

Comprehensive Maternal Care Program

December 14, 2021

Governor DeWine's Children's Initiative

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
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.



Coordinating Policy, Process and Practice

*Integration of community-based services into
the traditional healthcare system*



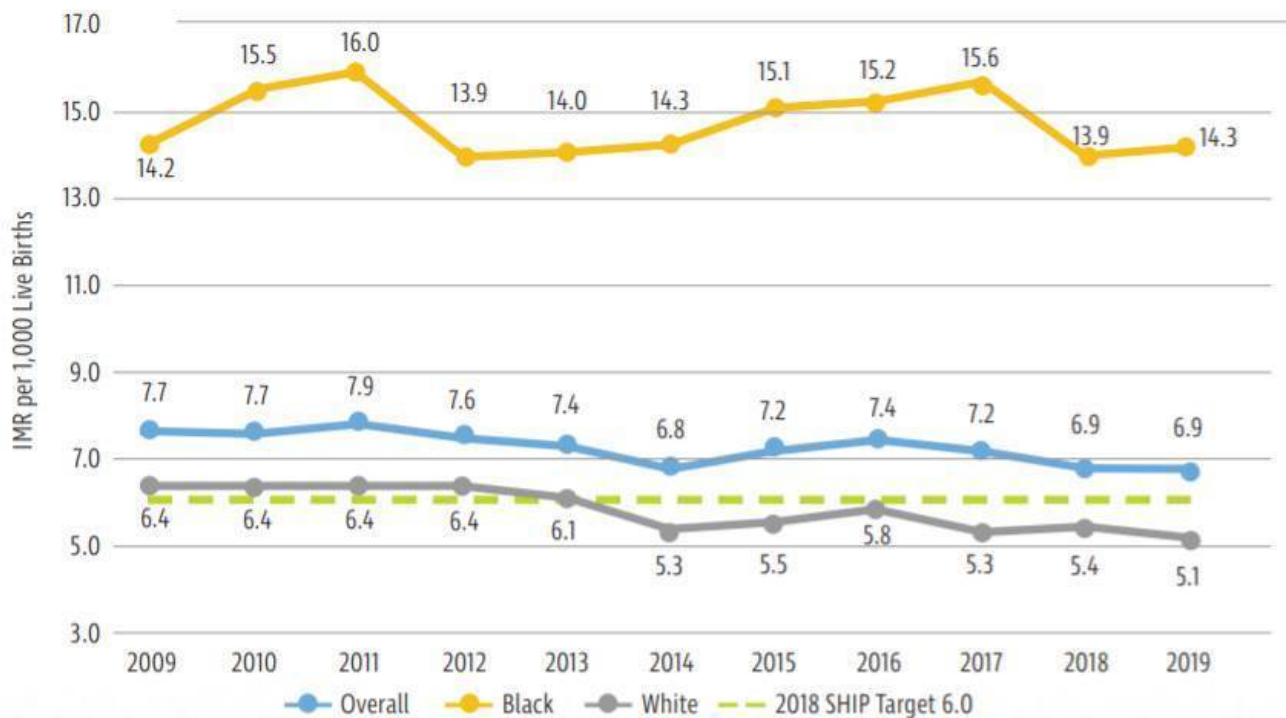
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Ohio's Infant and Maternal Mortality Opportunities

Infant Mortality By The Numbers

Figure 2: Infant Mortality Rate (per 1,000 live births) by Race, Ohio (2010 – 2019)

