patients complete cultural competency training on an annual basis • Assess cultural demographics of clients served at least annually and have a plan to adapt cultural and linguistic competence training needs based on assessment	• Need diversified workforce • Lived experience can add value to cultural competency • Program pays the entities that have promulgated structural racism • CEs have to operationalize cultural competency training provided to staff	• Develop/enhance the CE's cultural competence policy and integrate throughout planning and operations to assure that services and supports are culturally appropriate for individuals with diverse backgrounds, values, beliefs and practices. • Develop an effective educational or training program to assure training requirement timeframes are met for current/new employees and includes a provision to annually assess cultural demographics and update training needs accordingly.

*Kirwan Institute Implicit Bias; Physician's Practical Guide to Culturally Competent Care; or meets criteria specified by ODM

ODM proposes the following criteria to evaluate CE's ability to meet cultural competency requirements:

Does not meet expectations:

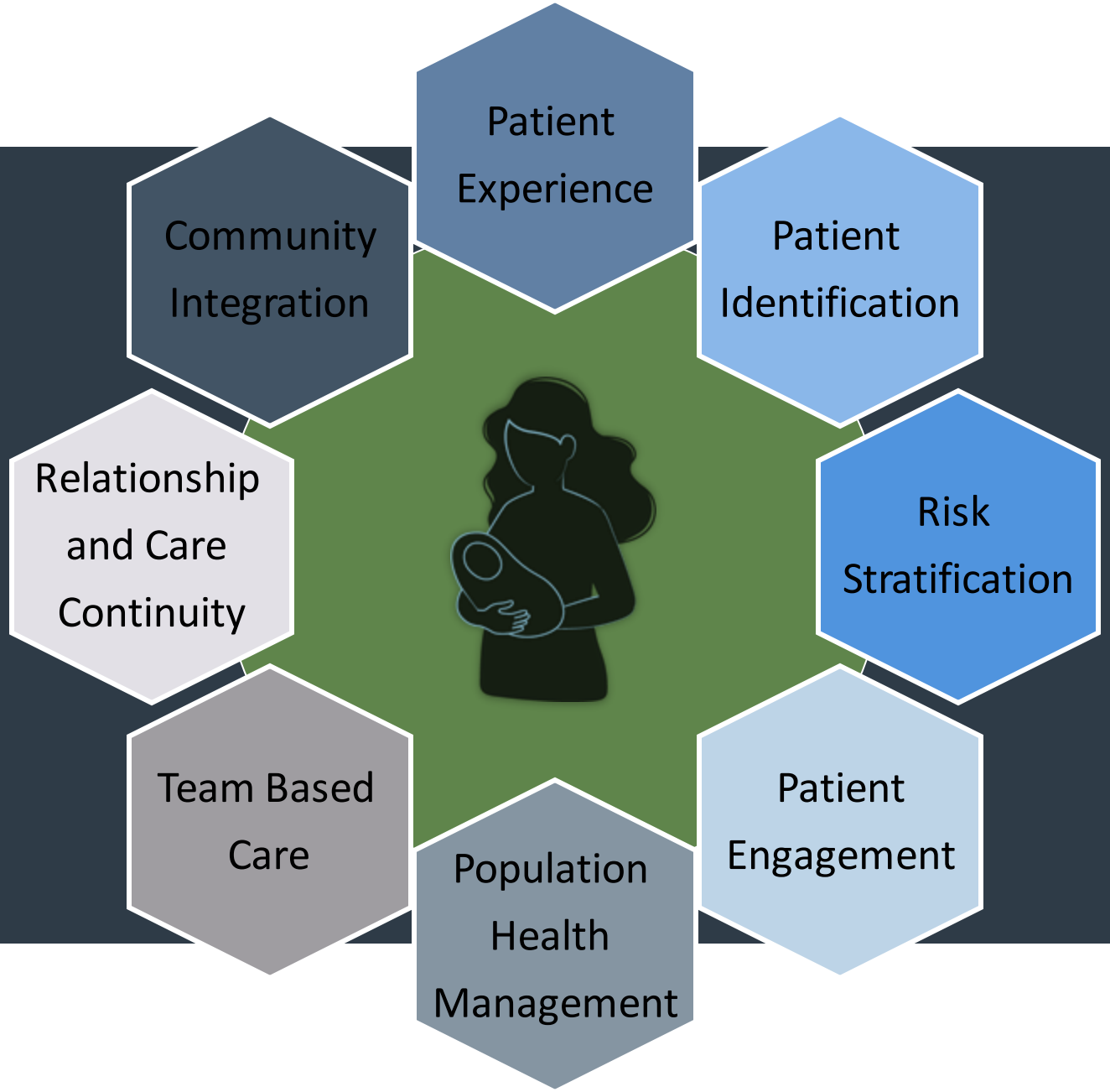
- CE does not have a comprehensive training program that assures current staff are trained within 6 months of enrollment and annually thereafter; nor has a requirement for new employees to complete training within 90 days of start date.
- CE does not have method to verify that PEs complete cultural competency on an annual basis.
- CE does not have an organization-wide cultural competence policy.

