Groundwork Ohio Response to

Ohio Department of Medicaid
Request for Information

GroundworkOhio.org

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Groundwork Ohio is a fiscally-sponsored project of Community Initiatives

The Ohio Department of Medicaid, 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. Ohio's current early childhood "system" built to respond to the incredible needs of our young children is a patchwork of programs spanning five state departments and numerous funding streams that provide early learning opportunities and physical and behavioral health care to support the healthy development of children birth through age five and their families. Too often these systems are underfunded, do not talk to one another and fail to take into consideration the realities and limitations on the families being served, adhering instead to the ease and convenience of the programs.

But to do so effectively, the Department must focus with intensity on our youngest and most vulnerable moms and babies.

Why?

Because 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 these 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.

The Ohio Early Childhood Story

In Ohio, only 40% of kindergarteners come to the classroom ready to learn. It is no surprise then that only 43% of Ohio's workforce has a degree or credential for available jobs. This is no surprise because of what we know about brain science and it is why investments made in quality birth to five interventions before Kindergarten yield upwards of a 13% return on public investment. Our state has not, however, adequately invested in young children and many children have been left behind as evidenced by the following data:

- Premature Births: 11.9% of all Ohio births are premature.
- Infant Mortality: Ohio ranks 41st out of 50 states for infant mortality with a rate of 7.4 for every 1,000 live births.
- Early Childhood Poverty: 1 in 5 Ohio children live in poverty. 1 in 4 Ohio children ages 0-4 live in poverty.
- Trauma: Ohio ranks 46th in the nation for kids experiencing childhood trauma. 49% of Ohio kids have had at least one adverse childhood experience (ACE) 1 in 7 Ohio kids have three or more ACEs.
- Kindergarten Readiness: 40% of Ohio kindergarteners are ready for kindergarten.

Some children are left behind more often than others. Poverty disproportionately impacts young children and families of color, making it even more difficult to overcome adversity and maintain healthy development. While these children include those living in poverty, data illustrates that poverty alone does not tell the whole story. A child's race and where they live foretells a distinct and critical narrative that must be examined separately to understand the problem fully, as even those children of color who are not poor are too often not achieving at the rate of their white peers. Achieving equitable outcomes for all children requires investing in those who are more often left behind and giving them what they need for lifelong success.

- Premature Births: 1 in every 7 African American babies are born premature compared to 1 in every 10 white babies
- Infant Mortality: 15.2 black babies die before their first birthday compared to 5.8 white babies for every 1,000 births. Black babies are dying at nearly three times the rate of white babies.
- Early Childhood Poverty: 1 in 3 children age 0-4 living in Ohio's rural Appalachian region live in poverty. 1 in 2 black children age 0-4 live in poverty.
- Trauma: 40% of white children have had an ACE versus 51% of Hispanic children and 61% of black children (based upon a national data set).
- Kindergarten Readiness: 26.7% of economically disadvantaged Ohio kindergartners are ready for kindergarten compared to 57% of their higher income peers. The gap between poor students and their higher income peers remains steady throughout a child's schooling. 23.9% of black children (less than poor children) are ready for kindergarten compared to 47% of their white peers. The gap between black children and their white peers does not remain steady. It actually gets worse throughout their schooling.

Leveraging Medicaid to Advance Healthy Early Childhood Development

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 to improve outcomes in learning, behavior, and health for vulnerable young children. 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 also share 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 recognized how child health is shaped by nonmedical factors. We have to 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.

The First 1000 Days

We are calling on the Department of Medicaid, managed care, pediatricians, education, child welfare, social services, mental health and child advocates to support and operationalize a Medicaid-driven, cross sector approach to improving child health and development outcomes in the first three years of life. Why the First 1000 days?

- 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 sectors.
- Because Medicaid is already one of our most effective means of improving child outcomes and it can be leveraged to do more.

We appreciate the recent changes that the Medicaid program has made that are improving health outcomes for pregnant mothers and children such as the following:

- Managed care enrollment on day one to speed up access to care coordination to ensure pregnant women are connected to prenatal care quickly;
- Extending coverage for 12 months for mothers after delivery to facilitate continuous coverage;
- Infant mortality reduction strategies focused on smoking cessation, birth spacing, and safe sleeping; and
- Comprehensive Primary Care, including the upcoming Comprehensive Primary Care Program for Kids.