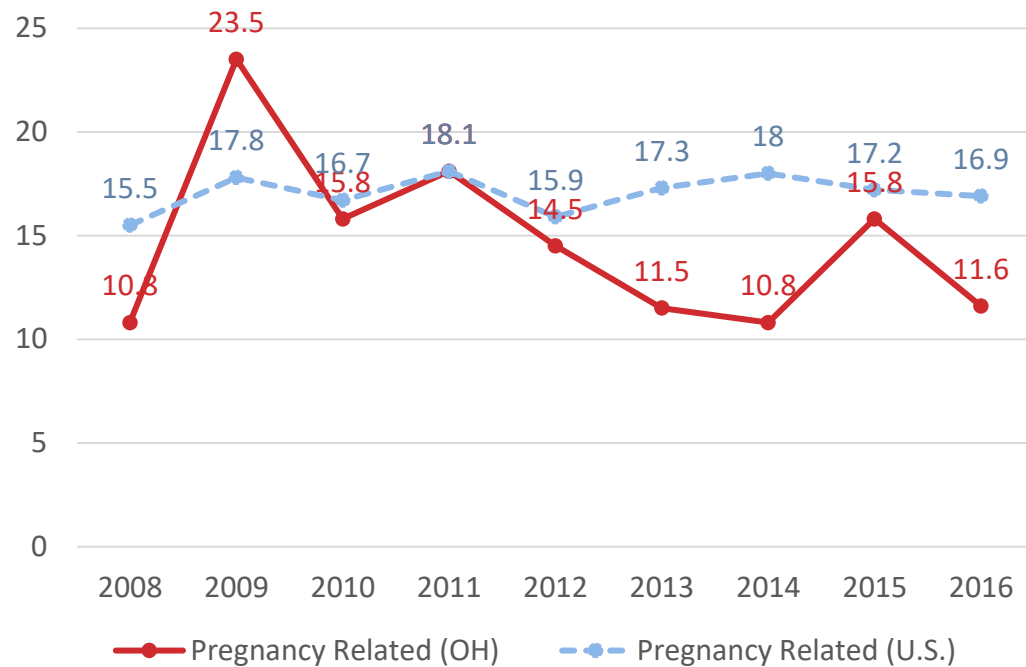


Data Source: Resident Birth and Mortality Files from the Ohio Department of Health Bureau of Vital Statistics.

- Ohio had its second lowest infant mortality rate in a decade in 2018-2019.
- The gap between Black and white infant mortality rates remains unacceptably large.
- In 2019, one in every 70 Black babies did not live to see their first birthday.

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.

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/pregnancy-associated-mortality-review> Accessed on 12/02/21

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)



Department of
Medicaid



ODM's Investments in Healthy Moms and Babies – Learnings and Opportunities

Key Infant Mortality Community Learnings



In communities with Medicaid-funded CBOs, women have expressed the following key barriers to improved 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...



"...having to wait eight weeks to see a doctor, after I found out I was pregnant was really hard for me, especially after I lost a baby. I was scared that I was going to lose another one, and now they are telling me I have to wait eight weeks to see a doctor."

...How we are attempting to
change



ODM's statewide initiative to address people's concerns by developing a comprehensive **maternal and infant support program**

- Enhance access to services and supports
- Improve patient experiences and outcomes

