



Groundwork Ohio Response to

Ohio Department of Medicaid

Request for Information #2

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Groundwork Ohio is a fiscally-sponsored project of Community Initiatives

The Ohio Department of Medicaid (ODM), through its agency leadership and the opportunity afforded by managed care plan procurement, is uniquely positioned to advance our state's kids, families and communities by investing in the healthy development of Ohio's most at-risk young children. As ODM continues its process of procuring new managed care vendors, we answer the below RFI questions with a renewed ask to the Department to prioritize Ohio's youngest children. This will not only build a strong foundation for their healthy development and lifelong success, but also strengthen the future of the Ohio Medicaid program.

1. Person-Centered Care

Through the procurement, ODM intends to improve the engagement and experience of individuals and their families as they access care throughout the Medicaid system. Groundwork proposes that ODM support MCOs and providers to become person-centered organizations dedicated to improving the experience of individuals they serve by requiring them to demonstrate a special understanding of, prioritize, and deliver upon outcomes for young children and their families. If MCOs are in the business of improving health outcomes, they must engage in prevention strategies focused on meeting the needs of their youngest members. We believe managed care procurement is an opportunity to work toward a new standard of care for Ohio children prenatal through five with the following commitments:

1. Deliver and maximize for young children the full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to provide comprehensive and preventive health care services. The Ohio Department of Medicaid should support the delivery and maximization of this benefit for young children by utilizing all enforcement levers including tools, incentives, and penalties.
2. Commit to the goal of health equity for young children through the delivery of the EPSDT benefit, any Medicaid financed services and other plan-level commitments to young children so access to services and child outcomes are not determined by income, race, geography, intellectual ability, physical ability or any other social factors.
3. Provide a clear signal to all providers working with young children that the state recognizes and pays for treatment specific to young children through practice and policy including the recognition and incorporation of specialized diagnostic codes using DC:0-5™: Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-5).
4. Identify and address the unmet social needs and risk factors of young children that have a significant impact on health outcomes and costs, and coordinate both the health and social components of care that will have the most influence on outcomes for young children with the support of community-based organizations.
5. Measure and track quality improvement for young children and meet progress benchmarks.

In making these commitments, plans should be made accountable to answering the following questions as it concerns young children and their families:

- How would you ensure children under the age of 5 get the full benefit of their EPSDT entitlement? (e.g. maternal depression screen, dyadic therapy, two generation interventions)

- What is your quality agenda for young children? How would you measure and track your progress?
- How will you prioritize prevention services and supports for young children (e.g. preventing multi-system babies)?
- How will you advance health equity for children and families?
- How are you engaging community partners to best serve young children and their families (e.g. care coordination, case management, wrap around services, social/emotional development)?
- How are you performing on and looking to improve developmental screenings and appropriate follow-up to screenings?
- How are you working to promote high-performing medical homes like CPC for young children?
- What does your pediatric provider panel look like? How does it support young children and families?
- How are you engaging with and identifying high-risk pregnant moms?
- How are you working to reduce barriers to accessing care (e.g. social determinants of health)?
- In what ways are you ensuring children are ready to learn when they arrive in the kindergarten classroom?
- How are you supporting young children and families in crisis?
- How are you communicating with members about their rights? How do young children and family voices influence your practices?

Regarding the use of technology to communicate with individuals, we ask that ODM and MCOs use data to drive decisions about communication strategies based on population—parents of young children are utilizing different platforms than our older members. In addition to reaching parents, we need to meet children where they are. Young children are often with their parents, caregivers and grandparents but are part of a greater community and are often in home visiting, early intervention and child care programs as well. MCOs should strategically partner with other state programs, systems and CBOs not just to deliver services, but to assist them in communicating about wellness activities. MCOs also need to be prepared to deliver information in a way that is developmentally appropriate for the audience it is trying to ultimately reach, in this case young children.

MCOs and providers must take a leadership role in reducing the impact of health care disparities and the extent to which health outcomes are determined by poverty, race and geography. To do so, they must have an understanding of the brain science of early childhood development. Brains are built on a foundation of early experiences. Ninety percent of brain development happens from birth to age five and eighty percent happens by age three. In the first few years of life, more than one million neural connections are formed every second. These neural connections, the brain's architecture, are formed through the interaction of baby and their environment through early enriching experiences. While genes provide a blueprint for brain architecture, neural connections must be formed through repeated use. All children are born with the ability to reach their highest potential, but connections that form early either form a strong or weak foundation for the connections that form later. These critical interactions with adults lay the foundation for all later learning, behavior and health.