We thank you for the opportunity to offer recommendations to build upon this progress and consider the opportunity to lead a cross-systems approach focused on the First 1000 days of a child's life to improve outcomes for young children as Ohio seeks to improve its managed care program. Managed care should play a critical role in this approach.

Recommendations

- **Align state programs through a Kid's Quality Agenda.** The state should adopt a kid'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. 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.

- **Incentivize cross-system care coordination.** Care coordination for young children and their families should not just be focused on medical services but should coordinate services for children across educational and social service settings, and also work to help families navigate the many types of services that 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.
- **Incentivize plans to improve health outcomes through non-medical interventions.** Plans should be selected based on their ability to improve health outcomes for children and their families through the use of social impact interventions.
- **Maintain integrated health plans.** Carving out health care services and placing them in a specialty plan adds additional complexity for families and providers without a clear improvement in care.
- **Keep families together.** Families should be kept together in the same managed care plan through auto assignment and other attribution-based models.
- **Incentivize 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.
- **Make decisions based on data and evidence.** Reward and evaluate health plan partnerships and progress based upon data-driven, evidence-based outcomes.

Providing a Proactive Response to the Decrease in Coverage Rates for Children

Medicaid is an important source of coverage for young children and ensuring timely enrollment and continuous coverage for families of young children is foundational. Ohio, like many other states has seen the number of children enrolled in Medicaid fall since the middle of FY 2017. While some of the decline can be associated with the increase in employment, the most recent American Community Survey showed an increase of about 20,000 uninsured children in Ohio. We know that a stronger economy is not the driving factor for this increase and so Medicaid should continue to investigate the data to address the root causes for this substantial trend change.

Recommendations

- The state should use the plans to promote enrollment and continuous coverage for children through their targeted outreach and mass marketing campaigns. We recognize that children are part of a family unit. Accordingly, strategies to increase access and coverage for families should reflect this fact.
- In conjunction with consumer stakeholder groups, the state should develop consumer friendly-FAQs to address known misperceptions about Medicaid that are barriers to enrollment for children such as eligibility levels for children and adults, estate recovery, and public charge.

Prioritizing 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; and explore his/her environment and learn, within the context of family and cultural expectations.

Recommendations

- 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 downstream 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 services.
- 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.

Advancing Child Health Equity through Data, Evaluation, and Accountability.

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 don't measure equity and disaggregate by race, geography and other social factors, we cannot deliver on outcomes.

Recommendations

- Medicaid plans should be selected based on their strategy to improve health equity for children and their families and their commitment to quality metrics disaggregated by race and other factors.
- The state should track and report outcome and demographic data for children by health plan and fee for service and by OEI region for the following:
    - Wellness visits;
    - Preventive dental services; and
    - Lead screening.
- The state should develop 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 metric could be a quality metric for health plans and could also be used to improve Ohio's CPC model for kids.
- Support the development of integrated cross-system child databases and data system development for cross-sector referrals.

[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

Improving Evidence-Based Home Visiting Through Medicaid

Groundwork is very supportive of the Governor's goal to triple the number of families served through home visiting. With its substantial federal match, ability to reach 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 know that 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 that 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 aren't 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 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 provide needed, but distinct services, and 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 both of 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.

Ensuring a Strong Transition Plan to Protect Progress

Over the past eight years, the state has worked with the five current plans and its external quality review organization through a series of quality improvement projects to improve outcomes for children. While our progress has been slow it has been steady. As Ohio Medicaid potentially brings in new plans and others exit, please ensure that the gains that have been made are not lost. As with any potential change in provider plans, we want to think critically about how not to lose momentum in better meeting the needs of young children. Accordingly, we recommend continued stakeholder engagement inclusive of the consumer voice to gather feedback on state-directed topics. This may include maintenance of the requirement for plans to have family advisory councils or consider outside advocates to convene stakeholders as a forum to gather consumer feedback.