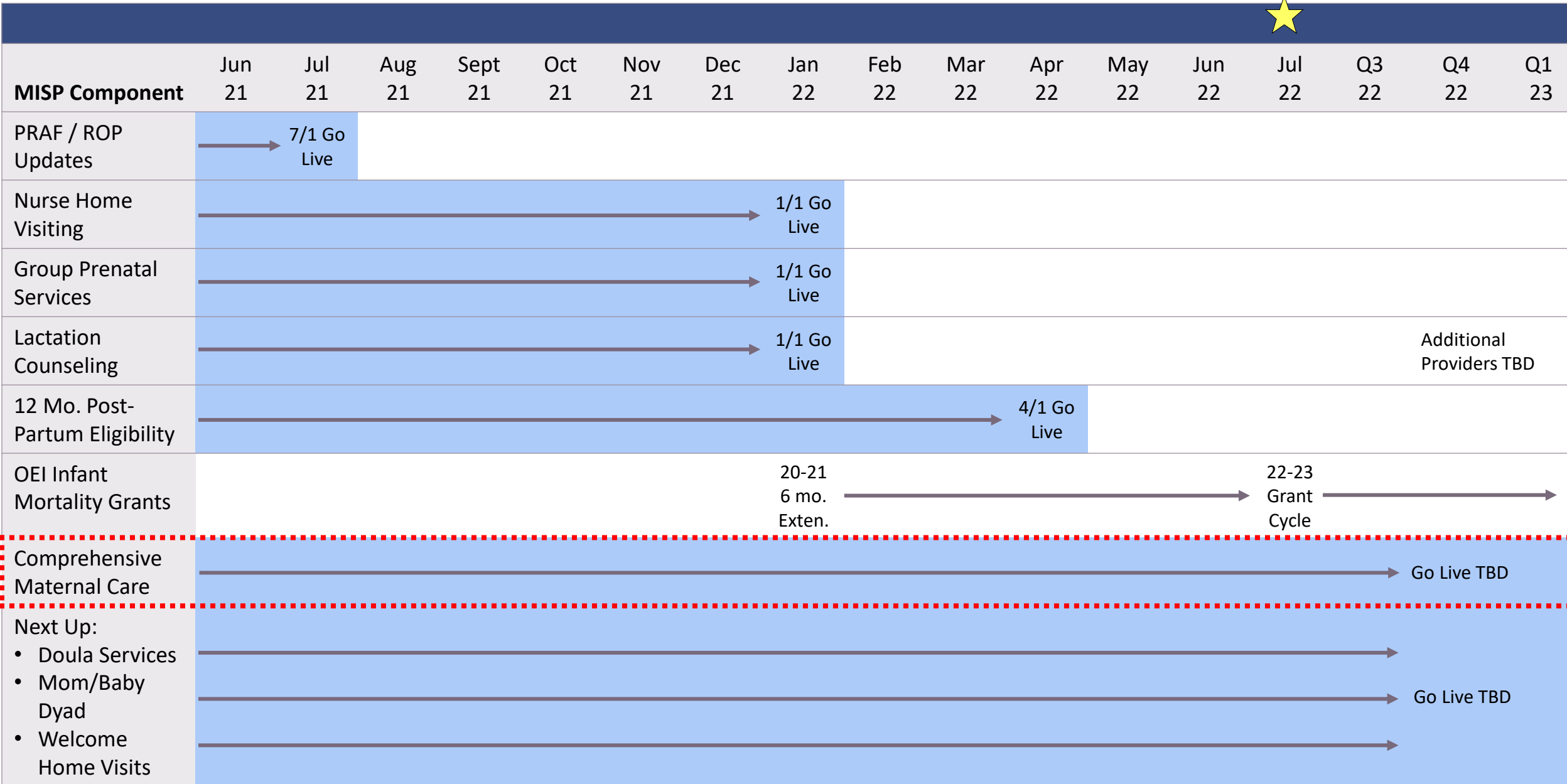
What is the Maternal and Infant Support Program (MISP)?

MISP is the umbrella term for program changes that provide additional support to moms and babies and includes:

- Pregnancy Risk Assessment Form (PRAF) updates and increased reimbursement
- Report of Pregnancy (ROP) creation and reimbursement
- Nurse home visiting
- Group pregnancy services
- Lactation consultants and services, including DME updates
- 12-month postpartum Medicaid coverage
- Continuation of Ohio Equity Institute Infant Mortality Grants with MCOs
- Comprehensive Maternal Care
- Doula services
- Mom / Baby Dyad
- Welcome home visits

MISP Timeline

Next Generation
of Managed Care
Go-Live





Department of
Medicaid



Comprehensive Maternal Care Program

Ohio's vision for CMC is to promote customized, high-quality, continuous and comprehensive **equitable** perinatal care

- ✓ Improved maternal and infant outcomes
- ✓ Improved provider cultural competency
- ✓ Improved patient experience
- ✓ Improved cross-system collaboration

- Give women and their families the clinical and community supports they need to improve outcomes, while helping them build a longitudinal trusting relationship within the health care system
- Deliver person-centered, customizable interventions to women and babies by creating a framework for providers and community partners to work together

Alignment to ACOG Perinatal Care Guidelines

- Ensure access to services
- Identify risks early
- Provide linkage to the appropriate level of care
- Ensure adherence, continuity, and comprehensiveness of care
- Promote efficient use of resources

CMC – What it is

- A comprehensive population health strategy for OB-GYN practices specific to women of reproductive age
- An alternative payment model designed to help OB-GYN practices implement activities in alignment with patient-centered medical home principles
- An opportunity for OB-GYN practices to conduct practice-level improvement strategies using data, reporting, consumer feedback, and peer support

CMC – What it is NOT

- A replacement for:
 - Community Based Organizations
 - Evidence-Based Home Visiting
 - Individual Care Management for Each Attributed Person
 - Broader Health Equity strategy
- A checklist of items to be completed
- Funding for individual services
- Continuing the status quo in perinatal care

Why CMC?