Unfortunately, not all children have access to the same early enriching experiences. Without consistent and responsive caregiving, the brain architecture does not form as expected and will lead to disparities in learning and behavior. Early learning and healthy development are inextricably linked. Without intervention in the most critical early years of a child's brain development, we see gaps in the health and

educational achievement among economically disadvantaged children. These gaps widen as children grow older leaving children with economic disadvantages two years behind their peers by age five. This science informs ODM and MCOs alike. If you want to reduce disparities you have to close them when they begin in the earliest years where there is the greatest opportunity to influence brain development by both encouraging healthy behaviors and mitigating the impacts of trauma and adversity. MCOs accordingly have an interest in engaging in early learning and healthy development strategies in the first five years of life to reduce health disparities.

MCOs can support providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy by providing training on the culture of poverty, implicit bias and cultural competence. Culturally relevant strategies include relevant care delivery to the age group of the Medicaid beneficiary and acknowledges that young children do not come in pieces—they come in a family unit. Providers need continued training on responding to the needs of young children and their families informed by best practices and updated research. They also need opportunities to understand and be able to refer to and communicate about the benefits of non-clinical interventions and the value of CBOs in their community. Providers also need to be educated about the full scope of the EPSDT benefits package and be trained in and utilizing the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) as an age-appropriate approach for assessing infants, toddlers and preschool children.

MCOs have to also be committed to ongoing data collection and evaluation to reduce and monitor progress on reducing health disparities, guide prevention strategy and act proactively about what they expect in the adult population based upon the child population.

4. Fiscal Intermediary

Groundwork is supportive in concept of a fiscal intermediary to improve the operation of the Medicaid program, but the thoughtful choice of entity and the payment model employed for this entity are critical. This entity should be adequately incentivized and motivated to do their job well. Their work must go beyond setting up an initial process and implementation to exhibiting a clear commitment to continuous improvement as the Medicaid program evolves and the entity learns from its experience. Additionally, the entity must have a keen understanding that the processes (e.g. prior authorization, medical necessity) for which they will be serving as the intermediary look different for the pediatric population. For example, pediatric medical necessity must incorporate different considerations that reflect the needs and development of children. This distinction and the thoughtful planning around it are critical and cannot be overstated—we understand that plans mix them up often which delays or prevents kids from getting the care they need to survive and thrive. When addressing some of the processes, it may be helpful under EPSDT to have a risk stratification or assessment process for children who have certain risk factors to determine whether they get a certain service (e.g. care coordination). Some states use these risk factors for program or service eligibility (e.g. Early Intervention, prior authorization, or medical necessity for dyadic therapy, etc.).

5. Enrollment

ODM intends to redistribute individuals who do not affirmatively select an MCO across all MCOs using an automatic assignment algorithm. Groundwork believes that ODM's efforts to standardize the Medicaid program across MCOs is important, but that building in some competition and incentives through automatic assignment are a healthy way to ensure performance and accountability on Medicaid outcome

and population priorities. Accordingly, Groundwork proposes that automatic assignments for plan enrollment be contingent upon plan quality.

These quality metrics should include some standardized metrics and others specific to population so that the enrollee's profile is considered when making an assignment. For example, a pregnant woman should be assigned to a plan who is producing the best outcomes for pregnant women at the time of enrollment. Similarly, young children should be assigned to a plan best delivering upon their needs, both in terms of outcome metrics and innovative programming and relationships with CBOs.

In order to avoid unnecessary disruption, the algorithm should also consider prior enrollment, especially for foster and adopted children in transition. Where disruption is necessary, the decision should be made in the child's best interest and the transition of care should be supported between payors.

The algorithm should be transparently communicated to best inform the decisions of all actors in the Medicaid program. This is particularly important for special populations including foster and adopted children where counties currently have the option to choose the plan to serve this population. ODM should educate counties about how plans are able to serve this special population.

Additionally, families must be kept together in the same managed care plan regardless of whether they are enrolled through auto-assignment or other attribution-based models.

