Report on Pregnant Women, Infants, and Children

State Fiscal Year 2021

Governor Mike DeWine | Lt. Governor Jon Husted | Director Maureen Corcoran

medicaid.ohio.gov

December 31, 2021

Governor Mike DeWine
Ohio House Speaker, the Honorable Bob Cupp
Ohio Senate President, the Honorable Matt Huffman
Ohio House Minority Leader, the Honorable Emilia Strong Sykes
Ohio Senate Minority Leader, the Honorable Kenny Yuko
Ohio Commission on Infant Mortality, Representative Gayle Manning, Co-Chair
Ohio Commission on Infant Mortality, Senator Stephanie Kunze, Co-Chair
Joint Medicaid Oversight Committee, Representative Thomas F. Patton, Chair
Legislative Service Commission Director, Wendy Zhan

RE: Pregnant Women, Infants, and Children Report - State Fiscal Year 2020

The attached report is provided in compliance with Section 5162.13 of the Ohio Revised Code requiring the Ohio Department of Medicaid (ODM) to report annually about the effectiveness of the Medicaid program in meeting the healthcare needs of low-income pregnant women, infants, and children. In addition, this report focuses on infant mortality, preterm births, and low birthweight infants.

The rates reported for infant mortality, preterm births, and low birthweight infants are calculated for individuals who have Medicaid and individuals who do not have Medicaid based on both Medicaid data and infant death and birth files from the Ohio Department of Health Bureau of Vital Statistics.

The linkage process to match vital statistics information to Medicaid deliveries was updated and improved beginning with the report issued in 2020. At the same time, the methodology used to calculate infant mortality rates was revised to align with the standard utilized by public health officials, including the National Center for Health Statistics (NCHS) and the Ohio Department of Health (ODH). These changes have been applied to all years from 2017 forward. Given these notable revisions and a greater match success with the new linkage process, direct comparison to outcomes reported in prior years (2016 and earlier) is not informative.

Sincerely,

Maureen M. Corcoran, Director

Contents

PLEASE NOTE: When race data is collected through Ohio Benefits, it is an optional, self-reported data field. Due to the significant level of non-reported race data on Medicaid eligibility/claims records, this information will not always be included in this report

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Section 1: Profile of Ohio Births

1.1 Overall Medicaid Enrollment

Figure 1 presents the average monthly enrollment in Ohio Medicaid for calendar years (CY) 2017-2020. Many factors cause fluctuations in average enrollment. Policy changes (changes in eligibility criteria or enrollment processes), program changes (new eligibility programs/funding), and economic changes (Medicaid is a countercyclical program: enrollment and spending generally increase when there is a downturn in the economy leading to increased unemployment) are all elements affecting Medicaid enrollment over time.

Of note is the impact of the coronavirus pandemic on Ohio's Medicaid program. Throughout 2020, Ohio faced increased economic, medical, and mental health risks associated with the global pandemic. Medicaid caseload and associated spending grew significantly, reflecting a notable rise in unemployment. Additionally, the federally required maintenance of effort (MOE), a condition of receiving enhanced Federal Medical Assistance Percentage (FMAP), required Ohio Medicaid to maintain eligibility standards, methodologies, and procedures; restrict imposing new premiums or other cost-sharing, and maintain benefits for those enrolled as of March 2020. In short, throughout most of the calendar year 2020, Medicaid was not permitted to disenroll individuals from the program until the end of the federal public health emergency (PHE) unless they moved from the state, passed away, or voluntarily disenrolled. Ohio Medicaid's average monthly enrollment grew during the first months of the pandemic.

While we don't yet understand the full impact of the pandemic on the health and wellbeing of pregnant women, children, and infants served by Medicaid, healthcare utilization fell well below industry standards – particularly during the initial pandemic onset – likely causing delays or entire missed opportunities for preventative and wellness interventions.

It should be noted that these pandemic-related factors alone do not entirely capture the dynamics of Medicaid enrollment. Fluctuations are expected and must be reviewed in context with program goals and expenditure expectations.

Figure 1: Ohio Medicaid Enrollment, CYs 2017-2020			
Average Monthly Enrollment			
2017	2018	2019	2020
3,071,625	2,928,962	2,813,449	2,945,326

1.2 Profile of Ohio Births and Medicaid Demographics

Medicaid plays a significant role in access to healthcare for pregnant women and children in Ohio. In CYs 2017-2020, Medicaid consistently paid for approximately 53-55% of births in Ohio (see Figure 2). The information below is based on the total number of births to Ohio residents found on the CYs 2017-2020 birth files provided by the Ohio Department of Health (ODH) Vital

Statistics (VS) file; Medicaid-paid deliveries are identified via Medicaid claims/eligibility data. Throughout this report, comparisons are made between individuals with Medicaid and individuals without Medicaid based on the linked VS birth and death data and Medicaid claims/eligibility data. The VS to Medicaid deliveries match process was updated and improved. These changes have been applied to all years from 2017 forward. Due to substantially greater match success with the new process, additional births to mothers with less stable living arrangements and less consistent engagement with public services are now included. This affects outcome measures and so a direct comparison to prior years (2016 and earlier) reported in previous year's reports is not informative. Please see Appendix A for more information on the linkage process. The population of individuals without Medicaid, often referred to collectively as "non-Medicaid" in this report, includes those Ohioans with commercial insurance, without insurance, and those who are self-employed or otherwise obtain or purchase private insurance.

Figure 2: Ohio Births by Payer, CYs 2017-2020

	# of Births (N)				% of Total Births			
	2017	**2018**	**2019**	**2020**	**2017**	**2018**	**2019**	**2020**
All	133,892	132,136	131,423	126,341	100%	100%	100%	100%
Medicaid	74,174	71,344	69,532	67,726	55.40%	53.99%	52.91%	53.61%
Non-Medicaid	59,718	60,792	61,891	58,615	44.60%	46.01%	47.09%	46.39%

1.3 Demographic Information Related to Ohio Births

Throughout CYs 2017-2020, there are notable differences in the demographics of mothers with Medicaid-paid deliveries as compared to mothers with non-Medicaid paid deliveries (Figures 3-5). This report includes comparisons between individuals with Medicaid and those without Medicaid by demographic factors known to be associated with birth outcomes: race, ethnicity, maternal age, and marital status.[*]

1.4 Ohio Births by Maternal Race

The composition of Ohio's population has been stable over the last several years. As the graphs on the following page show, there are significant differences in race between the populations with and without Medicaid insurance. **The population with Medicaid has a six-fold greater proportion of Black births compared to the population without Medicaid**.

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[*] This number reflects births that occurred in Ohio, to Ohio residents.

Figure 3: Ohio Births by Maternal Race, CY 2017 - 2020

	2017 Medicaid	2017 Non-Medicaid	2018 Medicaid	2018 Non-Medicaid	2019 Medicaid	2019 Non-Medicaid	2020 Medicaid	2020 Non-Medicaid
Other/Unknown	7%	6%	7%	6%	7%	6%	8%	6%
Black	29%	5%	29%	5%	31%	5%	30%	5%
White	64%	89%	64%	89%	62%	89%	62%	89%
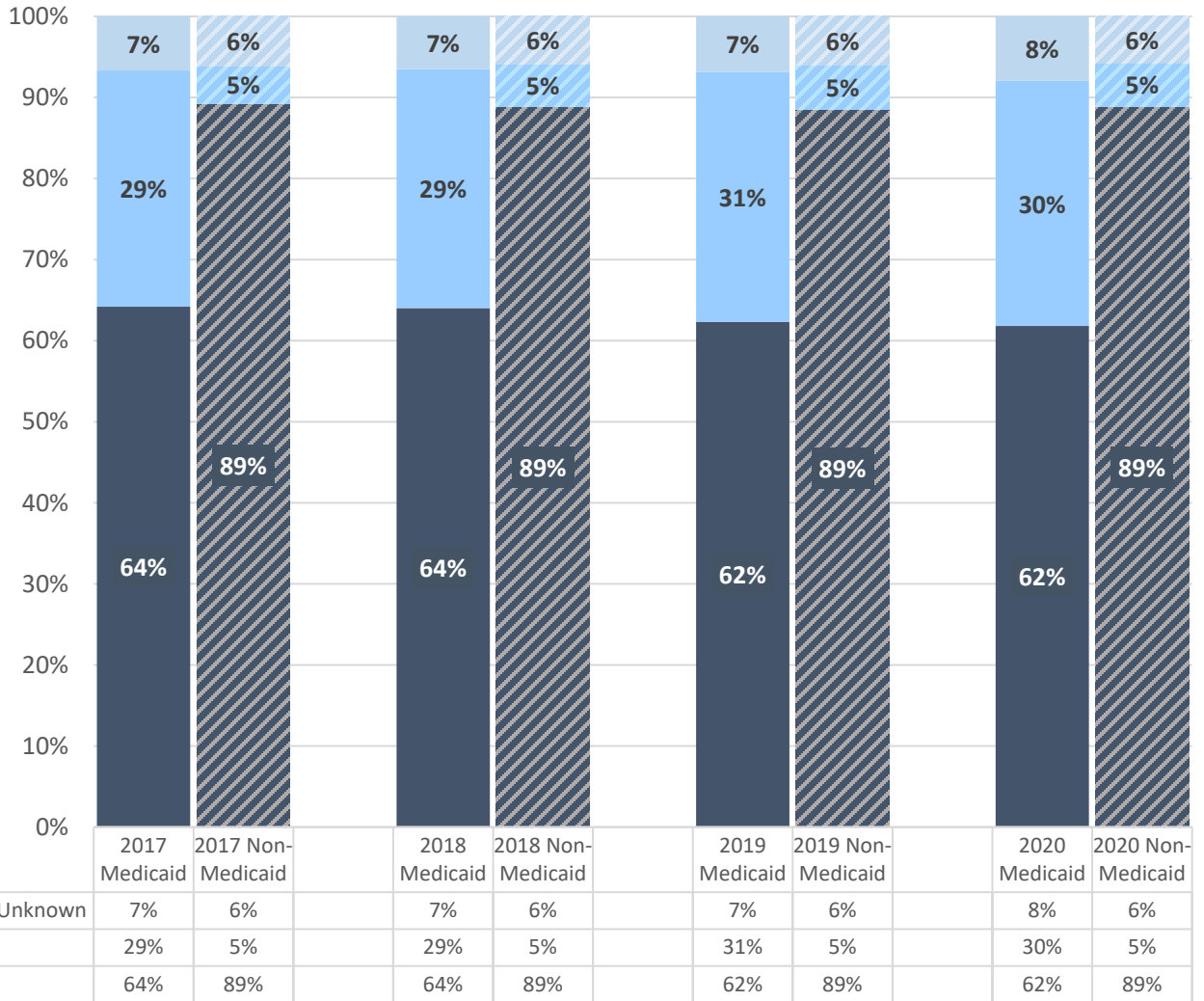
1.4.1 Births by Maternal Ethnicity

For CYs 2017-2020, Medicaid has consistently covered more births among the Hispanic population compared to non-Medicaid payers.

Figure 4: Ohio Births by Maternal Ethnicity, CYs 2017-2020

	2017 Medicaid	2017 Non-Medicaid	2018 Medicaid	2018 Non-Medicaid	2019 Medicaid	2019 Non-Medicaid	2020 Medicaid	2020 Non-Medicaid
Unknown	0%	0%	0%	0%	0%	0%	0%	0%
Non-Hispanic	92%	97%	92%	97%	92%	97%	91%	97%
Hispanic	8%	3%	8%	3%	8%	3%	9%	3%
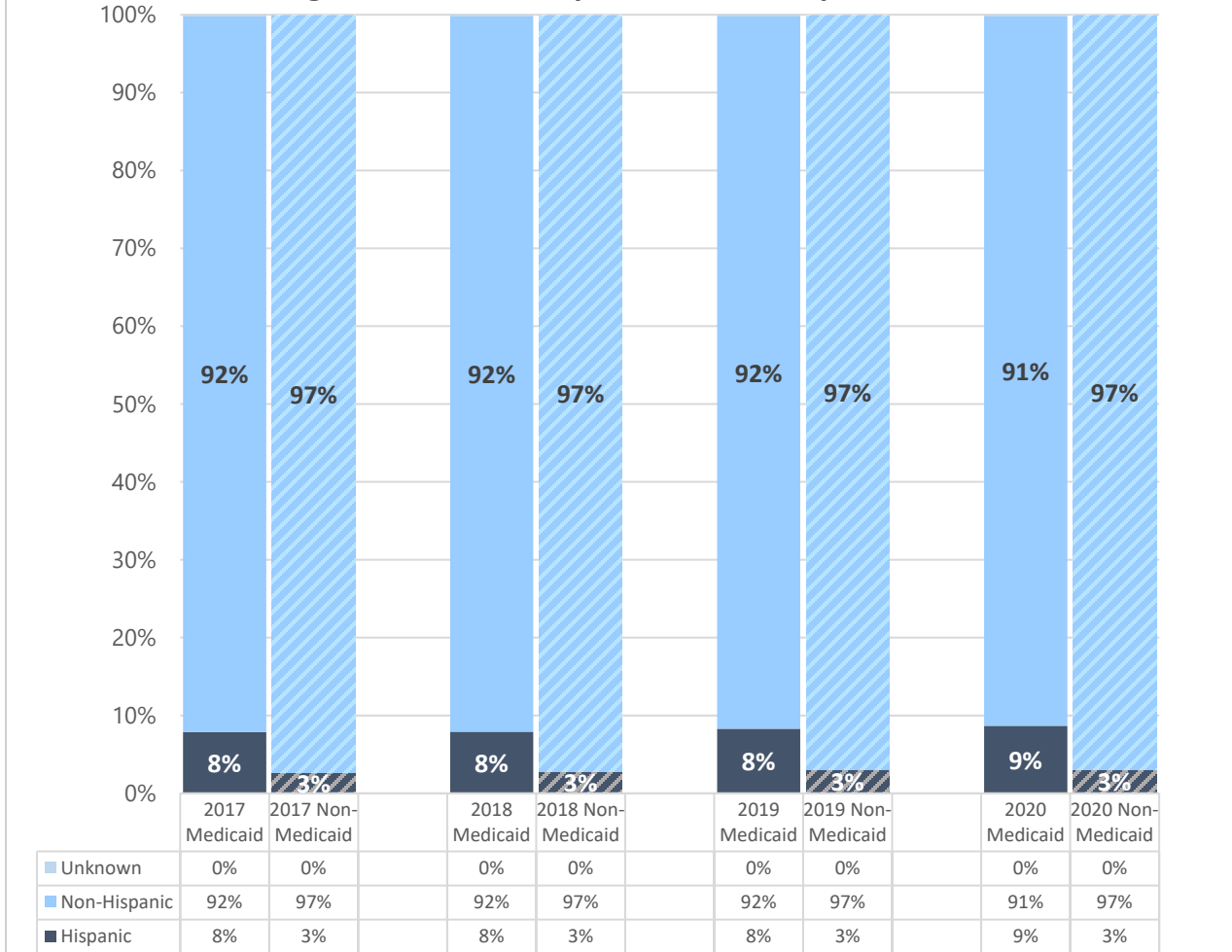
1.4.2 Maternal Age

As shown in Figure 5, the median maternal age of Ohio mothers with Medicaid differs from the median maternal age of women not receiving Medicaid benefits at the time of delivery. For CYs 2017-2020, the median age for mothers with a Medicaid-paid delivery was 26 years of age. The median age for women with non-Medicaid paid deliveries was 30 years of age in 2017, increasing to 31 in 2018, 2019, and 2020.