Meets Expectations:

- CE has a comprehensive training program deemed acceptable by ODM for current and new employees, administered within required timeframes.
- CE has a method to ensure all partners who come into contact with a woman have received cultural competency training on an annual basis.
- CE has an organization-wide cultural competence policy.

Exceeds Expectations:

- CE has an organization-wide cultural competence policy that is integrated throughout planning and operations. Policy includes the following components: guiding principles; governance, leadership and workforce; communication and language assistance; continuous improvement and accountability, etc.
- CE has a comprehensive and effective training program deemed acceptable by ODM for current and new employees, administered within required timeframes. Training program includes an assessment of staff knowledge on cultural competence, various training methods, ongoing education requirements, and a method to measure and track health care disparities data, patient satisfaction, etc. that is used to inform service delivery.



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

What we proposed	What we would like to know
Patient Identification • Have a process to accept referrals from multiple sources • Identify women who are eligible for the mom and baby bundle program using ODM attribution files and the PRAF	• ODM intends to enable non-OB providers (EDs, partnering entities) to submit a web-based notification of pregnancy. Would CEs leverage this function and in what way? • What is missing? What needs further clarification?
Risk Stratification • Use risk stratification information from multiple sources including payers, PRAF, screening tools, electronic health records and patient history • Assure a PRAF is submitted for every attributed Medicaid individual	• Does your organization have experience with risk stratification today? • Does your organization submit the PRAF today?

Activity Requirements (cont.)

What we proposed	What we would like to know
Patient Engagement • Engage attributed Medicaid individuals early in their care and encourage them to be active participants in their care delivery • Deliver services in a manner that meets the social, cultural, and linguistic needs of the attributed Medicaid individuals • Ensure appropriate consents are in place to support full exchange of information in compliance with state and federal regulations • Educate attributed Medicaid individuals about program participation in benefits including services in the community through community partner entities	• What level of effort is required by your practice to engage patients? • What are challenges that your practice faces with locating and/or engaging patients that you could use help with? • How do you think your engagement efforts could be enhanced? • What resources/strategies can partnering entities offer to assist with patient engagement? • What is missing from this activity? What needs clarification?

Activity Requirements (cont.)

What we Proposed	What we would like to know
Population Health Management • Identify attributed Medicaid individuals 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 • Have a planned improvement strategy	• What strategies do you use today to improve population health? • How do you see efforts being enhanced through this model? • What data points do you need to access to perform this activity? • What are we missing? What needs clarified?
Team Based Care • Define care team members (including OBs, primary care, and pediatricians, as applicable) and their roles and responsibilities • Establish care team meetings and planned, formal communication among team members • Have active relationships with providers and community partnering entities based on patient population needs. • Track and follow up on referrals to medical, behavioral health, and community service providers rendering medical and supportive services through the partnering entities.	• Who are care team members in your practice today? • How do you see the care team being enhanced through this model? • How do you hold care team meetings and share information both within and across sites/providers of care? • What strategies does your practice/entity use to track and follow up on referrals? What data do you need to access to perform this activity? • What are we missing? What needs clarified?

Activity Requirements (cont.)

What we proposed	What we would like to know
Relationship and Care Continuity • Plan for transition of attributed Medicaid individuals to appropriate providers and resources as they move through the care continuum • Have a process in place to honor continuity in relationship with providers rendering medical and supportive services through partnering entities	• What experience does your organization have with assuring continuity in provider-patient relationships within/across organizations? • How do you think this could be enhanced through the MBB model? • What are we missing? What needs clarified?
Community Integration • Prefer and offer the use of community partnering entities for the provision of supportive services to attributed Medicaid individuals • Have a documented support and engagement plan including regularly scheduled collaboration opportunities with key stakeholders to discuss shared goals of improving maternal and infant outcomes and strengthening relationships between the community and health care system • Track documented, assessed community needs and local entities that can help attributed Medicaid individuals meet those needs	• Relationships and arrangements between the CEs and PEs is a planned discussion at the Community Advisory Group scheduled for January 30.

Activity Requirements (cont.)

What we proposed	What we would like to know
Patient Experience • Assess its approach to improving the patient experience at least once annually through quantitative means covering access to care, cultural competence, holistic care and self-management support • Use the collected information to identify and act on opportunities to improve patient experience and reduce disparities • Provide information back to the patient, the community partnering entities, patient and family advisory council, the MCPs, and ODM.	• What tools do you use to evaluate patient experience across multiple domains? • Do you have a process today to identify and act on opportunities to enhance the patient experience? • Does your organization have a patient and family advisory council that routinely meets to review patient satisfaction/experience data? • What is missing? What needs clarification?

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 was sent to all participants in the Jan. 9 meeting to solicit additional feedback
  - Draft rule will be posted to Mom & Baby Bundle webpage for informal review
- ODM will hold additional stakeholder engagement regarding 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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