6. Health and Wellness

To improve health outcomes and support individual wellness, ODM will use a state-driven population health strategy designed to reduce infant mortality and preterm births, increase healthy behaviors, promote tobacco cessation, and address healthcare inequities. Groundwork is excited that ODM envisions a robust community-based organization and MCO partnership infrastructure to accomplish this goal. We would propose that in order to reduce infant mortality and preterm births, increase healthy behaviors, and reduce health inequities, advancing the following bundle of services through this partnership with a specific focus on the earliest years of a child's life is required:

A Framework for Leveraging Medicaid Managed Care Plans to Advance a Quality Agenda for Ohio's Youngest Children

PRIORITY	GOALS	METRICS	SERVICES
<p>1. Prenatal-3</p> <p>2. Health Equity</p>	<p>Ohio's youngest children are...</p> <p>HEALTHY.</p> <ul style="list-style-type: none"> • They can maximize access to integrated physical and behavioral health care. • Their exposure to lead is reduced and the negative impact of lead exposure is mitigated. • Barriers to their healthy development are identified early and they have access to early interventions to overcome or mitigate barriers to healthy development. <p>SAFE.</p> <ul style="list-style-type: none"> • Their incidence of exposure to trauma is reduced and the negative impacts of trauma are mitigated. • Their family is stabilized and there are fewer young children entering into custody or kinship care. <p>NURTURED.</p> <ul style="list-style-type: none"> • They have secure attachments and nurturing relationships with adult caregivers. <p>CONNECTED.</p> <ul style="list-style-type: none"> • They experience a continuum of care and continuity of care with supported transitions. • They have access to family and community supports that contribute to their healthy development. <p>READY FOR SCHOOL</p> <ul style="list-style-type: none"> • They have access to high quality learning environments. • Their parents are supported to be their child's first and best teacher. 	<p>What are the consistent set of metrics that measure goals across all services?</p> <p>Metrics that measure goals across all services should be considered include existing traditional Medicaid metrics for children in addition to other health and education metrics that health plans may commit to tracking for their children through coordination with child serving local and state agencies in addition to community partners.</p> <p>This core set of metrics would measure the following:</p> <ul style="list-style-type: none"> • Birth outcomes • EPSDT screen data & well child visits • Lead screen • A health service follow-up metric • Dyadic or two-generation service participation benchmarks (e.g. home visiting, parenting programs, etc.) • Reduction in children entering the child welfare system • Kindergarten Readiness 	<p>What services are necessary to achieve the goals?</p> <p>Medicaid dollars should be leveraged and prioritized to pay for the following package of services for young children and their families:</p> <ul style="list-style-type: none"> • Evidence-based home visiting (Healthy Families America, Nurse Family Partnership, Parents as Teachers, Early Head Start) • Early Intervention • Early Childhood Mental Health Consultation • Case Management • Pathways HUB • Maternal depression screenings, diagnosis and treatment • Infant & Early Childhood Mental Health Treatment • Parental substance abuse and mental health counseling • Parenting Programs (Triple P) designed to improve children's social and emotional development <p><i>Note: Strategic financing with other federal dollars, including but not limited to Family First Prevention Services Act (FFPSA), Maternal, Infant and Early Childhood Home Visiting Act (MIECHV), and other federal and state funding streams should be analyzed to determine which services Medicaid should pay for versus which other services or service components can be paid by other funding streams with the goal of strategically maximizing and leveraging resources for young children.</i></p>

The role of community-based organizations in delivering on this Framework is as follows:

1. Identify and address the unmet social needs and risk factors of young children that have a significant impact on health outcomes and costs.
2. Support the coordination and delivery of health and social components of care that will have the most influence on outcomes for young children through a partnership with managed care organizations.
3. Implement the Framework by sharing the priorities and goals of the Framework, measuring goals and delivering the enumerated services by responding to and delivering upon a Request for Proposal through the Ohio Department of Medicaid or from a managed care plan.
4. Commit to the goal of health equity for young children through the coordination and delivery of services to young children and their families so that access to services and child outcomes are not determined by income, race, geography, intellectual or physical ability or any other social factors.
5. Measure and track quality improvement for young children and meet progress benchmarks.

Additionally, the [NC Care 360](#) Model deployed by North Carolina is worth studying as a model to connect community-based services to Medicaid beneficiaries to address social determinants of health.