Figure 5: Ohio Births by Maternal Age and Medicaid Status, CY 2020
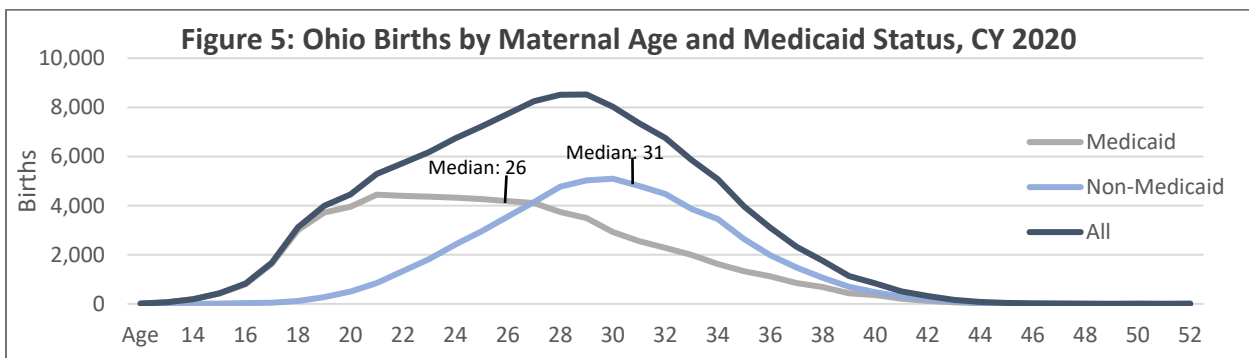
1.4.3 Marital Status

In 2020, 28% of women with Medicaid-covered deliveries were married as compared to 90% of women with non-Medicaid paid deliveries. This is similar to 2019 when 27% of women with Medicaid-paid deliveries were identified as being married.

Figure 6: Ohio Births by Marital Status, CYs 2017-2020

	2017 Medicaid	2017 Non-Medicaid	2018 Medicaid	2018 Non-Medicaid	2019 Medicaid	2019 Non-Medicaid	2020 Medicaid	2020 Non-Medicaid
Not Married	71%	9%	71%	10%	73%	10%	72%	10%
Married	29%	91%	29%	90%	27%	90%	28%	90%
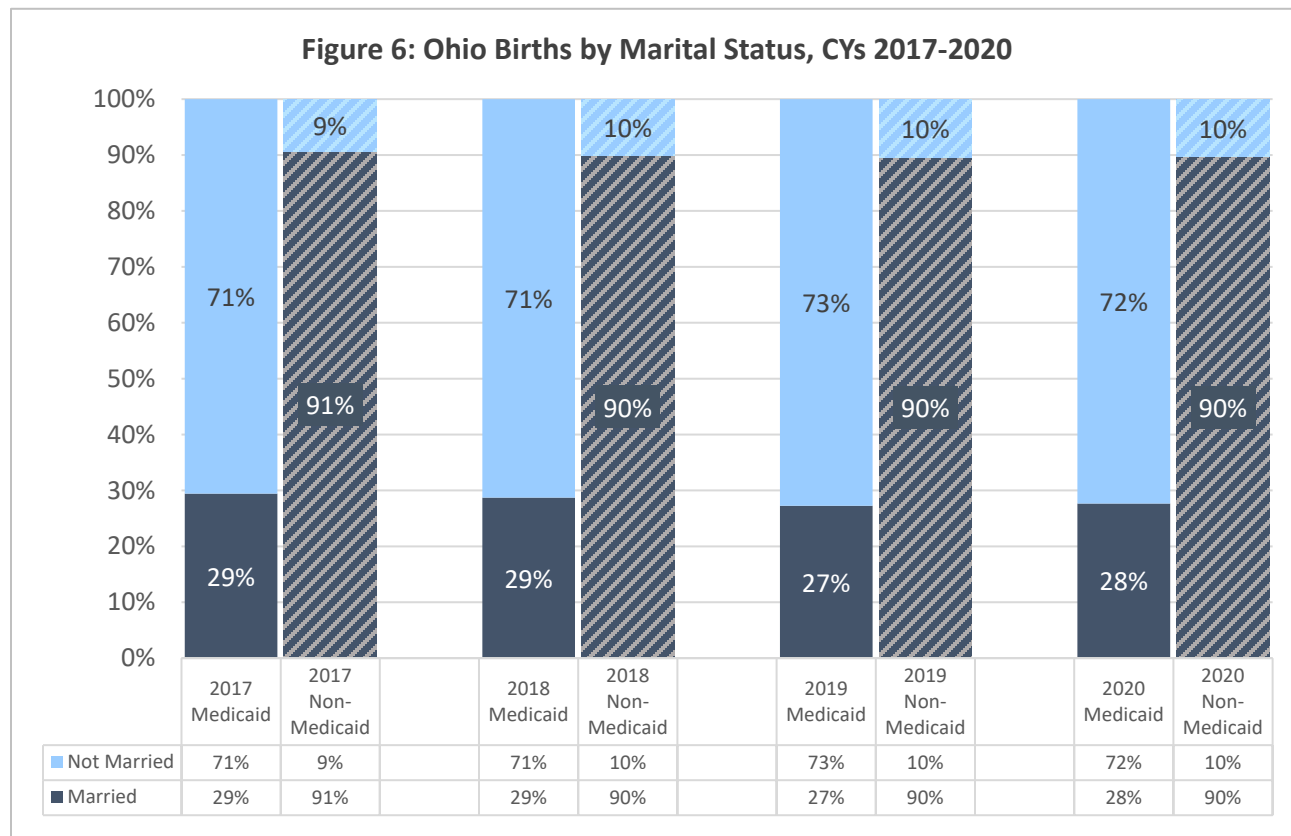
1.5 Medicaid Program Enrollment and Gestational Age

Using the linked VS/Medicaid data, in CY 2017, 2018, 2019, and 2020 respectively, 61,644 (CY 2017), 61,715 (CY 2018), 59,999 (CY 2019), and 57,839 (CY 2020) women enrolled in Ohio Medicaid delivered a liveborn infant[†]. Approximately two-thirds of the women were enrolled in Ohio Medicaid nine months prior to their delivery date (69% in CY 2017, 67% in CY 2018, 65% in CY 2019, and 64% in CY 2020). As these women were enrolled in Medicaid throughout their entire pregnancy, they were removed from the analysis below, which details gestational age at enrollment into the Medicaid program.

[†] The number is lower than the total number of births because the total births include both linked mothers and babies whereas this only includes mothers who were enrolled at delivery. Mothers who gave birth twice (e.g., January and December) were counted twice, once for each delivery. In the case of a multiple birth delivery (e.g., twins), the mother was counted once.

In this analysis, 18,908 (CY 2017), 20,546 (CY 2018), 20,828 (CY 2019), and 20,715 (CY 2020) women who delivered while covered by Medicaid were not enrolled in Medicaid prior to their pregnancy. Of the women who were not already enrolled in Medicaid prior to their pregnancy, 22% (CY 2017), 34% (CY 2018), 44% (CY 2019), and 47% (CY 2020) were enrolled in Medicaid during their first trimester. For these women, the average gestational age at first enrollment was 15.3 weeks in CY 2020, a notable change from 20.3 weeks in 2017 (see Figures 7-9). Please note that the date of first enrollment in Figures 7-9 reflects the initial Medicaid enrollment date regardless of program type. It is not specific to fee for service (FFS) or managed care organization (MCO) enrollment.

Figure 7: Average Gestational Age at First Enrollment for Women Not Enrolled Prior to Pregnancy, CY 2017-2020

Figure 8: First Enrollment by Gestational Age in Weeks, CY 2020
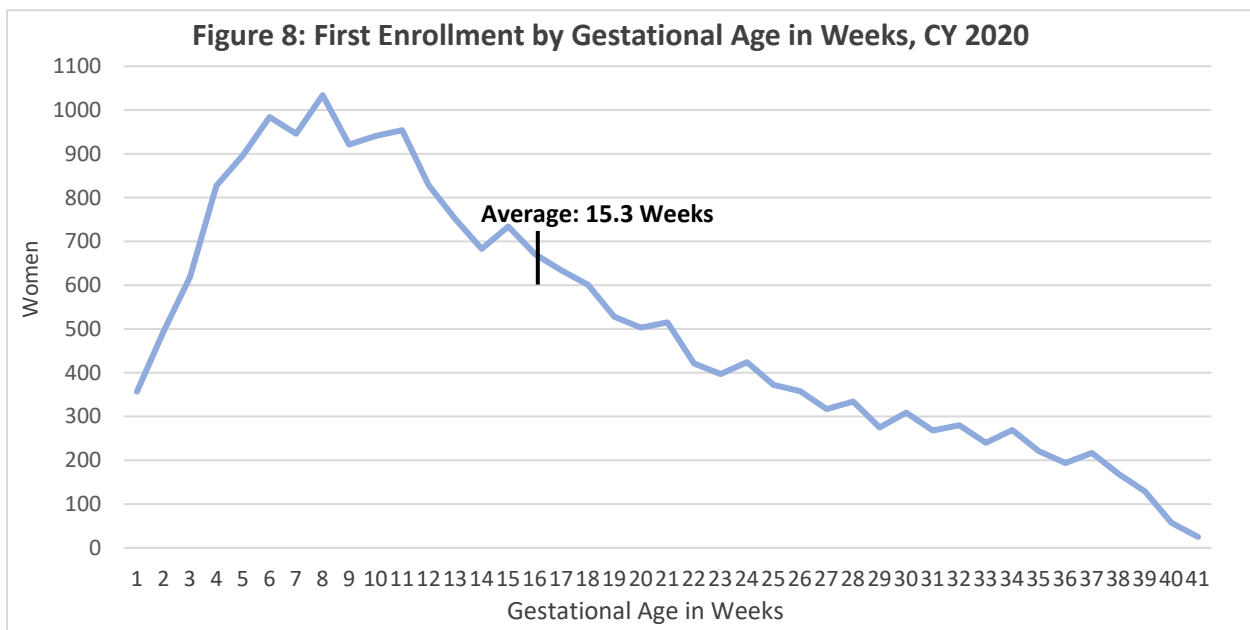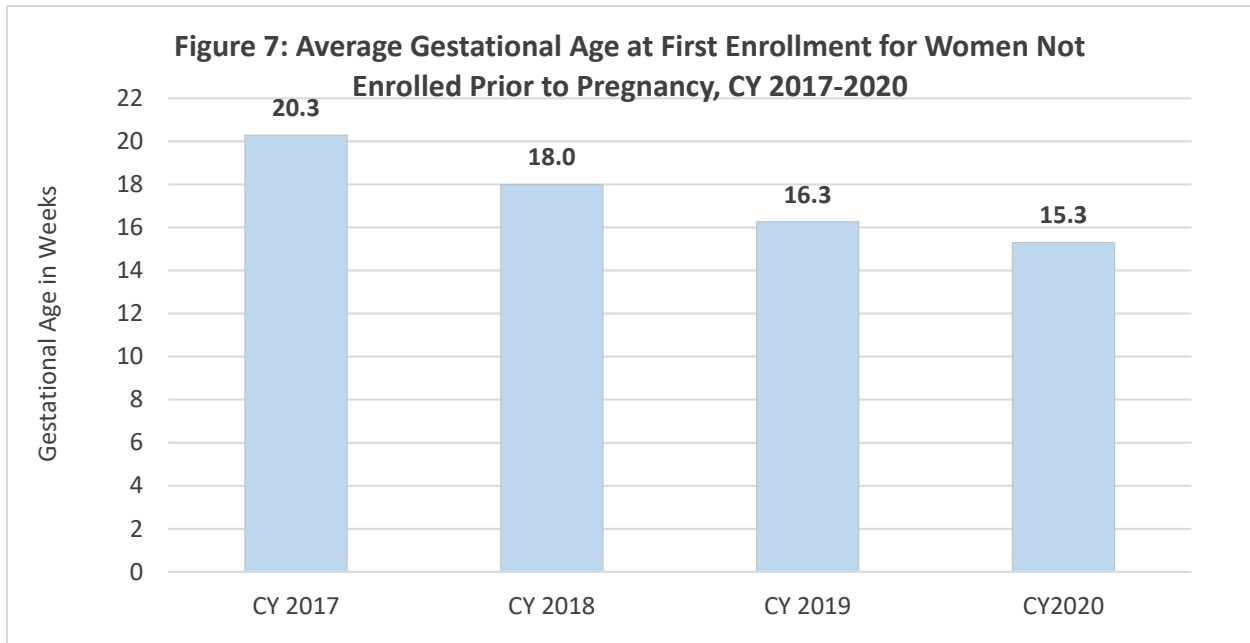
Figure 9: First Enrollment by Trimester, CY 2020

47% — 1st Trimester
37% — 2nd Trimester
16% — 3rd Trimester

■ 1st Trimester   ■ 2nd Trimester   ■ 3rd Trimester
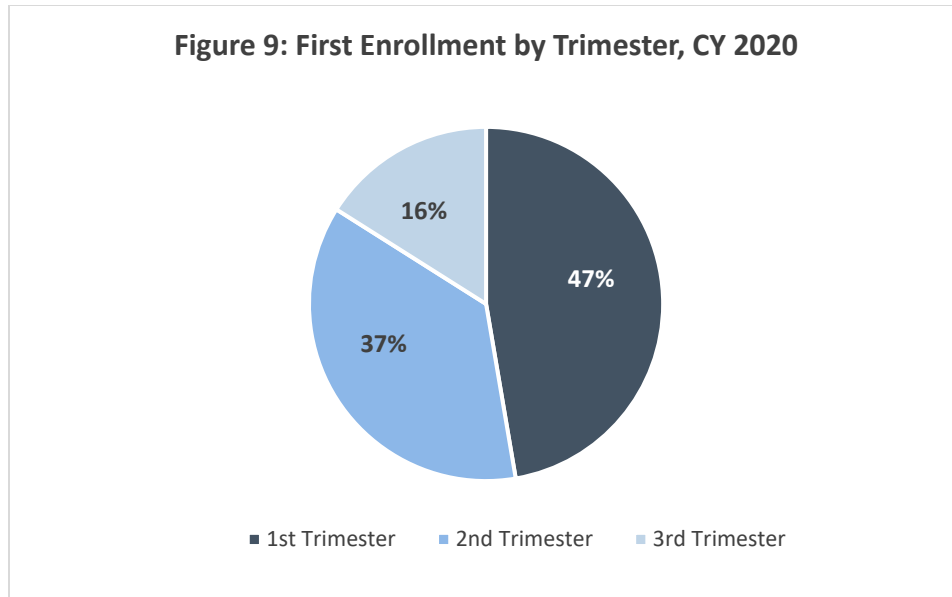
Section 2 Birth Outcomes and Risk Factors

2.1 Infant Mortality

For CYs 2017-2020, the methodology used to calculate infant mortality rates was revised to align with the standard utilized by public health officials, including the National Center for Health Statistics (NCHS) and ODH. This rate represents the number of deaths in a specific year divided by the number of live births within that same year, multiplied by 1,000. The infant mortality rates presented in prior years' reports were derived using a cohort approach, which identifies all infants who were born with Ohio maternal residence and follows them through their first year of life.