- Creates a locus of responsibility for coordinating care and assuring continuity of care *and* relationships to improve outcomes and experiences of care
- Provides a framework for best practice sharing and peer-to-peer learning
- Offers opportunities for consistency and alignment between providers and practices
- Uses practice-level data to highlight excellence and opportunities for improvement
- Provides funding to support population health activities to improve patient care and experience

Components of CMC Model



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graph LR; A[CMC Enrollment] --> B[Patient Attribution]; B --> C[Population Health Activities]; C --> D[Outcome Reporting and Monitoring]; D --> E[Per Member Payments and Performance Incentives]
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CMC Enrollment

Patient Attribution

Population Health Activities

Outcome Reporting and Monitoring

Per Member Payments and Performance Incentives



CMC Practice Eligibility



CRITERIA:

- Current Medicaid providers of prenatal & postpartum care
- Sufficient capacity to coordinate patient needs across systems
- 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

Patient Journey

← Continuous Eligibility →



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
- Attribute to provider based on algorithm defined by the state

Planning and Engagement

- Informed Consent
- PRAF completed, if applicable
- Provider identifies MISP options based on patient risk assessment and provides choice to woman
- Linkage to selected partnering entities
- Can be performed at any prenatal appointment

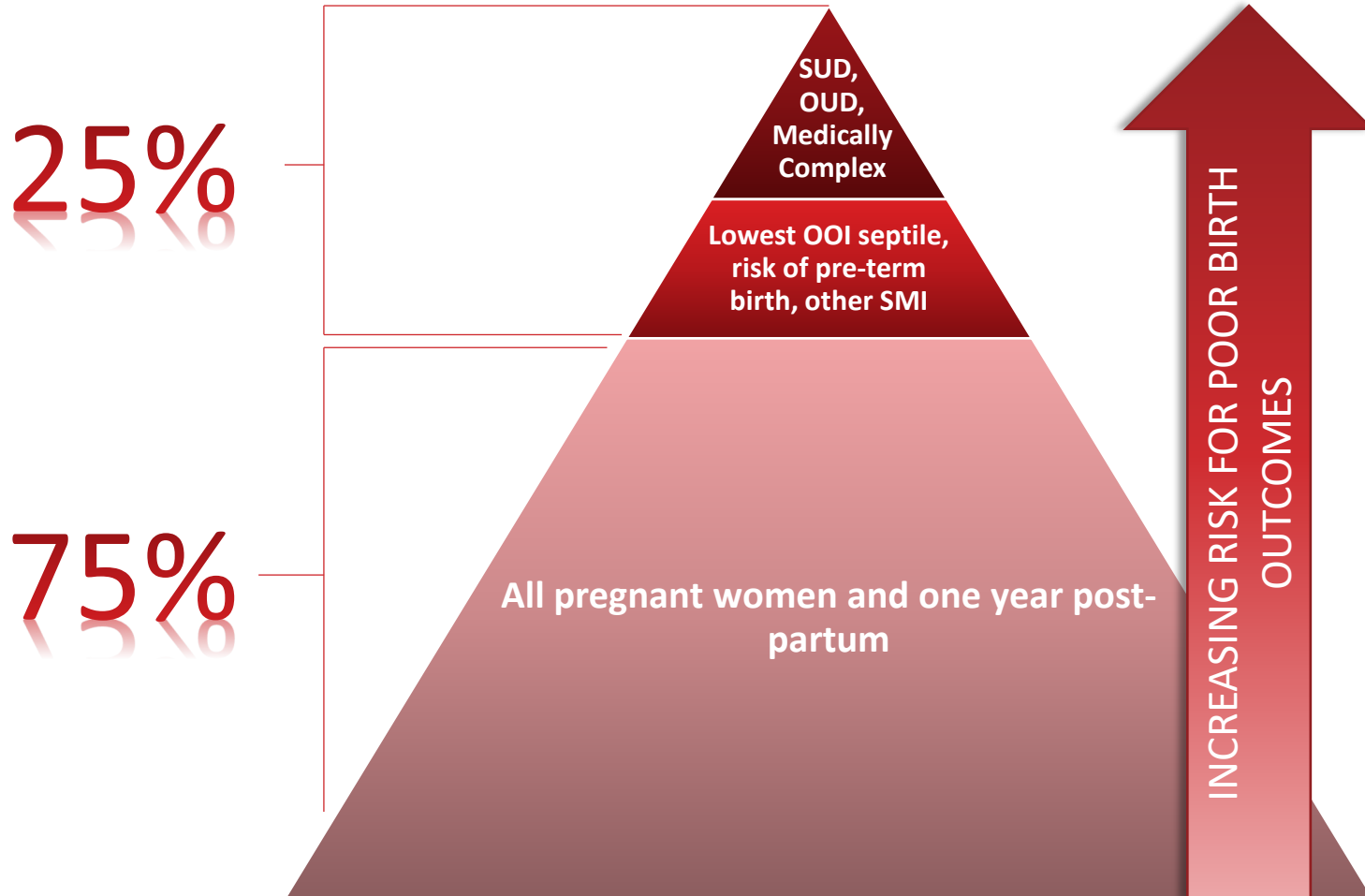
Team-Based Care

- 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

← Routine Source of Primary Care →

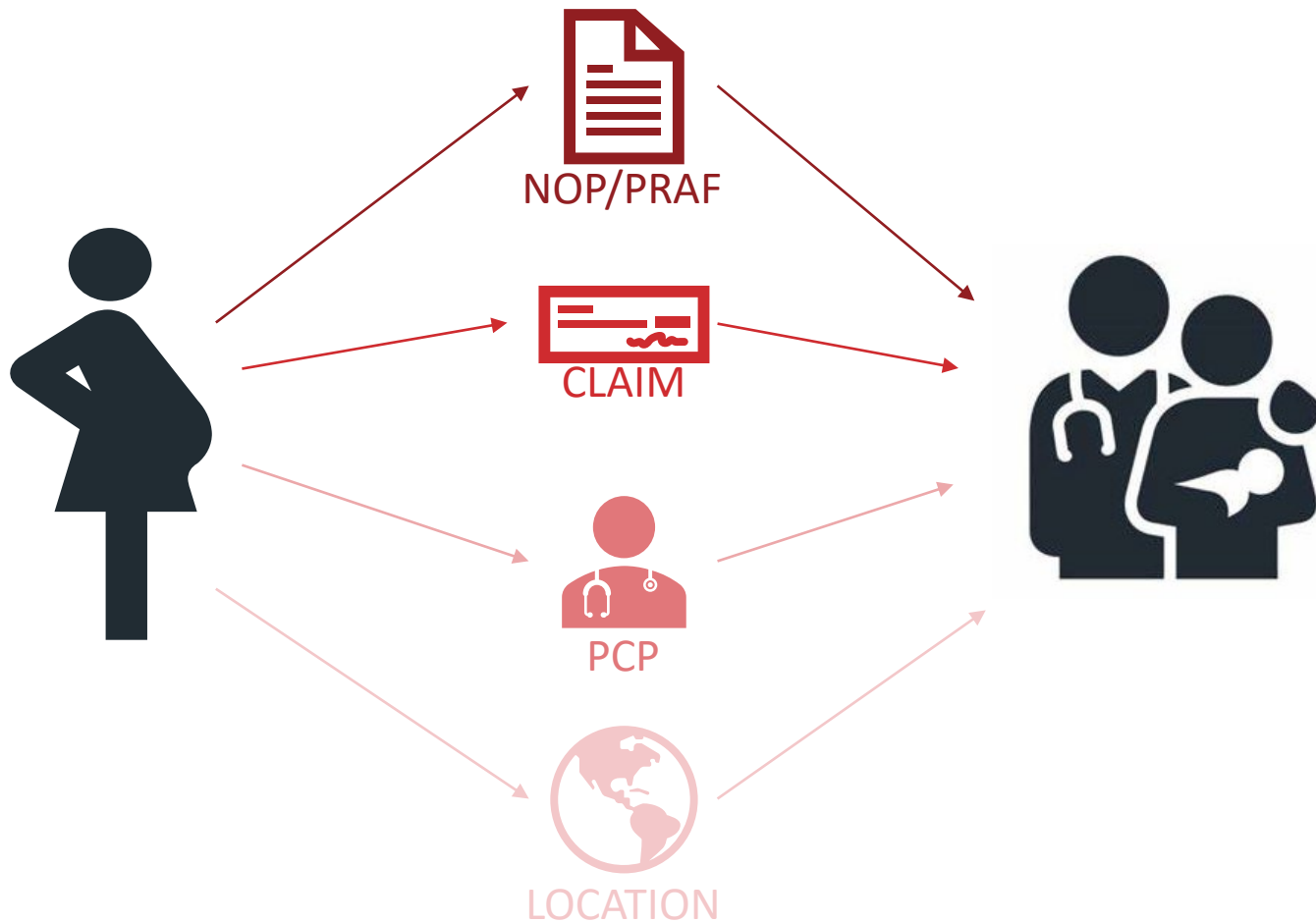
Postpartum Care

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

CMC Attribution



All women of reproductive age will be attributed to an OB/GYN

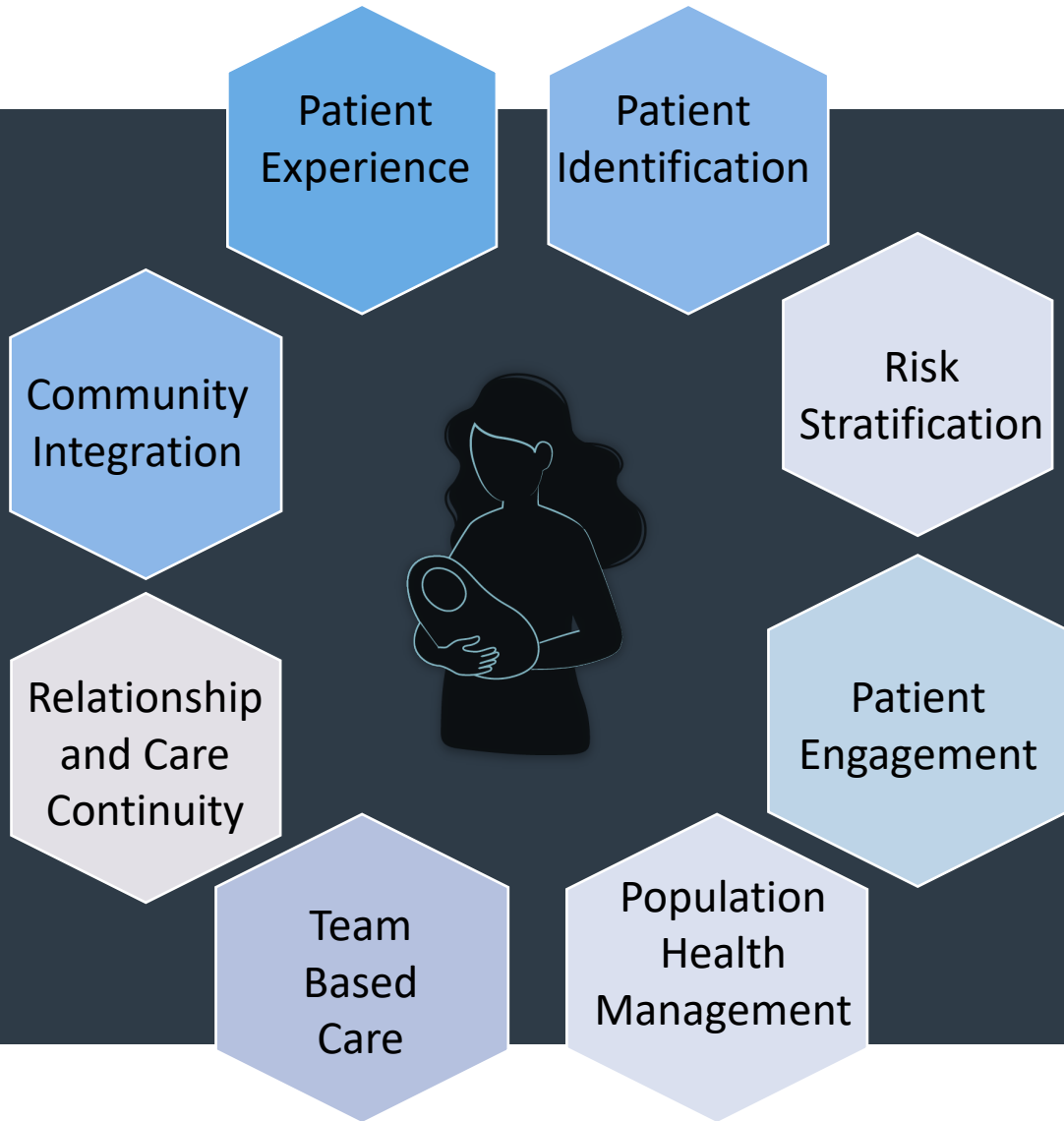
1. Notification of Pregnancy / PRAF provider/member choice
2. Pregnancy-related claims
3. Primary care provider relationship within the same health care system
4. Geography