7. Performance Incentives/Reimbursement Strategies

Groundwork shares the common challenge of harnessing health reform to reach our shared goal of promoting child health and development and preventing poor outcomes. Typically, health reform focuses on high cost, high-need individuals, not long-term prevention. It has not adequately reflected child development nor has it recognized how child health is shaped by nonmedical factors. We must continue to challenge our Medicaid system and its stakeholders to think differently about health reform for children so that its goals match child health needs.

Despite this challenge, ODM has led and built a value-based reimbursement program centered on team-based primary care or patient-centered medical homes. ODM should hold the MCOs accountable to the scaling of Ohio CPC to more practices and members participating in the model. They can support the Ohio CPC for Kids enhancements beginning in the 2020 program year and monitor practices' success on current Ohio CPC pediatric metrics and the additional CPC for Kids metrics linked to payment. MCOs should be used to build and shape the Ohio CPC for impact in the pediatric population.

ODM and MCOs need to be partners in continuing to design payment approaches for children's primary care, screening, care coordination, health-related services, and population health responses commensurate with their value (i.e. at levels that will sustain them in practice and incentivize their spread). Value for children is different than for adults. As such, the definition of "value" for young children should continue to be improved upon with a focus on longer term impacts of health improvements and cost-savings that are not necessarily limited to the health care system.

8. Quality Improvement

ODM, and the MCOs, through their contractual relationship with ODM, should adopt a children's quality agenda -- a set of shared goals and measures across all child-serving human services, health care, and education agencies -- and regularly measure and publicly report progress on these outcomes. ODM and MCOs should use and develop measurement approaches at the clinical level and at the population level that correspond to the quality agenda, a broad definition of child health and early childhood comprehensive systems. For Medicaid, this would include: EPSDT 416 data, Centers for Medicare and Medicaid Services (CMS) core set of children's health care quality measures, and other child health quality measures tied to high-value care. Measurement approaches should not, however, be limited by Medicaid.

As part of this strategy, the state should create a multidisciplinary team within the Medicaid department that focuses on addressing policy and regulatory barriers to better health outcomes for children and their families, including a focus on improving coordination and collaboration between the department, health plans, Title V, early intervention, early care and education, primary and secondary education, child welfare and child advocates. The department should develop Memoranda of Understanding (MOUs) among appropriate agencies to formalize new collaborative efforts.

The quality agenda should prioritize the social and emotional development of young children. Healthy social and emotional development in young children underpins a lifetime of healthy physical development. An increased focus on preventive screening, diagnosis and treatment is needed to ensure that young children have the capacity to experience, express and regulate emotions; form close, secure interpersonal relationships; explore his/her environment; and learn within the context of family and cultural expectations.

ODM and MCOs should explore the following strategies:

- Improve preventative screenings based on expert-recommended schedules and guidelines by building social and emotional screening, assessment, and interventions into care management requirements.
- Require plans to consider the social and emotional health of young children when establishing criteria for identifying who will receive intensive care management.
- Medicaid plans should be selected based on their strategy for addressing the social and emotional health of young children including, but not limited to, the following:
 - The quality and diversity of their networks to serve young children.
 - Their sophistication in leveraging their network and expertise to serve young children.
 - Their willingness to investigate the impact of upstream strategies and partnerships to impact the social determinants of early childhood health by connecting hard-to-reach families to resources.
 - Their willingness to innovate in terms of settings and provider types appropriate for early childhood mental health promotion, prevention and treatment services such as child care, home visiting and early intervention.
- Encourage plans to provide value-added services aimed at supporting the social and emotional health of children.
- Expand and improve upon parent/caregiver diagnosis as eligibility for dyadic therapy.
- Require young child- or pregnant woman-specific performance improvement projects to reduce infant mortality or impact other priority metrics (e.g. core set, HEDIS measures).

- Use incentive metrics to drive increases in prenatal care, postpartum visits, maternal depression screenings and follow up and well-baby care. A potential outcome measure could be the new HEDIS maternal mental health measure.