ODM calculated Ohio's infant mortality rate based on the linked VS/Medicaid data. The numerator for rates (deaths) is produced using information from death certificates (mortality dataset), while the denominator (live births) is calculated from information on the birth certificates (birth dataset). Therefore, for race and ethnic-specific rates, the numerator is based on infant race as reported on the death certificate, while the denominator is based on the mother's race as reported on the birth certificate. Please note that ODM's rates do not include Ohio residents who gave birth out of state, which is an important distinction between the rates published by ODH and those generated by ODM.

While the infant mortality rate for the Medicaid population gradually decreased between 2017 and 2019, it slightly increased in 2020, as detailed in the table below. ODH notes that Ohio has seen small but significant decreases in the overall infant mortality rate between 2011 and 2020.

In Ohio, the Black infant mortality rate is the lowest it has been in the last decade and has been trending downward. Since 2017, this downward trend also has been seen in the Medicaid

population, although slightly increasing between 2019 and 2020. Mothers in the Medicaid program experienced 9.49 deaths per 1,000 live births in 2017, 9.05 deaths per 1,000 live births in 2018, 8.67 deaths per 1,000 live births in 2019, and 8.90 deaths per 1,000 live births in 2020.

Figure 10: Ohio Medicaid Infant Mortality Rates by Medicaid Status, CYs 2017-2020

	Medicaid	Non-Medicaid
2017	9.49	5.17
2018	9.05	5.26
2019	8.67	4.69
2020	8.90	3.98

Figure 11: Ohio Infant Mortality Rates by Medicaid Status, Race, and Ethnicity, CYs 2017-2020

	Race			Ethnicity		
	White	Black	Other/Unknown	Hispanic	Non-Hispanic	Unknown
Medicaid						
2017	7.12	15.32	6.26	6.71	9.69	N/A
2018	7.01	13.73	7.55	6.90	9.23	N/A
2019	6.63	13.20	6.95	6.27	8.88	N/A
2020	6.80	13.95	5.72	5.62	9.23	N/A
Non-Medicaid						
2017	3.58	16.88	4.69	9.32	4.13	N/A
2018	3.89	14.45	2.79	2.88	4.42	N/A
2019	3.68	18.94	5.89	4.79	4.61	N/A
2020	3.51	10.50	5.05	3.98	4.09	N/A

Figure 11 shows the infant mortality rate broken down by Medicaid status, race, and ethnicity. Between 2017 and 2019 infant mortality rates went down slightly for both the white and Black populations in Medicaid; the most notable improvement was seen in Black women with Medicaid. The infant mortality rate for Medicaid-covered Black births has been steady for three years, with a marginal increase in 2020. The 2020 rate remains below the highest recent figure seen in 2017. Hispanic mothers historically have had the lowest overall infant mortality rates.

It is important to note that 2017 was among the highest rates of infant mortality in the last 10 years for the Black population. It is important to take denominator size (N) into account when comparing demographic breakdowns, including those of race and ethnicity. The Hispanic population is much smaller than the others, particularly in the non-Medicaid population,

resulting in wide swings in the rates. In addition, the Black population in the non-Medicaid population is also small.

2.2 Very Preterm Birth, Preterm Birth, and Low Birthweight

Prematurity (birth prior to 37 weeks gestation) and low birthweight (a birthweight under 2,500 grams) are significant risk factors for infant mortality.[‡] Prematurity is an issue that is not limited to the population of individuals with Medicaid but is a broader public health issue across the state. Very preterm birth (VPTB:<32 weeks gestation), preterm birth (PTB:<37 weeks gestation), and low birthweight (LBW) rates have remained consistent over time (CYs 2017-2020) for both Medicaid and non-Medicaid paid births (Figure 12).

Figure 12: Ohio Very Preterm, Preterm, and Low Birthweight Rates by Medicaid Status, CYs 2017-2020

	Very Preterm Birth		Preterm Birth		Low Birthweight	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
2017	3.13%	1.20%	12.25%	7.95%	10.86%	5.53%
2018	3.18%	1.04%	12.32%	7.73%	10.90%	5.34%
2019	3.32%	1.12%	12.72%	7.91%	10.89%	5.63%
2020	3.14%	0.88%	12.80%	7.29%	11.03%	5.19%

Similar to the racial and ethnic breakdown of infant mortality rates in section 2.1, the VPTB, PTB, and LBW rates by Medicaid status, race, and ethnicity remain consistent over time, with infants in the Medicaid program not faring as well (Figures 13 and 14). In parallel to the trends seen with infant mortality rates by race, the rates for VPTB, PTB, and LBW are higher for the Black populations for all four measurement years with or without coverage by Medicaid.

[‡] Centers for Disease Control and Prevention. Infant Mortality. Retrieved December 18, 2014 from http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm.

Figure 13: Ohio Very Preterm, Preterm, and Low Birthweight Rates by Medicaid Status and Race, CYs 2017-2020

	Medicaid			Non-Medicaid		
	White	Black	Other/Unknown	White	Black	Other/Unknown
Very Preterm Births						
2017	2.67%	4.30%	2.41%	1.11%	2.91%	1.41%
2018	2.86%	4.01%	2.54%	0.09%	2.64%	1.09%
2019	2.93%	4.24%	2.72%	0.09%	0.31%	2.00%
2020	2.82%	3.98%	2.36%	0.80%	2.01%	1.19%
Preterm Births						
2017	11.39%	14.65%	9.96%	7.61%	12.80%	9.28%
2018	11.66%	14.06%	10.99%	7.51%	11.67%	7.48%
2019	12.10%	14.25%	11.42%	7.56%	12.00%	8.96%
2020	12.06%	14.71%	11.02%	7.03%	11.05%	7.92%
Low Birthweight						
2017	9.43%	14.30%	9.62%	5.12%	9.84%	8.27%
2018	9.72%	13.69%	9.92%	4.92%	10.68%	6.96%
2019	9.59%	13.74%	9.96%	5.15%	9.87%	8.55%
2020	9.74%	14.26%	8.59%	4.79%	9.55%	7.49%

Figure 14: Ohio Very Preterm, Preterm, and Low Birthweight Rates by Medicaid Status and Ethnicity, CYs 2017-2020

	Medicaid			Non-Medicaid		
	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown
Very Preterm Births						
2017	2.56%	3.17%	6.01%	1.68%	1.12%	7.02%
2018	2.18%	3.26%	6.62%	0.09%	1.03%	17.07%
2019	2.29%	3.40%	6.02%	1.58%	1.09%	15.38%
2020	2.34%	3.21%	4.21%	1.09%	0.88%	4.55%
Preterm Births						
2017	11.35%	12.32%	12.03%	9.51%	7.90%	17.54%
2018	10.18%	12.48%	27.21%	7.32%	7.73%	21.95%
2019	11.22%	12.83%	23.31%	8.63%	7.87%	21.54%
2020	10.75%	12.98%	17.89%	8.23%	7.25%	18.18%
Low Birthweight						
2017	8.97%	11.01%	15.91%	6.50%	5.49%	15.79%
2018	8.17%	11.11%	24.06%	4.96%	5.35%	15.00%
2019	8.18%	11.11%	18.80%	6.43%	5.59%	17.46%
2020	8.04%	11.30%	19.79%	6.07%	5.17%	4.65%

Regarding ethnicity, VPTB and PTB rates are somewhat static and similar for the Hispanic population as compared to the non-Hispanic population among individuals with and without Medicaid. Hispanic LBW rates are lower than non-Hispanic LBW rates in the Medicaid subpopulation, while LBW rates for the Hispanic population as compared to the non-Hispanic population are similar in the subpopulation of individuals without Medicaid.

2.2.1 Risk Factors for Preterm Birth and Low Birthweight

In the section that follows, ODM describes risk factors for mothers covered by the Medicaid program compared to those who do not have Medicaid coverage. As the data shows, there is a greater risk for a preterm and/or low birthweight delivery if the mother had either a previous preterm birth or poor birth outcome, low maternal weight gain, smoked during pregnancy, delivered within 18 months of a prior delivery, or received little or no prenatal care.[1-3]

As shown in Figure 15, women with Medicaid experience higher rates of these risk factors compared to women without Medicaid, with the exception of space between births being 18 months or less, which is lower in the Medicaid population. In CY 2020, 7.96% of mothers covered by Medicaid had a previous preterm birth, down from 8.33% in 2019. For mothers without Medicaid, the rate was relatively consistent between 2019 (4.10%) and 2020 (4.13%).

While the measure for low maternal weight gain shows a slight increase in prevalence over time (CYs 2017-2019) for both Medicaid and non-Medicaid covered populations, the rate remained relatively consistent between CYs 2019 and 2020. Although the gap in smoking rates between Medicaid and non-Medicaid pregnancies slightly narrowed over time, the rates for pregnant women with Medicaid were approximately seven to eight times higher than rates for mothers not covered by Medicaid.

In CY 2020, 19.27% of mothers with Medicaid coverage smoked during pregnancy, compared to 2.18% of mothers without Medicaid. The previous poor birth outcome rate decreased for both Medicaid and non-Medicaid covered populations, from 6.99% in CY 2019 to 6.48% in CY 2020 for women covered by Medicaid, and 5.30% to 4.66% for women who do not have Medicaid coverage.

The rate of space between births being 18 months or less was 6.88% for mothers covered by Medicaid and 8.55% for mothers not covered by Medicaid, a slight improvement compared to CY 2019 for both populations. Between CYs 2017 and 2020, the rate of mothers with no prenatal care has been essentially stable at 2.18%-2.23% for Medicaid pregnancies, and 0.61%-0.80% for non-Medicaid pregnancies. For all the tables and trends below please note the limited number of observations. More data will be required to ascertain the strength of the trends.

Figure 15: Selected Risk Factors for Prematurity and Low Birthweight, CYs 2017-2020

	Previous Preterm Birth		Low Maternal Weight Gain		Smoking During Pregnancy		Previous Poor Birth Outcome		Birth Spacing (<18 months)		No Prenatal Care	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
2017	7.45%	3.94%	33.68%	23.39%	22.63%	2.67%	6.57%	4.52%	6.44%	7.97%	2.23%	0.64%
2018	8.15%	4.18%	34.14%	24.25%	21.84%	2.67%	7.76%	6.37%	6.89%	8.24%	2.18%	0.68%
2019	8.33%	4.10%	34.27%	24.65%	19.87%	2.64%	6.99%	5.30%	6.97%	8.58%	2.18%	0.80%
2020	7.96%	4.13%	34.11%	24.91%	19.27%	2.18%	6.48%	4.66%	6.88%	8.55%	2.21%	0.61%

Figure 16: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Medicaid-Paid Births by Race, CYs 2017-2020

	Previous Preterm Birth			Low Maternal Weight Gain			Smoking During Pregnancy			Previous Poor Birth Outcome			Birth Spacing (<18 months)			No Prenatal Care		
	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown
2017	6.31%	10.22%	6.33%	31.53%	37.08%	39.63%	29.29%	12.09%	4.32%	5.44%	8.95%	7.00%	6.53%	6.56%	5.04%	1.99%	2.87%	1.65%
2018	6.91%	11.12%	6.91%	32.16%	37.24%	39.69%	28.47%	11.30%	4.09%	6.58%	9.82%	7.17%	6.80%	7.32%	5.92%	2.05%	2.58%	1.67%
2019	7.15%	10.94%	7.41%	32.38%	36.90%	40.02%	26.18%	10.44%	3.90%	6.03%	9.00%	6.80%	7.11%	7.09%	5.13%	2.03%	2.57%	1.82%
2020	7.05%	10.32%	5.77%	31.40%	37.34%	43.98%	25.77%	9.72%	3.44%	5.82%	8.04%	5.62%	7.00%	7.22%	4.56%	2.07%	2.49%	2.22%

When comparing these pregnancy risk factors across racial breakdowns within the Medicaid program, mothers who are white have fewer risk factors (Figure 16) compared to mothers who are Black and of other or unknown races. This disparity is most pronounced in the previous preterm birth measure and the low maternal weight gain measure. In CY 2020, only 7.05% of white mothers had a previous preterm infant compared to 10.32% of mothers who are Black, and 31.40% of white mothers had a low maternal weight gain compared to 37.34% of Black mothers. The measure of smoking during pregnancy in the population of white mothers covered by Medicaid is well over twice the rate for the Black population covered by Medicaid, decreasing most over time for Black mothers from 12.09% in 2017 to 9.72% in 2020.

Figure 17: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Non-Medicaid Paid Births by Race, CYs 2017-2020

	Previous Preterm Birth			Low Maternal Weight Gain			Smoking During Pregnancy			Previous Poor Birth Outcome			Birth Spacing (< 18 months)			No Prenatal Care		
	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown	White	Black	Other/ Unknown
2017	3.82%	6.79%	3.51%	22.57%	32.97%	28.19%	2.84%	1.98%	0.72%	4.32%	7.90%	4.83%	8.03%	8.21%	6.92%	0.56%	1.47%	1.15%
2018	4.04%	6.85%	3.93%	23.40%	34.04%	28.37%	2.84%	2.08%	0.62%	6.09%	9.57%	7.61%	8.32%	8.32%	7.00%	0.63%	1.59%	0.65%
2019	3.92%	7.91%	3.15%	23.65%	33.53%	30.67%	2.80%	2.55%	0.52%	5.08%	8.82%	5.20%	8.67%	8.80%	6.94%	0.71%	1.54%	1.27%
2020	3.96%	7.19%	3.89%	23.89%	35.37%	31.08%	2.31%	1.72%	0.48%	4.47%	8.14%	4.40%	8.61%	8.95%	7.18%	0.56%	1.15%	0.87%

The trends in risk factors for individuals without Medicaid are similar. Black mothers without Medicaid coverage again experience greater rates of risk factors, particularly for previous preterm births or previous poor birth outcomes, but also for low maternal weight gain and no prenatal care. For those women not insured by Medicaid, smoking rates are slightly lower for Black women (1.72% in CY 2020) compared to 2.31% for white women in CY 2020 – strikingly less than the 9.72% for Black women and 25.77% in CY 2020 for women covered in the Medicaid program.

Figure 18: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Medicaid-Paid Births by Ethnicity, CYs 2017-2020

	Previous Preterm Birth			Low Maternal Weight Gain			Smoking During Pregnancy			Previous Poor Birth Outcome			Birth Spacing (<18 months)			No Prenatal Care		
	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown
2017	7.00%	7.49%	9.49%	38.16%	33.29%	35.41%	8.61%	23.83%	17.48%	6.40%	6.59%	5.84%	5.44%	6.53%	1.60%	1.47%	2.29%	4.24%
2018	7.68%	8.18%	14.70%	40.20%	33.62%	31.71%	7.22%	23.10%	18.07%	7.13%	7.62%	8.09%	6.07%	6.97%	5.05%	1.52%	2.24%	0.88%
2019	7.93%	8.36%	7.52%	39.48%	33.81%	33.75%	6.95%	21.00%	26.80%	6.03%	7.08%	7.52%	5.49%	7.11%	4.50%	1.77%	2.21%	5.60%
2020	6.98%	8.05%	6.93%	41.97%	33.36%	35.71%	6.52%	20.48%	18.82%	5.50%	6.58%	4.95%	5.93%	6.97%	8.57%	2.05%	2.21%	11.24%

When considering ethnicity, Hispanic populations covered by Medicaid have slightly lower rates of these risk factors compared to non-Hispanics in all areas, with the exception of low maternal weight gain, which impacts 41.97% of Hispanic women compared to 33.36% of non-Hispanic mothers (CY 2020). Rates of these risk factors are generally not widely disparate between Hispanic and non-Hispanic populations, except for smoking during pregnancy, which is almost three times higher in non-Hispanic women compared to Hispanic women (20.48% vs 6.52% in CY 2020). For women without Medicaid, the Hispanic and non-Hispanic populations have similar rates of these risk factors given the fact that this subgroup is small, rendering the data subject to wide fluctuation.