Attribution will be updated monthly



Bringing Health Systems and Communities Together to Support Pregnant Women and Improve Outcomes

- ✓ Improved provider cultural competence
- ✓ Improved patient experience
- ✓ Integration of community supports and medical/BH services
- ✓ Improved maternal and infant outcomes



Activity Requirements

CMC-enrolled practices will receive a prospective payment for each attributed patient to support activity requirements

Activity Requirements

Patient Identification

- Identifies eligible women using ODM attribution files and the pregnancy risk assessment form; 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 referrals

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 providers and community-based entities on patient population needs
- Tracks and follows up on referrals to medical, behavioral health and community services and ensures no gaps in care

Relationship and Care Continuity

- Process in place to honor continuity in relationship with providers and community partners
- Plans for transition of patients to appropriate providers and resources through the care continuum

Community Integration

- Has a documented community engagement plan including regularly scheduled opportunities for key local stakeholders to collaborate on shared goals of improving maternal and infant outcomes and strengthening relationships between the community and the health care system
- 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.
- Uses the collected information to identify and act on improvement opportunities to improve patient experience and reduce disparities
- Feeds information back to the patient, community, patient and family advisory council, ODM, and MCOs.

Prioritize
outcomes
over
process

By reimbursing for population health activities, focus can be on meeting each patient's specific needs

Minimize
provider
burden

No complicated billing system to master or additional data submission

Aligning
care

Create incentives to integrate care across systems and settings

Alternative Payment Model

Designed to encourage and finance transformation, fund new care and operations and reward value

Potential Quality Metrics – For Payment

- Prioritizing metrics that are (1) directly tied to outcomes, and (2) under the purview of influence of the CMC practice
 - Postpartum Care
 - HIV Screening
 - Hepatitis B Screening
 - TDAP Vaccination
 - Tobacco Cessation

Potential Quality Metrics – Information Only Year One, potential tie to payment at a later date