9. Employment, Education and Training

Considering the approved 1115 waiver, individuals enrolled through Ohio's Medicaid expansion will be required to demonstrate that they work 20 hours per week or are engaged in other allowable activities, including job search, education and training, or community service. To the extent that some individuals subject to the requirement may be parents or caregivers, we would encourage MCOs to support partnerships with quality child care programs so their beneficiaries have the opportunity to seek and retain employment without putting their child into low-quality or unsafe child care. Given that Ohio has one of the lowest publicly funded child care eligibilities in the country at 130% FPL, there may be Medicaid beneficiaries who do not qualify for subsidized care but, given the high cost of care in the private market, cannot afford quality or even safe care options. In consideration of Ohio's other priorities for children under the current administration, MCOs should be encouraged to innovate with how to support families through child care without limitation to the expansion population.

Regarding educating or training individuals for future employment opportunities, MCOs should be encouraged to sponsor programs and connect with vocational education or other higher education institutions. Special consideration should be given to programs that support capacity building in critical occupations that reflect the administration's other priorities, particularly related to families and children. This includes building capacity among the child care and home visiting workforce in addition to other health care and occupations that support the interventions the MCOs are advancing alongside CBOs. As a result, MCOs may be able to support their beneficiaries in obtaining the requisite training and securing employment that supports the MCO beneficiary population more broadly. We have current models across the state and supported by the Ohio Department of Job and Family Services and local communities that could inform MCOs how to support employment in the child care field for example.

If ODM requires MCOs to actively participate with each other, ODM and other stakeholders to develop a collective impact approach to workforce development (Question 19), ODM and MCOs should consider the same cross sector approach as described above.

10. Dental Services

Groundwork echoes the importance of dental services to ensuring improved health outcomes and wants to place special attention on pediatric dental services that support healthy habits and prevent high cost dental services. Successful approaches should include strategic financing of mobile dental clinics and school-based dental clinics, especially where there are network gaps in rural areas. MCOs should partner with CBOs and other service providers (child care, home visiting, schools, pediatricians) to ensure penetration of dental services in hard to reach populations across the state.

11. Transportation

ODM needs to ensure that pregnant women or children using non-emergency transportation can bring their other children or another caregiver with them to support her care and the care of her children. This has been a barrier in other states who have not specified that other children can join in transportation.

12. Care Coordination

Defining and financing differentiated levels of care coordination/case management is a core part of high-quality care. Medical homes, by definition, include care coordination/case management as a part of standard practice, but some families need more intensive, relational care coordination. Care coordination should respond to risks identified at levels of intensity reflecting child and family needs. Effective care coordinators demonstrate skills in engaging families, building family strengths and being culturally, ethnically, and linguistically responsive.

While the focus of ODM has been on improving care for children with complex needs, Groundwork believes that while responding to this acute need of children who are often in crisis is necessary, it is not a sufficient. This response lacks a prevention strategy for young children who are presenting different risk factors and who are on a trajectory to become older children with complex needs. ODM should also focus on care management and coordination in the preventative care context to keep kids from needing complex care management.

Groundwork asserts that ODM through MCOs, should incentivize cross-system care coordination. Care coordination for young children and their families should not only be focused on medical services but should coordinate services for children across educational and social service settings. These services should also work to help families navigate the many types of services they need including housing, food, and educational assistance. Care coordination may be delegated to another entity, such as a Pathways HUB or community health worker, but outcomes need to be tracked and reported.

MCOs and/or coordinating care entities and community-based organizations should meet the expectations respectively laid out in Questions 1 and 6 in implementing a framework that prioritizes the needs of very young children and their families through care coordination and a bundle of preventative and treatment services.

Additionally, Groundwork supports the utilization of Care Guides to be responsible for closing referral loops and tracking cases until a resolution is reached or a warm handoff is made to a longer-term solution. A risk stratification model can help determine when a Care Guide is deployed in those limited times of need.

ODM should also incentivize plans to improve health outcomes through non-medical interventions and more integrated service systems. Plans should be selected based on their ability to improve health outcomes for children and their families through social impact interventions.

13. Services for Children Involved in Multiple State Systems

While Groundwork supports the collaborative work that has culminated in well-deserved attention to services for children involved in multiple state systems or with complex behavior health needs, we comment on this question in light of what we know about early childhood development and the inextricable links between physical and behavior health. Groundwork supports maintaining integrated health plans. Carving out health care services and placing them in a specialty plan adds additional complexity for families and providers without demonstrating a clear improvement in care.

Groundwork also mimics its response to the previous question to reinforce that while responding to this acute need of children who are often in crisis is necessary, it is not a sufficient response to improving care and outcomes for children with complex needs because it lacks a prevention strategy for young children.