Figure 19: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Non-Medicaid Paid Births by Ethnicity, CYs 2017-2020

	Previous Preterm Birth			Low Maternal Weight Gain			Smoking During Pregnancy			Previous Poor Birth Outcome			Birth Spacing (< 18 months)			No Prenatal Care		
	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown	Hispanic	Non-Hispanic	Unknown
2017	4.97%	3.91%	1.64%	29.92%	23.22%	14.89%	1.87%	2.69%	6.00%	4.78%	4.52%	1.64%	7.42%	7.99%	8.33%	1.13%	0.62%	3.85%
2018	5.54%	4.14%	10.64%	29.48%	24.09%	34.48%	1.62%	2.70%	2.70%	7.15%	6.35%	4.26%	6.48%	8.29%	10.81%	1.05%	0.67%	8.11%
2019	4.31%	4.09%	5.48%	31.87%	24.38%	45.24%	1.44%	2.68%	4.44%	5.70%	5.28%	6.85%	7.07%	8.62%	11.76%	2.13%	0.74%	8.47%
2020	4.57%	4.12%	2.13%	29.32%	24.78%	18.92%	1.20%	2.20%	7.50%	4.44%	4.67%	8.51%	7.67%	8.57%	15.79%	1.10%	0.59%	4.65%

2.3 Preterm Birth Reduction Effort

The state of Ohio remains committed to reducing the incidence of preterm birth, one of the largest contributors to infant mortality. In CY 2019, ODM began the process of formalizing its population health management framework as part of Next Generation Managed Care. ODM's population health approach focuses on identifying populations at the highest risk of poor outcomes, assessing medical and social needs, and designing policies, programs, and initiatives to address these needs. ODM's Next Generation Managed Care model emphasizes person-centered co-design with individuals, families, communities, and providers. Co-design not only assists in effectively identifying successful intervention strategies, but also facilitates alignment and collaboration across the health system for greater collective impact and sustainability.

To support this approach, ODM is continuing its long-standing preterm birth prevention partnerships with perinatal clinicians and hospitals affiliated with the Ohio Perinatal Quality Collaborative (OPQC), as well as Medicaid Managed Care Organizations (MCOs), sister state agencies, home health agencies, pharmacies, and community organizations. ODM is also encouraging increased data usage, data sharing, and aligned measurement by these partners across the health care system. This includes encouraging greater MCO use of the enhanced maternal care file which combines vital statistics and claims history for Medicaid-insured individuals, allowing for proactive MCO efforts to support individuals.

The timely identification of pregnancy and pregnancy-related risk factors is one of the greatest needs in the effort to prevent preterm births. Building on past quality improvement efforts, ODM worked with partners to first create, and then update a standardized web-based reporting form to communicate pregnancy status and key medical and social needs: the Pregnancy Risk Assessment Form (PRAF 2.0). In CY 2020, ODM also introduced a second electronic form, the Report of Pregnancy (ROP).

Both forms are used for timely pregnancy identification and directly link to Ohio's eligibility system to prevent the inadvertent loss of healthcare coverage during pregnancy. They also serve as referrals to the Ohio Department of Health's home visiting, tobacco cessation, and WIC programs, and allow Medicaid managed care organizations to link women to other needed services.

The forms differ in the depth of information collected and the provider types that use the forms. The ROP is used by non-obstetric providers and community partners to identify pregnant women who can then be connected with an obstetrician by their MCO to facilitate earlier receipt of prenatal care. The PRAF is used by providers of obstetric services to identify additional medical needs and can be used to create a progesterone prescription. If progesterone for the prevention of preterm birth is indicated and the patient elects to receive injections within her home, this same PRAF can be optionally used to automatically notify the appropriate specialty pharmacy and home health agency to eliminate complexity and expedite the timely provision of this important therapy.

In July 2020, ODM introduced a policy change to incentivize the use of the electronic version of the PRAF 2.0 through increased reimbursement. Questions pertaining to substance use during

pregnancy also were added to allow for greater connectivity to resources for mothers and infants impacted by substance use disorders.

The ROP, first introduced in the calendar year 2020, builds upon the initial work with the PRAF 2.0 by allowing non-obstetric providers (e.g., emergency room physicians) to easily report the pregnancy of a patient insured by Medicaid. Like the PRAF 2.0, the web based ROP communicates the pregnancy to Ohio's eligibility system, Ohio Benefits, ensuring that the woman's Medicaid coverage is continued through the postpartum period. The ROP also can be used by MCOs to connect women to an obstetrician if needed. Once connected to an obstetrician, pregnancy-related risk factors can be identified using thePRAF 2.0.

Figure 20: Overall Progesterone Rates for Medicaid-Paid High-Risk Pregnancies by Maternal Race and Ethnicity, CYs 2017-2020

	Overall Rate	Race			Ethnicity	
		White	Black	Other	Hispanic	Non-Hispanic
2017	33.13%	30.73%	35.83%	44.90%	41.65%	32.70%
2018	34.84%	33.73%	37.36%	27.29%	28.19%	35.32%
2019	34.97%	34.52%	36.13%	31.07%	30.73%	35.28%
2020	33.47%	32.11%	35.38%	33.70%	28.96%	33.80%

Figure 20 reflects the percentage of women with Medicaid who had a high-risk pregnancy, as determined by either a prior preterm birth or shortened cervix during their pregnancy, who were administered progesterone to help prevent preterm birth. ODM recognizes that this measure is not precise enough to exclusively identify progesterone candidacy, but it does identify a subpopulation of women who are at a much higher risk of preterm birth. The percentage of women receiving progesterone began to decrease between 2019 and 2020, likely reflecting current research emphasizing the effectiveness among a more limited population with preterm birth due to short cervix. This trend warrants close monitoring and comparison to the percentage of Medicaid women who have had previous preterm births due to short cervix to ensure that progesterone administration is appropriate.

Additional trends that warrant further exploration are adverse pregnancy outcomes due to social determinants of health-related risks and risks related to a history of late miscarriages. Linkage to community support through group prenatal care and the use of less traditional providers (doulas, midwives) brings focus to non-health system connections for the reduction of preterm birth. Individuals with histories of late miscarriages are not captured as having preterm births but are at higher risk for preterm birth during the next pregnancy. Interventions addressing both these populations are being considered. In 2022, ODM intends to implement additional programs, providers, and services that support moms and babies through data-driven, evidence-based initiatives. These programs will leverage the PRAF 2.0 to ensure women

receive timely connections to physical, social, and emotional supports that are necessary to meaningfully reduce disparities in health outcomes.

ODM continues to work with preterm birth prevention partners, especially in communities that experience the greatest racial disparities in infant mortality, to improve the use of the electronic PRAF to spur immediate connectivity to community and health services, including evidence-based home visiting programs such as Nurse Family Partnership.

In 2016, ODM and Medicaid's managed care organizations established the Community Infant Mortality Partnership with community-based organizations in Ohio's nine counties with the highest infant mortality disparities. This partnership's purpose is to activate communities to address the racial disparities and social determinants of health and isolation that negatively impact this critical period of life.

In SFY 2020-2021, MCOs awarded over $25 million to 121 community-based organizations to focus on key evidence-based interventions including prenatal care (group education formal and informal), home visiting (e.g., Nursing Family Partnership), and utilization of community health workers independently and through Pathways Hub model. In addition, a variety of other interventions were funded including doulas, peer-to-peer support, women's neighborhood advisory groups, support groups, breastfeeding support, fatherhood initiatives, and centralized intake/care connectors.

To date, 35,000+ women and their families have received support and services through this partnership. Community-based organizations have activated communities/neighborhoods and reported different improvements, including improved connectivity and trust among women, improved breastfeeding rates, and reduced preterm births.

ODM also has hosted focus groups to listen to the voices of women in their pregnancy and postpartum experiences. Women in the Medicaid program expressed distrust in the health systems citing a lack of provider empathy and inadequate communication. They also expressed a lack of social support, community resources, and routine coverage of community services such as doulas and lactation nurses. These are all being taken into consideration as ODM implements strategies to continuously improve maternal and infant outcomes.

Table 1: Medicaid Managed Care Organizations Community Infant Mortality Partnership with Community-Based Organizations*

	Centering Pregnancy	Home Visiting	Community Health Workers	Other Community-Based Interventions
Butler	★	★	★	★
Cuyahoga	★	★	★	★
Franklin	★	★	★	★
Hamilton	★		★	★
Lucas			★	★
Mahoning	★	★	★	★
Montgomery	★	★	★	★
Stark	★	★	★	★
Summit	★	★	★	★
This does not include programs funded by other state agencies and local/private sources				

While some efforts to improve pre-term birth rates are anchored in Ohio's health systems, there is growing awareness of the importance of the social factors or determinants that contribute to poor birth outcomes. As such, ODM and the MCOs continue to support community infant mortality grants that attempt to scale community-based work that may garner more trust for the culturally appropriate social and emotional support that families require given the extra stressors of pregnancy. Most of the communities have chosen to support ODH evidence-based home visit programs, Centering™, or group prenatal care efforts and the use of community health workers that are often connected to a Pathways Hub. This community initiative also welcomes innovation from doulas, fatherhood groups, and others committed to the care of mothers and infants.

Based on the experiences and learnings from the MCOs' community-based infant mortality reduction grant efforts, as well as the feedback provided to ODM in the focus groups referenced above, the Department of Medicaid began implementing new statewide benefits and enhanced coverage for additional perinatal supports through its Maternal and Infant Support Program (MISP). Additional information about the MISP can be found in section 2.5 below.

2.4 Smoking Cessation

Smoking is one of the most common modifiable risk factors for infant mortality as it increases the risk of preterm birth, low birthweight, and sleep-related deaths. Ohio is expanding publicly funded maternal and child health programs and recommended clinical practice guidelines from the U.S. Public Health Service that teach how to encourage smoking cessation. The state also

promotes a nationally recognized, evidence-based smoking cessation model to reduce smoking among women during pregnancy. The Moms Quit for Two program utilizes the "Baby and Me – Tobacco Free" model and is offered across Ohio by many local health departments, Ohio Equity Institute teams, and other community organizations.

ODM is continuing to partner with the Ohio chapter of the American Academy of Pediatrics to assist caregivers and families in reducing smoke exposure and unsafe sleep environments for Ohio infants. The Smoke-free Families Pediatric Project provides pediatric practices with evidence-based screeners and tools to connect caregivers and families to resources and counseling services. An evaluation of the project showed that half of the caregivers who reported smoking or vaping at their infant's initial visit during the project period reported cutting back or quitting by their second visit. Efforts in 2021 are focused on spreading the project to Comprehensive Primary Care practices throughout Ohio.

Figure 21: Tobacco Cessation and Counseling for Women 15-44 Years of Age by Race and Ethnicity, CYs 2017-2020

	Overall Rate	Race			Ethnicity	
		White	Black	Other	Hispanic	Non-Hispanic
2017	10.72%	11.72%	8.87%	9.19%	9.55%	10.76%
2018	21.14%	22.23%	18.92%	20.58%	23.55%	21.04%
2019	35.89%	36.53%	33.43%	41.60%	38.99%	35.74%
2020	33.01%	33.09%	31.94%	38.05%	37.69%	32.76%

There has been a dramatic increase in the rates of tobacco screening and counseling for women across all races and ethnicities in the Medicaid program. Beginning in 2017, the Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention measure was added to the list of quality metrics for providers participating in Ohio's patient-centered medical home initiative, the Comprehensive Primary Care (CPC) program. This level of accountability, as well as additional focus through the Smoke-Free Families quality improvement efforts, the Baby and Me-Tobacco Free model, and the 2018 Medicaid support for the Quitline, may all have influenced these improvements.

2.5 Maternal and Infant Support Program

As mentioned briefly above, in 2021, Ohio began to implement its Maternal and Infant Support Program (MISP), which focuses on providing services and strategies to advance the goals of reducing and eliminating racial disparities in maternal and infant outcomes and reducing infant mortality. Through the MISP, Ohio Medicaid is supporting perinatal and infant care through clinical interventions, evidence-based and evidence-informed community-based services and

creating a space for improved cultural competencies and individually configured services. Personalized care gives families the clinical and community supports they need to improve outcomes while helping them build a longitudinal trusting relationship with the healthcare system.

The MISP uses the PRAF as a cornerstone to link women to clinical and community-based care. ODM is making several changes effective January 2022 to offer pregnant women additional services and support. ODM is updating its lactation consulting and breastfeeding support rules to expand access to breastfeeding resources and services. The group pregnancy education rule is also being updated to increase access to group prenatal care and reimburse for innovative approaches to group pregnancy education. ODM also will begin to cover evidence-based home visiting through its nurse home visiting rule update, which will allow reimbursement of services consistent with the Nurse Family Partnership model of home visiting.

In April 2022, ODM plans to extend Medicaid eligibility for pregnant and postpartum women from the end of the month of the 60th day postpartum to the end of the 12th month postpartum for all women. Extending eligibility for a full year postpartum ensures women have access to critical services that impact maternal morbidity and mortality as well as infant health, including treatment for postpartum depression, medical care for chronic conditions such as cardiovascular disease, breastfeeding resources, family planning resources, and continued evidence-based home visiting.

Throughout 2022, ODM will meet with stakeholders to develop a framework for additional maternal and infant supports, including doula services, comprehensive maternal care, postpartum home visits, and concurrent care for moms and babies affected by substance use disorders.

Section 3: Perinatal Episode of Care

ODM has implemented a value-based payment mechanism bundling together an entire episode of care for the delivery of a newborn infant. The episode is triggered by a live birth and includes all prenatal care 280 days before the delivery through postnatal care 60 days after discharge from the delivering facility. The obstetrical provider is assigned as the principal accountable provider (PAP) as he/she is in the best position to guide ideal birth outcomes, both in quality and cost. The PAP subsequently receives relevant reports to assist in the management of this population. Please see https://medicaid.ohio.gov/episodes for more details.

Due to the COVID-19 pandemic, ODM will not assess providers' performance or issue financial incentives for program years 2020, 2021, and 2022. However, ODM will issue informational-only reports for these periods and continue to track quality metric results for the perinatal episode. The most influential quality metrics in the perinatal episode have been rates of

prenatal human immunodeficiency virus (HIV) screening, caesarean sections, and post-partum visits. Despite the disruptions in healthcare delivery, in 2020 Ohio PAPs maintained the previous year's prenatal HIV screening rate, averaging 84%. The postpartum visit rate decreased only by 2% with an average of 78%. The average caesarean section rate was lowered again with a statewide average of 27%. The care of the newborn is addressed through three separate episodes across low-, moderate-, and high-risk levels based on gestational age.