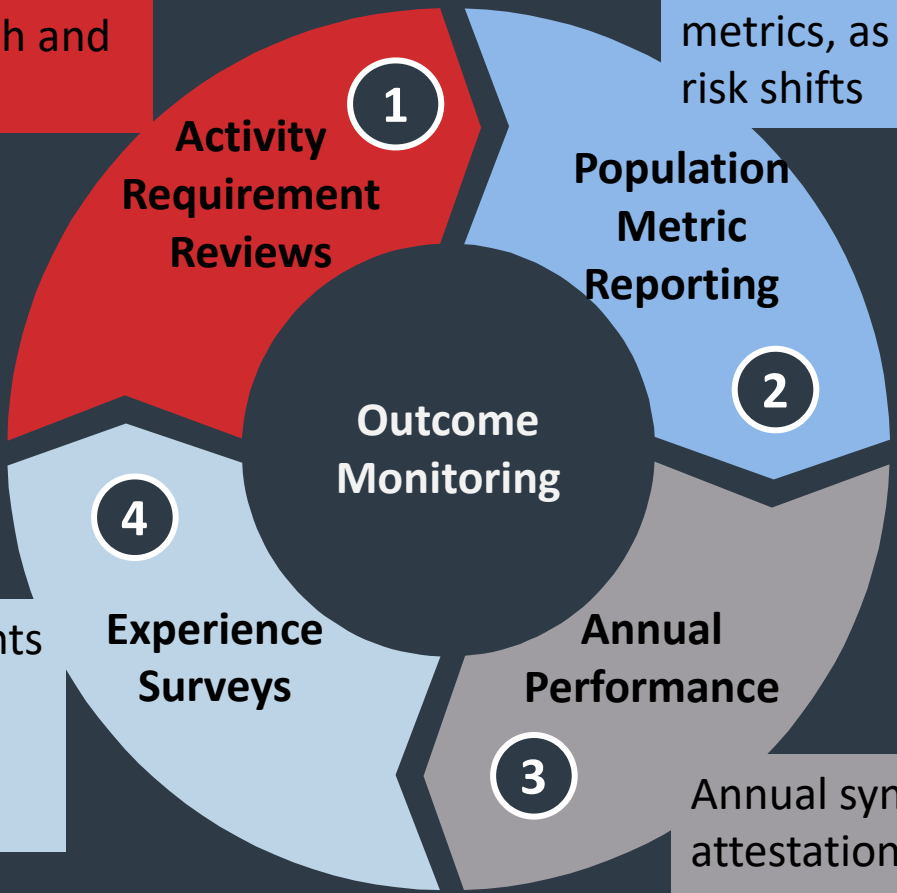
- Prioritizing metrics that (1) influence outcomes, and (2) are able to be influenced by CMC practice
 - Prenatal Visit by Nine Weeks Gestation
 - Breastfeeding Rates at 60 days postpartum
 - NTSV Cesarean Birth rate
 - High Risk Composite
 - Behavioral Health Services
 - Preterm Birth Interventions
 - New Opioid Fill Rate
 - Substance Use Disorder Treatment
 - Maternal Depression Screening
 - WIC Enrollment rate

Potential Quality Metrics – Information Only

- Prioritizing metrics that indicate of holistic health and quality of care
 - Preterm birth rates
 - Percentage of Low Birthweight Babies
 - Dental Visit
 - Infant Well Care Visit
 - Flu Vaccinations

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



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

Outcome Reporting and Monitoring

Payment Structures

- Per member per month payment based on patient risk level
 - Supports population health activities e.g. team based care, patient engagement, community integration
- Incentive payments for performance
 - Rewards excellent metric performance and outcomes with additional annual payments

Discussion

- What **opportunities** to improve patient experience of care and clinical outcomes could be included in the model?
- What may **incentivize** OB/GYN practice participation?
- What are perceived barriers to OB/GYN practice participation?
- What additional elements may we want to include in model design?
- Which elements of the model may we want to reconsider?
- Other thoughts on CMC development?

Next Steps

- ODM will reach out to potentially eligible practices for inclusion in a series of Clinical Advisory Group meetings January-March 2022
 - Interested practices can email MISP@medicaid.ohio.gov
 - ODM has developed a list of practices currently providing prenatal care services to >150 women per year
 - Includes outpatient hospital practices, FQHC/RHCs, professional medical groups
- ODM will set up another stakeholder meeting to review CAG recommendations and draft program framework in April 2022