14. Behavioral Health Services

Groundwork is pleased that the State continues to work with behavioral health providers, managed care organizations and other stakeholders to stabilize the integration of behavioral health services into managed care. We believe that MCOs should be incentivized to provide integrated care. Providers should be incentivized to integrate physical and behavioral health care, collaborate with other community partners, and align with the state's quality strategy. Performance measures related to young children could be linked to developmental screening rates. Performance measures should also reflect referral to services and actual treatment or delivery of the recommended service in addition to other innovative prevention efforts lead by the MCOs or in partnership with CBOs.

Regarding the array of services, clinical settings should have a process for screening, as well as discussing and responding to results that can lead to diagnoses and linkages to critical services for young children (e.g. Early Intervention, family support programs, Head Start, home visiting, high quality child care). ODM should explore all vehicles through which to finance services identified through screening and diagnosis that include specialty medical services, but also evidence-based services to improve child health and development, including two-generation models and family support services

Additionally, ODM should require mental health and related screening for infants, young children, pregnant women, mothers and other caregivers— with follow-up for those with identified risks, including further age-appropriate diagnoses (e.g. promotion and use of DC:0-5), parent-child dyadic therapies, and other Infant and Early Child Mental Health (IECMH) services, particularly those that can respond to trauma experienced by the child or family.

15. Opioid Use Disorder and Substance Use Disorder

Medicaid plays a central role in efforts to address the state's opiate epidemic including the coverage of evidence-based interventions and treatment, providing tools and support to providers, and enhancing the state's capacity. Groundwork again wants to place a spotlight on the invisible victims of the opioid epidemic, Ohio's youngest children. The opioid crisis extends far beyond those experiencing addiction—the mental and physical health, social-emotional well-being, and potential for long term success of Ohio kids affected by the opioid epidemic are severely at risk. Investing in quality early learning and healthy development strategies for our youngest Ohioans can increase their resiliency, buffer the trauma caused by the epidemic, and reduce their likelihood of using drugs as an adult. Caring for the youngest and most vulnerable victims of the opioid epidemic must be prioritized as our state responds to this crisis.

Studies have shown that high-quality early childhood interventions decrease rates of drug use, especially among males who account for 66% of Ohio's opioid overdose deaths each year. Studies have shown that, compared to a control group, males who received a high-quality early childhood education were half as likely to be arrested for drug related offenses. Furthermore, home visiting programs, which are an integral part of Ohio's early childhood system have been proven to decrease rates of maternal drug abuse, reduce the effect of parental addiction on children, and improve family economic self-sufficiency. These links, along with positive impact on attainment levels and employment outcomes, suggest that an investment

in quality early learning and healthy development strategies in Ohio would have a significant long-term impact on the opioid crisis.

In addition to preventing the impacts of drug abuse by investing in prevention strategies, MCOs need to support, share and improve performance to expand access and improve outcomes for individuals with substance and opioid use disorder. MCOs should treat those with substance and opioid use disorder alongside their family and in a manner that restores them to participate in both their family and community. This means taking responsibility for their children. Groundwork supports the increased use of dyadic care models and evidence-based interventions that empower parents not only to combat substance use but also to be a nurturing and supportive parent who is prepared to support their child's healthy development.

16. In Lieu of Services

ODM currently only recognizes Institutions for Mental Disease as in lieu of services. These are alternative services in a setting not included in the state plan or otherwise covered by the contract, but are medically effective substitutes for state plan services included in a contract. They act as cost-effective substitutes for state plan services. ODM should explore the feasibility of adopting other in lieu of services to meet the needs of young children particularly through non-clinical interventions and the provision of services in alternative settings in recognition of the barriers faced as a result of the social determinants of health to accessing those services. ODM should evaluate new in lieu of services across MCOs that reflect the priorities of the administration and the needs of young children. ODM should also be open to MCOs proposing in lieu of services through the procurement process to meet the same goals.

For example, in lieu of providing infant-parent psychotherapy in a clinical setting, ODM may explore recognizing evidence-based home visiting models where they are getting a service in the home that shares some of the outcomes of psychotherapy. Integrated therapeutic preschool or child care for infants and toddlers where they are getting therapeutic services in their child care, preschool, Early Head Start or Head Start setting could also stand in the place of psychotherapy.