ODM is working to refine the perinatal episode with additional views of the high-risk population using new sources of data, including social determinants of health, and new quality measures (e.g., evidence-based practices for high-risk women, connections to community supports, and metrics of neonatal outcomes). These enhancements are expected to bring focus to a higher-risk subset of women, thereby connecting payments for high-quality healthcare in the Medicaid program to a statewide strategy that helps reduce disparities in maternal and infant outcomes.

Section 4: Prenatal and Postnatal Visits

4.1 Measure Results by Statewide Average, Medicaid MCOs, and FFS

HEDIS, the Healthcare Effectiveness Data and Information Set, is a healthcare quality measurement tool developed by the National Committee for Quality Assurance (NCQA) that is used by more than 90% of America's health plans to monitor the provision of health services across five domains of care. Self-reported, audited HEDIS data from Ohio's five current MCOs were used to examine prenatal and postpartum care within the Medicaid program, as detailed in Figure 22. Self-reported, audited HEDIS rates may contain data from both claims and medical record reviews (hybrid methodology).

Figure 22: Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2017-2020

	Timeliness of Prenatal Care		Postpartum Care	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE				
2017	81.1%	P25-P50	63.4%	P25-P50
2018	83.5%	P50-P75	65.8%	P50-P75
2019	86.89%	P50-P75	77.53%	≥P90
2020	85.11%	P25-P50	76.79%	P50-P75
BUCKEYE				
2017	86.6%	P50-P75	63.7%	P25-P50
2018	79.1%	P25-P50	59.4%	P10-P25
2019	90.75%	P75-P90	78.35%	≥P90
2020	84.91%	P25-P50	75.43%	P25-P50
CARESOURCE				
2017	78.6%	P25-50	62.3%	P25-50
2018	83.7%	P50-P75	66.4%	P50-P75
2019	82.00%	P25-P50	75.67%	≥P90
2020	87.10%	P25-P50	76.89%	P50-P75
MOLINA				
2017	82.8%	P25-50	62.6%	P25-50
2018	83.0%	P25-P50	67.4%	P50-P75
2019	98.54%	≥P90	79.81%	≥P90
2020	84.43%	P25-P50	74.21%	P25-P50
PARAMOUNT				
2017	83.0%	P25-50	69.1%	P50-75
2018	86.4%	P50-P75	70.3%	P75-P90
2019	91.48%	≥P90	79.56%	≥P90
2020	86.13%	P25-P50	79.56%	P50-P75
UNITED HEALTH				
2017	83.7%	P50-75	64.3%	P25-50
2018	85.5%	P50-P75	65.5%	P50-P75
2019	87.35%	P50-P75	80.05%	≥P90
2020	82.97%	P10-P25	77.86%	P50-P75

Using the HEDIS methodology, in 2020, 85.11% of women in Medicaid MCOs received timely prenatal care, which was a slight decrease from 86.89% in 2019. The percentage of women who received a postpartum visit on or between 7 and 84 days after delivery decreased less than one percent in 2020 to 76.79%, from 77.53% in 2019.

The percentile ranking represents how Ohio's Medicaid MCOs' HEDIS results compare with national Medicaid benchmarks collected by NCQA. For example, Ohio's Medicaid MCOs were between the 25th and 50th national percentiles for the timeliness of prenatal care HEDIS measure in comparison with other Medicaid MCOs across the country in 2020, and between the 50th and 75th percentile in 2018 and 2019. For the postpartum visits (between 7 and 84 days after delivery), Ohio's Medicaid MCOs were between the 50th and 75th percentile in 2020, greater than the 90th percentile in 2019, and between the 50th and 75th percentile in 2018. Please note that the period evaluated for the postpartum visit was changed for 2019 to "between 7 and 84 days after delivery"; for prior years, the postpartum visit period was "21 to 56 days after delivery." This change should be taken into consideration when comparing the 2019 Postpartum Care Visit rates to prior year rates.

While performance is largely better than average by these measures, ODM is still focused on improving maternal and infant outcomes and eliminating disparities in ways that may not be reflected by this measurement framework.

Section 5: Behavioral Health Services

ODM, in collaboration with the Ohio Department of Mental Health and Addiction Services (OMHAS), implemented significant revisions and enhancements to the Medicaid behavioral health benefit beginning in January 2018. Changes included the addition of new services for people with high intensity needs, and alignment of the procedure codes used by Ohio's behavioral health providers to better integrate physical and behavioral healthcare. In 2020, pregnant women enrolled in Medicaid with a behavioral health condition continued to receive behavioral health services near to pre-Pandemic rates.

Of the women enrolled in Ohio Medicaid identified as having had a birth via the linked VS/Medicaid data†, 25% (17,723) in CY 2017, 26% (17,669) in CY 2018, 27% (18,059) in CY 2019, and 28% (18,212) in CY 2020 had a behavioral health clinical condition identified by a primary diagnosis on a Medicaid claim† (Figures 23 and 24). Of those women, approximately 39% received services from a community mental health center (CMHC) in 2020 compared to 40% in 2019, and 22% received addiction services from a substance use disorder (SUD) clinic in 2020, essentially unchanged from 2019. Women receiving SUD clinic services, 12% (2,210) in CY 2017, 12% (2,192) in CY 2018, 11% (2,028) in CY 2019, and 11% (1,970) in CY 2020 utilized medication assisted treatment (MAT) services for substance abuse issues.

Figure 23: Women with a Medicaid-Paid Delivery in CY 2020 with a Behavioral Health Clinical Condition

18,212

47,378

■ Without a Behavioral Health Condition
■ With a Behavioral Health Condition
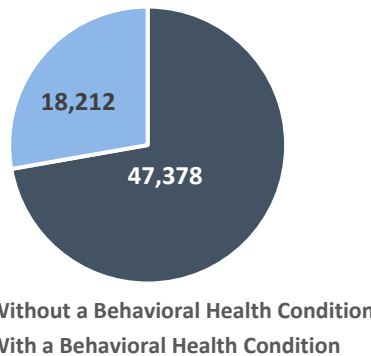
Figure 24: Women with a Medicaid-Paid Delivery in CY 2020 with a Behavioral Health Clinical Condition Treated by a Mental Health Provider

18,212   18,212

7,075   4,042

MH   SUD
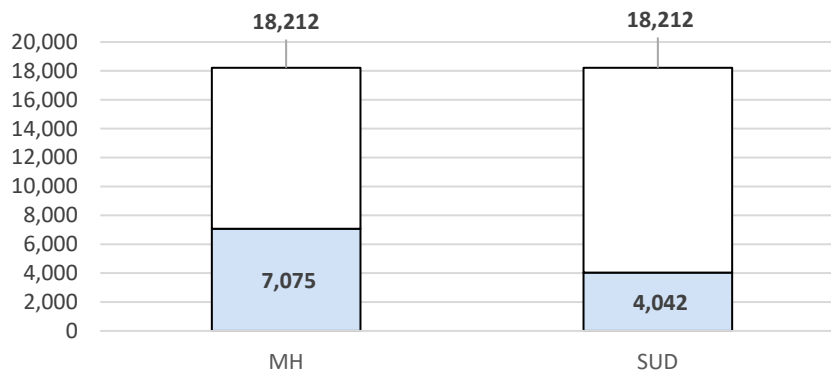
As the state addressed emerging health threats due to coronavirus, Governor DeWine enacted an emergency telehealth rule to protect Ohioans from the virus without disrupting care. That rule enabled more than 860,000 Medicaid members to take advantage of telehealth services, filing more than 5.8 million claims during the first year of the pandemic.

Telehealth was particularly critical to members with behavioral and mental healthcare needs, including those battling addiction, who were most vulnerable to the isolation and economic pressures resulting from COVID-19. Emergency telehealth flexibilities allowed providers to maintain needed services in urban settings and to increase access to care for members in rural communities and small towns. More than 3.3 million behavioral health services were rendered by OMHAS providers.

ODM continues efforts focused on the provision of Maternal Opioid Medical Supports (MOMS) to address the needs of pregnant and postpartum women with opioid use disorder. The current

Mother/Infant Dyad project builds upon past work within the MOMS pilot project and the MOMS+ project, described in more detail below.

The MOMS pilot coordinated behavioral health and prenatal care with social supports for pregnant women dependent on opioids. This resulted in greater use of behavioral health services, expanded MAT use, and greater postpartum retention in MAT, as well as reduced out-of-home placement for program participants compared to a matched sample of pregnant women dependent on opioids who received treatment as usual.

The MOMS+ project — launched in 2018 — used the MOMS pilot sites as the hubs of a hub-and-spoke model to mentor and support newly engaged outpatient maternity care teams across Ohio. While the hubs were more closely associated with the larger tertiary centers where higher-risk MAT inductions and other care could be delivered, the spoke or partner sites were supported by stronger local behavioral health and MAT programs, as well as pediatric practitioners who could continue long-term care. The mentoring sites also helped maternity care providers develop the capacity to provide induction therapy close to home, collaborate with local child welfare, and link to housing and other social service resources in their communities, culminating in more effective plans of safe care as referenced in the Comprehensive Addiction and Recovery Act (CARA).

Section 6: Medicaid Prenatal Care, Delivery, and Infant Costs

The average total cost during pregnancy of a woman enrolled in Medicaid (all covered services for nine months prior to the delivery month to one month after the delivery month) was $8,652 in 2017, $8,873 in 2018, $9,181 in 2019, and $10,005 in 2020 (see Figure 25). Prenatal and delivery costs[§] paid by Medicaid include direct FFS payments to service providers, and capitation and birth premium payments to managed care providers for women enrolled in managed care.

In 2020, the total cost paid by Medicaid for prenatal care and deliveries was $677,460,948 for 67,714 births. Of these Medicaid payments, 54% of these dollars ($363,228,586) paid for deliveries compared to 46% ($314,232,362), which covered prenatal care. Only costs incurred when a woman was enrolled in Medicaid are included in these figures, aswoman may have been enrolled in Medicaid for only a portion of her pregnancy, and in some instances only for the delivery of the infant.

[§] Delivery costs include FFS delivery costs, delivery capitation payments, and estimated delivery payments for certain managed care members as determined by the applicable capitation rate cell payment.

Costs paid by Medicaid during an infant's first year of life included direct FFS payments to service providers, and capitation payments to managed care providers for infants enrolled in managed care. In 2020, 69,532 infants were eligible and enrolled in Medicaid for at least a portion of their first year of life.

The total cost paid by Medicaid for the first year of life for infants enrolled in 2020 was $1,071,808,003. Only costs and member months for those months of the infants' first year of life in which the infant had Medicaid eligibility were included; an infant may have utilized Medicaid for only a portion of their first year of life.

Overall, costs for prenatal care, deliveries, and infants in the first year of life increased from CY 2019 to CY 2020. Total costs for prenatal care and deliveries increased by 6% from 2019 to 2020, with the average cost per woman with a delivery increasing by 11%; the average cost per member month increased by 9%. The number of deliveries decreased by 2.6% from 2019 to 2020 (i.e., from 69,532 deliveries in 2019 to 67,714 in 2020). For infants in the first year of life, total costs increased by 8.7% from 2019 to 2020, average cost per infant increased by 11.6%, and average cost per member month increased by approximately 11.6%. The total number of infants decreased by 11%.

For CY 2020, managed care costs accounted for approximately 91% of the costs for infants in the first year of life, approximately 95% of delivery costs, and approximately 96% of the total costs for deliveries and prenatal care. The FFS costs for infants in the first year of life, deliveries, and total costs for deliveries and prenatal care accounted for 9%, 5%, and 4% of total costs for each category, respectively. There were no industry standard data sources available with current costs of national Medicaid prenatal care, deliveries, and/or infant care for comparison with Ohio data.

Figure 25: Total and Average Cost of Deliveries, Prenatal Care, and Infants, CYs 2017-2020

	Deliveries	Prenatal Care	Total Prenatal Care and Delivery Care	Infants— First Year of Life
Total Beneficiaries				
2017	74,174	74,174	74,174	70,004
2018	71,344	71,344	71,344	74,174
2019	69,532	69,532	69,532	71,344
2020	67,714	67,714	67,714	69,532
Total Cost				
2017	$340,829,530	$300,849,744	$641,753,448	$863,649,749
2018	$335,816,208	$297,219,104	$633,035,312	$983,028,022
2019	$334,796,580	$303,576,712	$638,373,292	$985,688,704
2020	$363,228,586	$314,232,362	$677,460,948	$1,071,808,003
Average Cost/Beneficiary				
2017	$4,595	$4,056	$8,652	$12,337
2018	$4,707	$4,166	$8,873	$13,253
2019	$4,815	$4,366	$9,181	$13,816
2020	$5,364	$4,641	$10,005	$15,415
Total Member Months				
2017	N/A	578,599	724,286	883,697
2018	N/A	547,423	687,371	938,016
2019	N/A	528,879	665,666	884,819
2020	N/A	510,114	643,064	864,969
Average Cost/Member Month				
2017	N/A	$520	$886	$977
2018	N/A	$543	$921	$1,048
2019	N/A	$574	$959	$1,114
2020	N/A	$616	$1,053	$1,239

Section 7: Children in Medicaid

Ohio Medicaid provides care to nearly 3 million Ohioans—including approximately 1.3 million youth, more than 36,000 of whom are in the foster care and adoption system. The demographics of the infants, children, adolescents, and adults under 21 years of age are delineated in Figure 26.

7.1 Summary of Medicaid's Children's Eligibility and Demographics CY 2020

Figure 26: Medicaid Monthly Average by Age Group, Gender, Race, and Plan Type, CY 2020

AGE IN YEARS	Monthly Average	% of Total Medicaid Children
<1 Year	77,343	5.9%
1-5 Years	340,267	26.1%
6-12 Years	456,973	35.0%
13-18 Years	344,591	26.4%
19-20 Years	86,512	6.6%
GENDER		
Female	643,704	49.3%
Male	661,981	50.7%
Unknown	1	<0.1%
RACE		
Caucasian	737,928	56.5%
Black	408,098	31.3%
Asian/Pacific Islander	28,259	2.2%
American Indian Or Alaskan Native	8,236	0.6%
Other	238	< 0.1%
Not Provided	122,927	9.4%
PLAN TYPE		
MCO (Managed Care)	1,265,174	96.9%
Indemnity (FFS)	40,512	3.1%
TOTAL MEDICAID CHILDREN	**1,305,686**	

7.2 Children's Chronic and Behavioral Health Conditions Frequency Distribution

The overall monthly average number of youths under age 21 enrolled in Medicaid is 1,305,686. Of these Medicaid youth, 36% (469,493) have at least one chronic condition, and 36%[**] (464,175) have at least one behavioral health condition. While asthma and other respiratory conditions top the list for physical health conditions requiring care, attention deficit with hyperactivity disorder remains the most prominent behavioral health condition. Figures 27 and 28 detail additional clinical diagnoses that prompted care for youth in CY 2020.

[**] The percentage of youth having at least one behavioral health condition was inadvertently misreported in the Report on Pregnant Women, Infants and Children – SFY 2020.

Figure 27: Top 10 Most Prevalent Chronic Health Conditions among Medicaid Youth CY 2020

	Patient Count	All Medicaid Children
Asthma	83,779	6%
Other specified and unspecified upper respiratory disease	78,039	6%
Menstrual disorders	38,522	3%
Esophageal disorders	29,553	2%
Acute and chronic tonsillitis	26,333	2%
Headache, including migraine	24,384	2%
Allergic reactions	22,063	2%
Obesity	21,243	2%
Hearing loss	20,545	2%
Musculoskeletal congenital conditions	20,245	2%

Figure 28: Prevalence of Behavioral Health Conditions Among Medicaid Youth CY 2020

	Patient Count	All Medicaid Children
ADHD	139,717	11%
Anxiety	109,729	8%
Adjustment Disorders	98,742	8%
Conduct Disorder	76,923	6%
Other Depression	53,066	4%
Major Depression	40,556	3%
PTSD	30,696	2%
Autism	23,207	2%
Self-Harm	18,944	1%
Bipolar Disorder	10,798	1%
Other Psychological	10,768	1%
Impulse Control Disorders	6,828	3%
Schizophrenia	5,429	0.4%
Delirium Dementia	1,831	0.1%
Personality Disorders	1,607	0.1%
Mood Disorders	1,592	0.1%

7.3 Quality Measures for Children

Just as HEDIS results were used to assess quality for the maternity population, HEDIS specifications were utilized to assess care across three domains for children: primary care access and preventive care, acute and chronic care, and behavioral healthcare.

Data displayed in Figures 29, 30, and 31 include self-reported, audited HEDIS data from Ohio Medicaid's five MCOs. Self-reported, audited HEDIS rates may contain data from both claims

and medical record reviews (hybrid methodology), while FFS data is solely claims based (administrative); therefore, the results between MCOs and FFS is not comparable.

7.3.1 Primary Care Access and Preventive Care

HEDIS methodology for the well-care visit infant, child, and adolescent measures has been significantly modified; therefore, CY 2020 results cannot be trended for comparison with previous years' results. In 2020, 56.63% of infants in the Medicaid program had six or more well-child visits with a primary care physician during their first 15 months of life and 66.30% of infants between 15 and 30 months of age had at least two visits with a primary care physician. In CY 2020 49.89% of children aged 3 to 11, 45.18% of adolescents aged 12 to 17, and 24.02% of adolescents/young adults aged 18 to 21 had at least one well-care visit with a primary care physician. Older adolescents aged 18 to 21 represent the group of youth least likely to be seen for preventive services.

Figure 29: Well-Care Measures Medicaid MCO Self-Reported, Audited HEDIS Rates, CY 2020

	Well-Child Visits in the First 30 Months of Life (First 15 Months of Life, Six or More Visits)		Well-Child Visits in the First 30 Months of Life (Age 15-30 Months, Two or More Visits)		Child and Adolescent Well-Care Visits (3-11 Years)		Child and Adolescent Well-Care Visits (12-17 Years)		Child and Adolescent Well-Care Visits (18-21 Years)	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE										
2020	56.63%	P50-P75	66.30%	P10-P25	49.89%	P25-P50	45.18%	P50-P75	24.02%	P25-P50
BUCKEYE										
2020	51.44%	P25-P50	62.03%	P10-P25	45.12%	P10-P25	40.19%	P25-P50	21.55%	P25-P50
CARESOURCE										
2020	55.40%	P50-P75	67.17%	P25-P50	52.04%	P50-P75	47.36%	P50-P75	25.70%	P50-P75
MOLINA										
2020	61.50%	P75-P90	67.53%	P25-P50	49.44%	P25-P50	44.73%	P25-P50	23.04%	P25-P50
PARAMOUNT										
2020	61.35%	P75-P90	68.49%	P25-P50	49.71%	P25-P50	45.42%	P50-P75	23.39%	P25-P50
UNITED HEALTH										
2020	58.94%	P50-P75	64.76%	P10-P25	46.51%	P25-P50	41.66%	P25-P50	20.95%	P25-P50

Although the Pandemic had a substantial impact on dental utilization for children enrolled in Medicaid, childhood rates for immunizations slightly increased and lead screenings slightly decreased. Figure 30 delineates additional details related to dental services, immunizations, and lead testing. In 2020, 39.25% of children in the Medicaid program received at least one dental visit, a decrease from 51.47% in 2019. This decrease can be attributed, at least in part, to the COVID-19 pandemic.

It should be noted that the American Dental Association issued recommendations that all dental practices postpone elective procedures from March 16th-April 30th, 2020, and nationally dental utilization has not returned to pre-COVID levels. Dental utilization for adult Medicaid members, as well as children, also decreased from 2019 to 2020. The percentage of children two years of age with a Childhood Immunization Status, Combination 3[††] by their second birthday, increased from 62.0% in 2019 to 63.65% in 2020. The rate of lead screening in children two years of age slightly decreased, from 66.61% in 2019 to 64.53% in 2020. See Appendix D for a breakout of specific rates by managed care organization.

Figure 30: Preventive Measures Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2017-2020

	Annual Dental Visits		Childhood Immunization Status, Combination 3[‡‡]		Lead Screening in Children	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE MCO						
2017	**50.5%**	**P25-P50**	**63.3%**	**P10-P25**	**68.9%**	**P25-P50**
2018	**50.8%**	**P25-P50**	**63.9%**	**P10-P25**	**67.7%**	**P25-P50**
2019	**51.47%**	**P25-P50**	**62.00%**	**P10-P25**	**66.61%**	**P25-P50**
2020	**39.25%**	**P25-P50**	**63.65%**	**P25-P50**	**64.53%**	**P25-P50**

[††] Combination 3 vaccinations for Childhood Immunization Status includes DTap, IPV, MMR, HiB, HepB, VZV, and PCV.
[‡‡] Combination 3 vaccinations for Childhood Immunization Status includes DTap, IPV, MMR, HiB, HepB, VZV, and PCV.

7.3.2 Acute and Chronic Conditions

In 2020, among children aged 3 to 17 who were diagnosed with pharyngitis and received an antibiotic, 80.79% received a strep test. The percentage of children with asthma who were dispensed the appropriate rate of controller asthma medications to total asthma medications for children aged 5 to 11 was 78.74% and 72.95% for youth aged 12 to 18 in 2020. Please note that the HEDIS age group specifications for the pharyngitis measure were changed prior to 2020 and therefore comparable prior year rates are not available for comparison. Additionally, the Medication Management for People with Asthma measure was retired by HEDIS, so 2020 is the initial year the Asthma Medication Ratio measure results are included in this report.

Figure 31: Acute and Chronic Conditions Measures - Medicaid MCO Self-Reported, Audited HEDIS Rates, CY2020

	Appropriate Testing for Pharyngitis		Asthma Medication Ratio, 5-11 years		Asthma Medication Ratio, 12-18 years	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE MCO						
2020	80.79%	P25-P50	78.74%	P25-P50	72.95%	P50-P75

7.3.3 Behavioral Healthcare

The subset of measures described in Figure 32 can be used to gauge behavioral health services for youth in the Medicaid program. In 2020, the rate of children and adolescents who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment was 79.02%, a decrease from 81.25% in 2019. Although the 2020 rate decreased slightly from 2019, the 2020 rate exceeded the national Medicaid 90th percentile benchmark. The rate of adolescents aged 13 to17 who initiated alcohol or drug treatment and had two or more additional alcohol or other drug (AOD) services or medication-assisted treatment (MAT) within 34 days of the initiation visit decreased from 23.56% in 2019 to 19.77% in 2020; although the rate decreased, the 2020 rate was within the national Medicaid 75th-90th percentile benchmark. The rate of children who had a prescription for ADHD medication and remained on the medication for at least 210 days and had at least two follow-up visits in the 9 months after the initiation phase was 59.76% in 2019, decreasing slightly to 59.27% in 2020. See Appendix D for a breakout of results by managed care organization.

Figure 32: Behavioral Health Measures - Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2017-2020

	Use of First-Line Psychosocial Care for Children on Antipsychotics		Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, 13-17 Years		Follow-Up Care for Children Prescribed ADHD Medication Continuation/Maintenance Phase	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE MCO						
2017	75.1%	P≥90	22.5%	P75-P90	65.5%	P75-P90
2018	78.3%	P≥90	23.4%	P25-P50	64.6%	P75-P90
2019	81.25%	P≥90	23.56%	P75-P90	59.76%	P50-P75
2020	79.02%	P≥90	19.77%	P75-P90	59.27%	P50-P75

7.3.4 Behavioral Healthcare for Multi-System Youth

While children with Medicaid coverage have seen some improvements in behavioral health supports as indicated in the previous section of this report, children with complex behavioral health conditions remain in dire need of additional services and supports. Ohio currently ranks 40th in the nation in both young adults (aged 18 to 25) overdose deaths and major depressive episodes in adolescents (aged 12 to 17). Children with multi-system needs (e.g., in foster care, and/or having a developmental disability (DD), a serious emotional disturbance (SED), or a substance use disorder (SUD) diagnosis) often need to seek emergency and inpatient care, and behavioral health services make up a disproportionate amount of their healthcare service delivery costs.

To that end, the ODM is launching a new specialized managed care entity (MCE) for youth with complex behavioral health and multi-system needs: Ohio Resilience through Integrated Systems and Excellence or OhioRISE. OhioRISE will provide additional services and supports to approximately 50,000 children and youth who have complex behavioral health challenges and multi-system needs. OhioRISE aims to improve health and life outcomes for these children/youth and their families.

7.4 School-Based Healthcare

The Ohio Department of Medicaid recognizes the importance of encouraging and supporting a robust partnership between healthcare and education providers. School-based health initiatives help ensure students are in school, healthy, and ready to learn through a school or district's partnerships with healthcare providers and other community organizations. ODM supports

several efforts connecting primary care and behavioral health to school systems and education networks.

7.4.1 School-Based Measures Comparing Medicaid to Non-Medicaid Youth

Health is an important factor in shaping educational outcomes. To prioritize Ohio children's health, ODM and the Ohio Department of Education (ODE) partnered to understand the relationship between academic outcomes to the health status of youth in the Medicaid program. The school-based measures are standard measures routinely calculated by ODE and include touchpoints on a student's journey from kindergarten through high school graduation. Results for Medicaid and non-Medicaid populations in the school year 2018 are detailed in Figure 33, with lower performance on all measures for youth in the Medicaid program.

The percentage of third graders proficient on the English language arts state assessment increased for both Medicaid and non-Medicaid populations from the 2017-2018 school year to the 2018-2019 school year. For the Medicaid population, this proficiency increased from 48.3% in 2017-2018 to 53.5% in 2018-2019. For the non-Medicaid population, this proficiency increased from 72.0% in 2017-2018 to 78.2% in 2018-2019.

The percentage of seventh graders proficient on the mathematic state assessment decreased for both Medicaid and non-Medicaid populations from the 2017-2018 school year to the 2018-2019 school year. For the Medicaid population, this proficiency decreased from 43.3% in 2017-2018 to 41.0% in 2018-2019. For the non-Medicaid population, this proficiency decreased from 69.9% in 2017-2018 to 69.5% in 2018-2019.

Four-year high school on-time graduation rates increased for both Medicaid and non-Medicaid populations from the 2017-2018 school year to the 2018-2019 school year. For the Medicaid population, this proficiency increased from 73.4% in 2017-2018 to 74.5% in 2018-2019. For the non-Medicaid population, this proficiency increased from 91.6% in 2017-2018 to 92.1% in 2018-2019.

Due to the challenges posed by the COVID-19 pandemic, the ODE report cards for academic years 2019-2020 and 2021-2021 do not contain overall grades for any districts or buildings or individual grades or ratings for given components or performance measures. In keeping with legislation passed previously, which acknowledged the various obstacles to education the pandemic presented, information provided on report cards for these academic years includes graduation rates, Prepared for Success indicators, demographic and enrollment data, along with other district and school operational details. The following observations are reflective of these anomalies; thus, 2019-2020 and 2020-2021 rates cannot be compared to previous years for these measures:

- Chronic absenteeism rates and disciplinary incident rates decreased in the 2019-2020 school year.
- Chronic absenteeism rates increased in the 2020-2021 school year.
- Disciplinary incident rates decreased in the 2020-2021 school year.
- Third grade English and language arts and 7th grade mathematics rates have decreased in 2020-2021 from 2018-2019 due to the COVID-19 pandemic. Testing rates for 3rd grade English and language arts and 7th grade mathematics are not available for 2019-2020 due to COVID-19.

  Four-year high school on-time graduation rates increased for both the Medicaid and the non-Medicaid populations from the 2018-2019 school year to the 2019-2020 school year. For the Medicaid population, this proficiency increased from 74.5% in 2018-2019 to 77.0% in 2019-2020. For the non-Medicaid population, this proficiency increased from 92.1% in 2018-2019 to 92.4% in 2019-2020

Figure 33: School Years 2017-2018, 2018-2019, 2019-2020, 2020-2021 Measures by Medicaid Enrollment Status

ACADEMIC MEASURES	Percentage - Measure		N Size (Denominator)	
	Medicaid Enrolled[§§]	Non-Medicaid	Medicaid Enrolled*	Non-Medicaid
% Demonstrating Readiness **Kindergarten Readiness Assessment[***]**				
2017-2018 School Year	27.9%	52.9%	53,996	64,102
2018-2019 School Year	26.6%	53.4%	55,688	63,621
2019-2020 School Year	26.6%	53.3%	54,017	65,322
2020-2021 School Year	25.9%	54.2%	38,984	51,287
% 3rd Graders Proficient on **English Language Arts State Assessment[***]**				
2017-2018 School Year	48.3%	72.0%	62,150	73,560
2018-2019 School Year	53.5%	78.2%	60,801	69,926
2019-2020 School Year	N/A	N/A	N/A	N/A
2020-2021 School Year	35.4%	64.7%	51,770	66,498
% 7th graders Proficient on **Mathematics State Assessment[***]**				
2017-2018 School Year	43.3%	69.9%	48,627	74,156
2018-2019 School Year	41.0%	69.5%	52,350	72,508
2019-2020 School Year	N/A	N/A	N/A	N/A
2020-2021 School Year	26.3%	57.0%	47,354	67,123
Four-year On-time Graduation Rate (High School)				
2017-2018 School Year (2018 Grad Cohort)	73.4%	91.6%	47,749	90,289
2018-2019 School Year (2019 Grad Cohort)	74.5%	92.1%	48,407	89,287
2019-2020 School Year (2020 Grad Cohort)	77.0%	92.4%	46,190	89,672
2020-2021 School Year (2021 Grad Cohort - Data Lag)	N/A	N/A	N/A	N/A
Chronic Absenteeism Rate[†††]				
2017-2018 School Year	25.0%	9.9%	653,822	966,765
2018-2019 School Year	28.0%	10.8%	695,540	986,013
2019-2020 School Year	19.7%	7.2%	677,847	989,602
2020-2021 School Year	37.4%	14.7%	666,190	948,349
Disciplinary Incidents (per 100 FTE)[‡‡‡]				
2017-2018 School Year	N/A	N/A	N/A	N/A
2018-2019 School Year	40.3%	13.2%	670,314	947,247
2019-2020 School Year	30.3%	9.7%	656,017	954,286
2020-2021 School Year	8.5%	3.4%	653,477	924,034

7.4.2 Ohio's Healthy Students Profiles

In conjunction with school-based measures described in section 7.4.2 of this report, Ohio has developed Healthy Students profiles for every school district in the state. These profiles offer district and building-level insights into how key children's health indicators (e.g., asthma rates) correlate with key educational success indicators (e.g., chronic absenteeism). School districts can download their profiles, along with a guide and frequently asked questions, from the Ohio Department of Education website.