Another example may be that, in lieu of 4 discreet office services (occupational therapy, physical therapy, speech therapy and early childhood mental health consultation), ODM could recognize the services provided by a developmental specialist employing all of these services through Early Intervention in a home setting or other natural environment.

17. Centralized Credentialing

Groundwork's comments concerning centralized credentialing does not speak to the process contemplated but rather aims to ensure or request that ODM consider non-traditional or non-clinical providers that can provide preventative care for children and their parents. As ODM is building out this process, we also want to ensure that the Department considers opportunities to streamline credentialing across other systems, agencies and programs serving young children and their families (e.g. early childhood mental health, home visiting, early intervention, child care, schools, substance abuse treatment). Coordinating and leveraging the knowledge of these systems will prevent confusion and better support the workforce who is often shared among these various systems.

18. Standardizing Provider Requirements

While Groundwork has chosen not to fully address the questions posed in this section, we want to ensure that pregnant women can access medication assisted treatment (MAT) for substance abuse disorder regardless of type of enrollment. We recognize this as a potential workforce issue that necessitates consideration when standardizing provider requirements. Providers who care for pregnant women need to be trained in MAT and other addiction-related treatment.

21. Data and Information

ODM and MCOs should make decisions based on data and evidence. ODM should reward and evaluate health plan partnerships and progress based upon data-driven, evidence-based outcomes.

Groundwork references the use of data in regard to how it can be used to inform population strategy and in regard to quality and performance measures through this response, but also wants to stress that data is critical to advancing health equity. We know we cannot make significant demographic-level gains unless we target sub-groups of our most at-risk children. What we measure matters—if we do not measure equity and disaggregate by race, geography and other social factors, we cannot deliver on outcomes. MCOs should benchmark progress for health equity for children and their families by committing to quality metrics disaggregated by race and other factors.

ODM should track and report outcome and demographic data for children by health plan, fee-for-service, and by OEI region for the following:

- Wellness visits;
- Preventive dental services; and
- Lead screening.

The state should create and include a developmental inventory measure of kindergarten readiness as a performance metric for health plans similar to what is planned in Oregon.¹ This could be a quality metric for health plans and could also be used to improve Ohio's CPC model for kids.

In order to deliver upon improved health outcomes for children ODM must also support the development of integrated cross-system child databases and data system development for cross-sector referrals.

22. General Feedback

Improving Evidence-Based Home Visiting Through Medicaid

Groundwork is very supportive of the Governor's goal to triple the number of families served through evidence-based home visiting. With its substantial federal match, ability to reach the most high-risk families, and health benefit alignment, Medicaid provides a powerful tool for scaling up home visiting and sustaining this investment over time. With half of all Ohio births financed by Medicaid, the program also has unique access to vulnerable populations of women who could benefit from home visiting. We

¹ Oregon is currently working on specifications for this measure. More can be found at: https://childinst.org/wp-content/uploads/2018/09/HAKR_Technical_Workgroup_Report_2019_Final-with-Cover-Letter.pdf

know the Medicaid program is, in some instances, already funding home visiting through managed care grant funds and has plans to develop a Medicaid home visiting service. Evidence-based home visiting has consistently been proven to provide improvements in birth outcomes, early child development, school performance, and family self-sufficiency.

Recommendations

- Any new benefit that is developed to leverage evidence-based home visiting should be incorporated into the new managed care contracts.
- The state should ensure that evidence-based models are supported by strategic financing. This will require a review of rate structures so they sufficiently reflect the cost of building and sustaining programs given the growth goal.
- The state should ensure that evidence-based models are delivered to fidelity and have strong accountability to outcomes.
- The state should ensure that evidence-based home visiting is available to and prioritized for the most at-risk Medicaid populations.

Defining Roles for Evidence-Based Home Visitors and Community Health Workers

The state has been a leader in the development and investigation of promising and evidence-based practices to better meet the needs of our youngest and most vulnerable moms and babies. Ohio families have benefitted by the substantial work around Pathways HUBs, Targeted Case Management, and proven home visiting models for example. Given that many programs develop in discreet departments using specific funding streams, learnings are not often shared with other program innovations outside of these discreet parameters – even when program objectives and outcomes are similar. This phenomenon has created some confusion in the field, particularly as it relates to the different roles and competencies of community health workers and home visitors. Clearly defining these roles and core competencies, while creating a logic model illustrating how both disciplines should work together to leverage program strengths across departments, would benefit the field and the state as it seeks to further scale successful innovations. Both interventions provide needed, but distinct, services. Understanding how they should work together would eliminate program duplication and increase the efficiency and the effectiveness of the innovations.