7.4.3 Telehealth in Schools Blueprint and Pilot

Between March 2020-February 2021, the cross-agency team led by the Governor's Children's Initiative and the Lieutenant Governor's Office, operationalized a telehealth pilot project to connect students with behavioral health providers in the Switzerland of Ohio School (SOH) District in Monroe, Belmont, and Noble counties. ODM provided funding and subject matter expertise to construct a pilot program aimed at connecting the school district with behavioral health services while providing high-speed internet connections to Ohioans who did not have broadband access. The district was selected based on its large geographic catchment area, remote Appalachian location, and financial and healthcare access needs. During the 2020-2021 school year, 103 behavioral health telehealth appointments were completed across SOH. The pilot is currently in its second year of implementation.

The state continues to invest in telehealth strategies for school-aged children. In April 2021, the state announced the expansion of its telehealth pilot to the Muskingum Valley Educational Service Center (MVESC) service area. Forty-eight telehealth sites across six counties will be operationalized throughout 2022, offering remote access to behavioral and physical health providers in the school setting.

More information about the Telehealth in Schools Blueprint and Pilot can be found on the InnovateOhio website.

7.5 Children's Initiative

Shortly after being signed into office at the beginning of 2019, Governor DeWine signed an executive order to create the Governor's Children's Initiative. This office has been charged with taking bold steps to give Ohio kids a platform for lifelong success by:

- Elevating the importance of children's programming in Ohio and driving improvements within the many state programs that serve children.
- Advancing policy related to home visiting, early intervention services, early childhood education, foster care, and child physical and mental health.
- Initiating and guiding enhancements to the early childhood, home visiting, foster care, education, and pediatric health systems.

- Improving communication and coordination across all state agencies that provide services to Ohio's children.
- Engaging local, federal, and private sector partners to align efforts and investments to have the largest possible impact on improving outcomes.

Medicaid is incredibly important to ensuring coverage and access to care for Ohio's youngest citizens. As the health insurance provider for more than 1.3 million children in the state, and in some Ohio counties, as the insurer for more than 80% of children under the age of 5 residing in the county, Medicaid has a great opportunity to improve the lifelong potential for Ohio's kids.

Governor DeWine's administration has been enthusiastically and financially supportive of Ohio's ability to provide healthcare to low-income children and families. Ohio's governor remains focused on children. ODM initiated and continued several programs to support the Governor's Children's Initiative in CY 2020-2021, including:

- Committed to a two-year continuation of Ohio Medicaid's Infant Mortality grant program to support coordinated community programs that target the disparity in the African American infant mortality rate. ODM is on track to award $26 million in 10 counties for SFYs 2022 and 2023 to support this targeted disparity reduction effort.
- Initiated implementation of the Maternal and Infant Support Program (MISP) by creating reimbursement for a report of pregnancy form and increased reimbursement for submission of an electronic pregnancy risk assessment form to help connect women to timely and critical pregnancy services, including continued Medicaid coverage and referrals to evidence-based home visiting services, such as Healthy Families America, Parents as Teachers, and Nurse Family Partnership.
- Continued expansion of critical telehealth services and adapted existing population health improvement plans to address pandemic conditions.
- Continued its multi-system youth custody relinquishment prevention program in partnership with all child-serving state sister agencies. In SFYs 2020-2022 (as of December 2021,) ODM spent $25 million in 82 counties to serve 631 multi-system youths. The statewide program has also provided technical assistance to additional counties to assist with individual cases and to build local capacity to serve even more children.
- Continued its child-focused patient-centered medical home program, Comprehensive Primary Care for Kids, which incentivizes pediatric primary care providers to meet children's specific quality metrics, such as immunizations and lead testing, as well as performing pediatric-specific activities like caring for foster youth, transitioning older children to adult care, and providing school-based care. In 2021, ODM has paid more

than $8 million in per-member per-month incentives to CPC for Kids practices covering more than 800,000 children receiving Medicaid services.

- Selected a vendor to administer OhioRISE, the specialized managed care program referenced above, which will serve youth with complex behavioral health and multi-system needs that will provide new services to children under 21 enrolled in Medicaid through a collaborative delivery system. OhioRISE will customize care for those children most at risk for out-of-home placement.

- Launched the OhioRISE Advisory Council, a group of engaged stakeholders who provide critical feedback and expert advice for OhioRISE's services and operations.

- In partnership with OMHAS, selected a vendor and began work on a Child and Adolescent Behavioral Health Center of Excellence that will support OhioRISE and other sitewide efforts to create access to in-home and community-based services that will keep Ohio families together.

In 2022, Ohio intends to remain focused on children. In addition to continuing to administer the program changes initiated in CY 2021, Ohio plans to:

- Continue implementation of the MISP by adding Medicaid coverage for additional programs, providers, and services to the extent possible that supports moms and babies through data-driven, evidence-based initiatives.

- Implement the OhioRISE program referenced above to support multi-system youth through new services and supports provided within a framework of coordinated care.

- Focus on the individual through the next generation of managed care, including improvements in the design, delivery, and timeliness of care coordination. ODM is working on strong cross-agency collaboration and partnership among managed care organizations, vendors, and state partner agencies to support specialization in addressing critical needs.

- Continue to close gaps in care and ensure access to critical services and resources as an adaptation to the persistent conditions of the global pandemic.

Section 8: References

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Appendix A: Data Sources and Methodologies for Calculations

Data Sources

Medicaid information was obtained from Medicaid claims, premium payment records, and eligibility records from ODM's Medicaid Information Technology System (MITS), Business Intelligence and Analytical Research (BIAR) system, and Medicaid's Quality Decision Support System (QDSS). In addition, the ODH Bureau of Vital Statistics provided birth certificate data and linked birth certificate/death certificate data. Where information is reported for Medicaid individuals and non-Medicaid populations, the linked VS/Medicaid data was used.

Linkage of Ohio Birth Certificates to Medicaid Data

Individuals were matched between the vital statistics birth records and Medicaid administrative data using two methods: a match using Social Security Number (SSN) plus two or more of First Name, Last Name, and Date of Birth (DOB), as well as a probabilistic match.[§§§] When unique identifiers such as SSN are not available or do not provide an accurate match when confirmed using name and DOB, the probabilistic linkage is typically the most efficient and effective way to minimize the risk of linkage error.[****]

The probabilistic linkage algorithm utilized[††††] all identifying information to assess whether two records in two different datasets refer to the same individual. For identifiers that were not names, such as zip code or date of birth, the algorithm assessed both perfect agreement as well as similarity. Searching for similarity is critical when linking administrative data because a certain percentage of cases contain errors. For example, the date "3/24/1998" shares a certain resemblance to "3/24/2998", and it is possible that the latter is a typographical error and was supposed to be recorded as "3/24/1998." For names, the similarity criteria were more complex because names may differ across datasets for legitimate reasons such as the use of nicknames, name changes, and misspellings. Since mothers and infants appear in the same "Case" in the Medicaid systems, higher confidence in linkage results was obtained by confirming that the mother-infant pair in the vital stats record matched both the mother and infant on the same case in the Medicaid system.

Beyond perfect string matches, first and last names were assessed for similarity using a variety of methods, including but not limited to a string-matching score, phonetic equivalence, one of the names is a nickname of the other, the names share a string of five or more common

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[§§§] Fellegi, Ivan P, and Alan B. Sunter. 1969. "A Theory of Record Linkage." Journal of the American Statistical Association 64:1183-1210.

[****] Tromp, Miranda, Anita C. Ravelli, Gouke J. Bonsel, Arie Hasman, and Johannes B. Reitsma. 2011. "Results from Simulated Data Sets: Probabilistic Record Linkage Outperforms Deterministic Record Linkage." Journal of Clinical Epidemiology 64:565-572.

[††††] Link Plus, Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/npcr/tools/registryplus/lp.htm.

characters, and the first and last names appear to have been swapped. The linkage algorithm then compared this to a population-level database containing names, birthdays and other demographic information and estimate two probabilities: the probability *m* that two records on a certain field would agree if they belonged to the same individual, and the probability *u*, that the two fields would agree, but the records belong to different individuals. These probabilities were then used to create agreement and disagreement weights for each field within each record pair to translate the agreement, similarity, and disagreement patterns for a given record pair into a score linked to the probability that the two records refer to the same individual. Record pairs with extremely high matching scores were accepted as matches while record pairs with somewhat high matching scores will be manually reviewed to determine match status.

Match statistics are generated throughout the process and are ultimately used to quantify the success of the linkage process. The proportion of Medicaid mothers joined to their infants via a common Ohio birth certificate is known as the "match rate." The historical annual match rates for the VS-claims birth linkage are depicted in Table 1A.

Table 1A: Combined Average Match Rate to Vital Statistics Birth Records for Mothers (Deliveries) and Infants (Births) in Medicaid Administrative Data

2017	2018	2019	2020
98.4%	99.4%	98.4%	98.8%

Calculation of Costs During Pregnancy and the Cost of Deliveries

Costs were included for all Medicaid deliveries in CYs 2017-2020. Costs during pregnancy, for this report, include all costs for the nine months prior to the month of delivery, the month of delivery, and the month following the month of delivery.

The costs of deliveries for women enrolled in managed care include birth premium payments and estimated birth premium payments for women with managed care encounter claims for a delivery service(s), but no delivery premium payment (incurred but not paid deliveries). Estimated birth premium payments were determined using the mother's county of residence, the last date of service on the delivery encounter claim, and the applicable managed care delivery rate cell code and premium amount (delivery encounter claims included those with a $0 payment and no indication of third-party payment, and those with a net claim payment > $0).

Delivery payments for mothers with FFS claims include net payments for inpatient hospital claims with an Ohio diagnosis-related group (DRG) code for a delivery, as applicable for the date of service/delivery. For those mothers with FFS claims indicating delivery, but no inpatient claim

with an applicable DRG, the cost of delivery was estimated using the statewide FFS average net payment for inpatient claims with an Ohio DRG code for a delivery. There were deliveries identified for both managed care and FFS for which the Ohio Medicaid cost was $0: 1) managed care deliveries for which third party payment was rendered and the net payment (by the MCO) was $0; and 2) FFS claims with an Ohio DRG delivery code in a paid status where the net payment was $0. Delivery and prenatal care costs were estimated for infants with Medicaid IDs (a state-assigned unique identifier for Medicaid) identified on the ODH VS birth file where the mother's Medicaid ID could not be determined.

Calculation of Costs of Infants in Medicaid

Infant costs include all managed care premium payments for dates of service in the month of birth through the month of the infant's first birthday if the infant was enrolled in an MCO. In addition, infant costs include FFS claims with dates of service in the month of birth up through the first 365 days of life. Infants may have both FFS claims and managed care premium payments included in the analysis. For CY 2017, costs were estimated for approximately 1.2% of newborns for whom a Medicaid recipient ID could not be determined, but who we were identified on the ODH VS birth file and linked to a mother with Medicaid birth and delivery claims data.

Chronic and Behavioral Health Conditions

Chronic conditions were derived using a chronic condition indicator included in the Clinical Conditions Software (CCS), developed by the Healthcare Cost and Utilization Project (HCUP). The chronic condition indicator flags claims as chronic at the diagnosis code level and then groups the claim by clinical condition. With that, a clinical condition can be acute or chronic, but a member is not included in the count unless the diagnosis code was flagged as chronic by the chronic condition indicator (Figure 27).

Behavioral health conditions also were derived from the CCS. The CCS looks at the primary diagnosis code on FFS claims and encounter data and flags them according to what clinical condition they fall under. For some clinical conditions, diagnosis codes were modified to best capture the prevalence of behavioral health conditions across the Medicaid population (Figure 28).

Appendix B: Low Birthweight (LBW) Births by County, CY 2020‡‡‡‡

| County | Medicaid | | | Non-Medicaid | | |
County Name	LBW Births	Total Births	LBW Rate	LBW Births	Total Births	LBW Rate
Adams	22	184	11.96%	7	104	6.73%
Allen	83	720	11.53%	26	450	5.78%
Ashland	20	238	8.40%	8	289	2.77%
Ashtabula	59	648	9.11%	13	323	4.03%
Athens	21	280	7.50%	10	172	5.81%
Auglaize	14	217	6.45%	14	313	4.47%
Belmont	7	74	9.46%	■	■	10.81%
Brown	26	251	10.36%	9	181	4.97%
Butler	233	2374	9.82%	112	1974	5.67%
Carroll	19	125	15.20%	■	■	2.38%
Champaign	28	206	13.59%	12	206	5.83%
Clark	111	1044	10.63%	25	448	5.58%
Clermont	91	930	9.79%	62	1223	5.07%
Clinton	16	274	5.84%	17	192	8.85%
Columbiana	63	588	10.71%	10	323	3.10%
Coshocton	23	225	10.22%	■	■	1.96%
Crawford	24	309	7.77%	7	133	5.26%
Cuyahoga	1057	7665	13.79%	333	5472	6.09%
Darke	17	249	6.83%	■	■	1.36%
Defiance	25	216	11.57%	■	■	2.58%
Delaware	48	397	12.09%	89	1611	5.53%
Erie	50	410	12.20%	18	289	6.23%
Fairfield	77	781	9.86%	52	851	6.11%
Fayette	15	201	7.46%	■	■	3.68%
Franklin	1081	9625	11.23%	421	7797	5.40%
Fulton	21	215	9.77%	13	227	5.73%
Gallia	15	187	8.02%	■	■	3.70%
Geauga	22	184	11.96%	34	751	4.53%
Greene	58	685	8.47%	57	1003	5.68%
Guernsey	29	255	11.37%	9	185	4.87%
Hamilton	721	5559	12.97%	277	4654	5.95%

‡‡‡‡ Due to the possibility of revealing protected health information and/or government program participation some rows of data have been redacted from the publicly facing document to ensure compliance with federal rules and expectations.

County						
Hancock	28	338	8.28%	27	487	5.54%
Hardin	22	210	10.48%	14	177	7.91%
Harrison	███	███	8.62%	███	███	3.70%
Henry	11	121	9.09%	11	171	6.43%
Highland	36	298	12.08%	7	180	3.89%
Hocking	19	199	9.55%	███	███	2.35%
Holmes	11	120	9.17%	24	704	3.41%
Huron	31	347	8.93%	14	280	5.00%
Jackson	24	228	10.53%	6	146	4.11%
Jefferson	12	191	6.28%	███	███	6.25%
Knox	31	303	10.23%	22	409	5.38%
Lake	60	824	7.28%	74	1191	6.21%
Lawrence	███	███	███	███	███	███
Licking	78	913	8.54%	44	930	4.73%
Logan	22	251	8.77%	6	232	2.59%
Lorain	198	1735	11.41%	78	1443	5.41%
Lucas	388	3385	11.46%	101	1725	5.86%
Madison	16	212	7.55%	7	220	3.18%
Mahoning	188	1513	12.43%	44	764	5.76%
Marion	38	480	7.92%	11	202	5.45%
Medina	42	466	9.01%	46	1121	4.10%
Meigs	███	███	███	███	███	███
Mercer	13	167	7.78%	14	433	3.23%
Miami	46	543	8.47%	23	597	3.85%
Monroe	7	45	15.56%	███	███	3.03%
Montgomery	422	3744	11.27%	128	2421	5.29%
Morgan	6	94	6.38%	███	███	3.85%
Morrow	30	175	17.14%	7	175	4.00%
Muskingum	58	670	8.66%	19	339	5.61%
Noble	8	70	11.43%	███	███	1.35%
Ottawa	14	136	10.29%	11	176	6.25%
Paulding	6	102	5.88%	███	███	1.52%
Perry	21	275	7.64%	6	141	4.26%
Pickaway	22	284	7.75%	15	343	4.37%
Pike	25	239	10.46%	███	███	5.00%
Portage	64	601	10.65%	30	691	4.34%
Preble	16	208	7.69%	7	160	4.38%
Putnam	6	108	5.56%	16	293	5.46%
Richland	73	802	9.10%	22	523	4.21%
Ross	52	505	10.30%	11	236	4.66%
Sandusky	27	349	7.74%	11	252	4.37%
Scioto	33	486	6.79%	7	222	3.15%

Seneca	47	348	13.51%	15	256	5.86%
Shelby	15	264	5.68%	15	330	4.55%
Stark	264	2228	11.85%	74	1677	4.41%
Summit	378	2985	12.66%	132	2505	5.27%
Trumbull	135	1253	10.77%	25	671	3.73%
Tuscarawas	50	575	8.70%	23	487	4.72%
Union	25	180	13.89%	28	515	5.44%
Van Wert	13	128	10.16%	███	███	3.23%
Vinton	███	███	███	███	███	███
Warren	63	759	8.30%	80	1640	4.88%
Washington	20	248	8.07%	8	193	4.15%
Wayne	45	456	9.87%	53	944	5.61%
Williams	17	212	8.02%	███	███	2.26%
Wood	40	464	8.62%	32	714	4.48%
Wyandot	9	98	9.18%	███	███	3.67%

Appendix C: Preterm Births by County, CY 2020‡‡‡‡

County	Medicaid			Non-Medicaid		
County Name	Preterm Births	Total Births	Preterm Rate	Preterm Births	Total Births	Preterm Rate
Adams	31	184	16.85%	10	104	9.62%
Allen	90	721	12.48%	36	450	8.00%
Ashland	20	238	8.40%	16	288	5.56%
Ashtabula	77	648	11.88%	20	324	6.17%
Athens	29	280	10.36%	13	172	7.56%
Auglaize	31	217	14.29%	22	313	7.03%
Belmont	10	75	13.33%	■	■	5.41%
Brown	43	251	17.13%	14	181	7.74%
Butler	280	2379	11.77%	146	1975	7.39%
Carroll	18	125	14.40%	■	■	3.97%
Champaign	25	205	12.20%	19	206	9.22%
Clark	138	1045	13.21%	46	447	10.29%
Clermont	124	930	13.33%	104	1225	8.49%
Clinton	30	276	10.87%	26	192	13.54%
Columbiana	83	588	14.12%	24	323	7.43%
Coshocton	23	226	10.18%	11	203	5.42%
Crawford	34	309	11.00%	14	134	10.45%
Cuyahoga	1101	7687	14.32%	395	5479	7.21%
Darke	29	248	11.69%	19	295	6.44%
Defiance	23	216	10.65%	7	156	4.49%
Delaware	50	397	12.59%	114	1612	7.07%
Erie	46	411	11.19%	20	289	6.92%
Fairfield	110	783	14.05%	76	852	8.92%
Fayette	22	200	11.00%	11	136	8.09%
Franklin	1236	9643	12.82%	586	7807	7.51%
Fulton	28	216	12.96%	13	227	5.73%
Gallia	18	186	9.68%	■	■	2.83%
Geauga	24	184	13.04%	36	751	4.79%
Greene	82	683	12.01%	85	1003	8.48%
Guernsey	34	253	13.44%	12	186	6.45%
Hamilton	787	5574	14.12%	341	4656	7.32%
Hancock	28	339	8.26%	42	487	8.62%
Hardin	28	212	13.21%	11	177	6.22%
Harrison	7	58	12.07%	■	■	3.64%
Henry	17	121	14.05%	15	171	8.77%
Highland	42	295	14.24%	16	180	8.89%
Hocking	■	■	■	■	■	■

County						
Holmes	15	120	12.50%	39	703	5.55%
Huron	35	348	10.06%	25	280	8.93%
Jackson	25	228	10.97%	9	144	6.25%
Jefferson	15	189	7.94%	■	■	6.25%
Knox	43	304	14.15%	29	409	7.09%
Lake	78	827	9.43%	94	1191	7.89%
Lawrence	■	■	■	■	■	■
Licking	103	912	11.29%	62	929	6.67%
Logan	34	251	13.55%	16	233	6.87%
Lorain	219	1743	12.57%	114	1446	7.88%
Lucas	453	3401	13.32%	141	1723	8.18%
Madison	28	211	13.27%	14	220	6.36%
Mahoning	224	1518	14.76%	66	764	8.64%
Marion	61	480	12.71%	22	202	10.89%
Medina	52	465	11.18%	69	1122	6.15%
Meigs	11	112	9.82%	■	■	4.35%
Mercer	19	167	11.38%	30	434	6.91%
Miami	57	547	10.42%	38	598	6.36%
Monroe	■	■	■	■	■	■
Montgomery	478	3756	12.73%	208	2427	8.57%
Morgan	9	95	9.47%	■	■	7.69%
Morrow	35	175	20.00%	8	175	4.57%
Muskingum	80	673	11.89%	26	339	7.67%
Noble	■	■	■	■	■	■
Ottawa	18	137	13.14%	18	176	10.23%
Paulding	■	■	2.94%	■	■	4.55%
Perry	26	275	9.46%	10	141	7.09%
Pickaway	38	288	13.19%	26	343	7.58%
Pike	36	240	15.00%	8	100	8.00%
Portage	86	601	14.31%	41	691	5.93%
Preble	20	208	9.62%	15	158	9.49%
Putnam	19	109	17.43%	33	294	11.22%
Richland	82	805	10.19%	38	522	7.28%
Ross	62	506	12.25%	16	236	6.78%
Sandusky	41	353	11.62%	16	252	6.35%
Scioto	54	487	11.09%	16	222	7.21%
Seneca	47	349	13.47%	19	256	7.42%
Shelby	27	264	10.23%	27	330	8.18%
Stark	277	2233	12.41%	107	1680	6.37%
Summit	377	2984	12.63%	163	2506	6.50%
Trumbull	169	1253	13.49%	49	671	7.30%

Tuscarawas	70	575	12.17%	27	487	5.54%
Union	24	180	13.33%	42	515	8.16%
Van Wert	15	128	11.72%	████	████	3.23%
Vinton	16	72	22.22%	████	████	12.20%
Warren	77	761	10.12%	108	1641	6.58%
Washington	30	247	12.15%	12	193	6.22%
Wayne	48	456	10.53%	58	944	6.14%
Williams	23	212	10.85%	6	133	4.51%
Wood	51	464	10.99%	41	716	5.73%
Wyandot	11	98	11.22%	10	109	9.17%

Appendix D: Managed Care and Fee-For-Service Rates for Child Quality Measures

Table 2: Preventive Measures Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2013-2020

	Annual Dental Visits		Childhood Immunization Status, Combination 3		Lead Screening in Children	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	47.1%	P25-P50	65.9%	P10-P25	65.6%	P25-P50
2015	48.4%	P25-P50	62.8%	P10-P25	66.2%	P25-P50
2016	49.8%	P25-P50	60.9%	P10-P25	71.4%	P50-P75
2017	50.5%	P25-P50	63.3%	P10-P25	68.9%	P25-P50
2018	50.8%	P25-P50	63.9%	P10-P25	67.7%	P25-P50
2019	51.47%	P25-P50	62.00%	P10-P25	66.61%	P25-P50
2020	39.25%	P25-P50	63.65%	P25-P50	64.53%	P25-P50
BUCKEYE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	44.50%	P25-P50	66.2%	P10-P25	60.0%	P25-P50
2015	41.70%	P25-P50	63.9%	P10-P25	58.6%	P25-P50
2016	43.50%	P25-P50	62.0%	P10-P25	87.7%	P≥90
2017	45.50%	P10-P25	63.3%	P10-P25	80.2%	P75-P90
2018	45.96%	P10-P25	61.8%	P10-P25	75.4%	P50-P75
2019	46.08%	P10-P25	61.80%	P10-P25	62.77%	P10-P25
2020	32.46%	P10-P25	60.34%	P10-P25	58.39%	P10-P25
CARESOURCE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	50.40%	P25-P50	67.9%	P25-P50	68.4%	P25-P50
2015	51.30%	P25-P50	63.3%	P10-P25	68.1%	P25-P50
2016	53.10%	P50-P75	61.1%	P10-P25	69.6%	P25-P50
2017	53.40%	P25-P50	64.0%	P10-P25	68.1%	P25-P50
2018	53.67%	P25-P50	64.7%	P10-P25	67.6%	P25-P50
2019	54.20%	P25-P50	61.07%	P10-P25	67.64%	P25-P50
2020	40.46%	P25-P50	65.21%	P25-P50	65.30%	P25-P50
MOLINA						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	42.40%	P10-P25	63.1%	P10-P25	66.6%	P25-P50

2015	48.00%	P25-P50	60.0%	P10-P25	72.2%	P50-P75
2016	46.00%	P25-P50	59.6%	P10-P25	66.7%	P25-P50
2017	49.90%	P25-P50	65.5%	P25-P50	68.1%	P25-P50
2018	51.53%	P25-P50	63.3%	P10-P25	65.9%	P25-P50
2019	53.00%	P25-P50	63.26%	P10-P25	68.15%	P25-P50
2020	52.31%	P50-P75	63.99%	P25-P50	70.07%	P25-P50
PARAMOUNT						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	41.30%	P10-P25	61.8%	P10-P25	56.5%	P10-P25
2015	43.60%	P25-P50	62.3%	P10-P25	58.9%	P25-P50
2016	45.80%	P25-P50	63.3%	P10-P25	58.4%	P10-P25
2017	44.90%	P10-P25	58.4%	P10-P25	66.4%	P25-P50
2018	45.02%	P10-P25	66.9%	P25-P50	64.0%	P25-P50
2019	46.67%	P10-P25	62.29%	P10-P25	66.18%	P25-P50
2020	35.23%	P10-P25	65.45%	P10-P25P25-P50	65.45%	P25-P50
UNITED HEALTH						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	41.70%	P10-P25	60.1%	P10-P25	59.4%	P25-P50
2015	44.50%	P25-P50	63.5%	P10-P25	62.3%	P25-P50
2016	46.10%	P25-P50	57.7%	P<10	79.1%	P50-P75
2017	45.60%	P25-P50	61.3%	P10-P25	61.4%	P10-P25
2018	46.22%	P10-P25	60.6%	P10-P25	63.8%	P25-P50
2019	46.47%	P10-P25	65.21%	P10-P25	63.75%	P25-P50
2020	33.69%	P10-P25	63.26%	P25-P50	63.50%	P25-P50

Table 3: Behavioral Health Measures Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2013-2020

	Use of First-Line Psychosocial Care for Children on Antipsychotics		Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, 13-17 years		Follow-Up Care for Children Prescribed ADHD Medication Continuation/Maintenance Phase	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	75.5%	N/A	6.7%	P10-P25	61.7%	P75-P90
2015	77.1%	P≥90	16.1%	P50-P75	63.8%	P75-P90
2016	74.7%	P≥90	21.1%	P50-P75	64.3%	P75-P90
2017	75.1%	P≥90	22.5%	P75-P90	65.5%	P75-P90
2018	78.3%	P≥90	23.4%	P25-P50	64.6%	P75-P90
2019	81.25%	≥P90	23.56%	P75-P90	59.76%	P50-P75
2020	79.02%	P75-P90	19.77%	P75-P90	59.27%	P50-P75
BUCKEYE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	65.5%	N/A	9.5%	P25-P50	57.5%	P50-P75
2015	66.9%	P50-P75	11.9%	P25-P50	53.6%	P50-P75
2016	81.6%	P≥90	21.8%	P75-P90	54.5%	P50-P75
2017	78.9%	P≥90	23.1%	P75-P90	66.2%	P75-P90
2018	78.7%	P≥90	20.8%	P≥90	67.6%	P75-P90
2019	79.94%	≥P90	17.05%	P50-P75	57.29%	P50-P75
2020	78.17%	P75-P90	16.55%	P50-P75	56.62%	P50-P75
CARESOURCE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	81.2%	N/A	5.5%	P10-P25	64.7%	P75-P90
2015	81.1%	P≥90	19.4%	P50-P75	68.2%	P≥90
2016	74.2%	P75-P90	23.7%	P75-P90	69.2%	P≥90
2017	76.3%	P≥90	25.8%	P≥90	68.1%	P75-P90
2018	78.4%	P≥90	22.5%	P≥90	69.9%	P ≥ 90
2019	81.30%	≥P90	23.27%	P75-P90	61.43%	P50-P75
2020	78.85%	P75-P90	20.51%	P75-P90	59.45%	P50-P75

MOLINA						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	67.0%	N/A	7.3%	P10-P25	62.2%	P75-P90
2015	70.4%	P75-P90	8.2%	P10-P25	67.0%	P75-P90
2016	68.9%	P75-P90	8.5%	P10-P25	61.5%	P50-P75
2017	68.8%	P75-P90	12.8%	P25-P50	67.2%	P75-P90
2018	75.9%	P≥90	35.6%	P≥90	57.9%	P50-P75
2019	78.71%	≥P90	23.79%	P75-P90	62.01%	P50-P75
2020	80.31%	≥P90	19.16%	P75-P90	60.32%	P50-P75
PARAMOUNT						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	80.6%	N/A	6.7%	P10-P25	63.8%	P75-P90
2015	81.1%	P≥90	7.6%	P10-P25	62.2%	P50-P75
2016	80.9%	P≥90	10.0%	P10-P25	69.5%	P≥90
2017	81.6%	P≥90	8.3%	P10-P25	69.1%	P75-P90
2018	81.0%	P≥90	17.6%	P≥90	65.8%	P75-P90
2019	84.01%	≥P90	23.77%	P75-P90	55.91%	P50-P75
2020	79.72%	≥P90	15.76%	P50-P75	59.65%	P50-P75
UNITED HEALTH						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	60.2%	N/A	7.4%	P10-P25	40.2%	P25-P50
2015	68.6%	P75-P90	9.0%	P10-P25	42.8%	P25-P50
2016	71.2%	P75-P90	14.6%	P25-P50	45.2%	P25-P50
2017	66.9%	P50-P75	6.9%	P10-P25	40.8%	P10-P25
2018	77.7%	P≥90	22.2%	P≥90	40.3%	P10-P25
2019	82.49%	≥P90	31.73%	P≥90	54.35%	P25-P50
2020	79.28%	P75-P90	22.79%	P≥90	60.00%	P50-P75