We ask that Medicaid and the Department of Health take a shared accountability approach using both agencies as well as the health plans to advance these roles to leverage outcomes for pregnant moms, babies and young children. We also ask that Medicaid provide leadership in defining these roles, including through the use of the health plans. Doing so may and should require a broader vision of health outcomes that include, but are not limited to, birth outcomes. They must reflect the full needs of the family and child beyond the critical indicator of whether or not a child lives to their first birthday. While infant mortality is an absolutely critical measure, we cannot settle on that metric alone—Ohio babies deserve more than a first birthday. We should measure these outcomes and be mindful of the transitions inherent in the choices of programs we provide these families, so that vulnerable parents and young children are supported beyond the first year of life.

Recommendations

- The state should convene a conversation with stakeholders to outline how to define and view these strategies in a Medicaid context.

- The state should create an incentive in the community health worker structure to screen and refer families to home visiting services.
- The state should specify under what circumstances a mother could receive services from a community health worker *and* receive home visiting services to improve coordination and avoid duplication of services.
- Revise the managed care contract to clarify roles and uses for the services provided through each model.

Conclusion:

Groundwork Ohio shares a common goal with the state and the Ohio Department of Medicaid to ensure that all our children grow up healthy and equipped to reach their full potential. Because of what we know about the science of brain development, we understand that we have to use evidence-based practices in the earliest years to improve long-term outcomes in learning, behavior, and health. The key drivers of our shared goal include the following:

- Access to high quality medical care for pregnant women and children
- Evidence-based home visiting for vulnerable families
- High-quality early childhood education
- Two-generation programs in health and education
- Prevention and mitigation of toxic stress in early childhood
- Providing economic stability supports to increase family self-sufficiency
- Reducing neurotoxin exposure such as lead

We are calling on ODM and MCOs to support and operationalize a Medicaid-driven, cross sector approach to improving child health and development outcomes in the earliest years of life...

- Because children rely on Medicaid, especially in their first three years of life. Medicaid provides health care coverage for more than half of all Ohio infants and toddlers.
- Because pediatric primary care is regularly accessed by families and is the only (near) universal system for reaching families in the earliest years of a child's life.
- Because, as a public program, Medicaid has an interest in reducing long-term health care expenses and expenses to other public systems.
- Because Medicaid is already one of our most effective means of improving child outcomes and it can be leveraged to do much more.

23. Economic Considerations

The strength of the economy has a countercyclical impact on a state's Medicaid program. If an MCO wants to address the negative budgetary effects of an economic downturn, while maintaining a person-centered and effective delivery of care model, it must begin shifting focus and strategic resources to prevention efforts. We have to think about young children differently when it comes to value-based payment models and incentives in managed care because most of the population is relatively low cost. If our Medicaid program does not begin to shift the paradigm of investments to a child's earliest years our state will miss an incredible opportunity to build a strong foundation that will leave us less vulnerable to economic downturn in the years to come. We must invest now, in the earliest years, when it matters most to

changing long term health outcomes or the state will pay later in systems that will continue to fall victim to responding to adults and children in crisis.

25. Opportunity for Interview

Groundwork Ohio would welcome the opportunity for an interview with ODM to discuss the answers provided in our Response to the RFI.

- a. Groundwork Ohio
- b. Non-profit public policy research and advocacy organization (Interested Party)
- c. Lynanne Gutierrez
Policy Director & Legal Counsel
(614) 204-6106
lgutierrez@groundworkohio.org
- d. Shannon Jones, Executive Director of Groundwork Ohio
Lynanne Gutierrez, Policy Director & Legal Counsel
- e. Implementation of managed care procurement and evaluation of policies specific to pregnant women and young children.

Groundwork Ohio's mission is to champion high-quality early learning and healthy development strategies (from the prenatal period to age five), that lay a strong foundation for Ohio kids, families and communities. For more information and to contact us, please visit www.GroundworkOhio.org.