Texas MCO NMDOH Learning Collaborative In-Person Meeting

March 7, 2025

Made possible thanks to the support of the Episcopal Health Foundation and the Michael and Susan Dell Foundation

Center for Health Care Strategies
Better care where it's needed most

EPISCOPAL HEALTH FOUNDATION

TACHP Texas Association of Community Health Plans

TREATY OAK STRATEGIES

Michael & Susan Dell FOUNDATION

TAHP
The Texas Association of Health Plans

TEXAS Health and Human Services

Welcome & Introductions

Janet Walker
Texas Association of Community Health Plans

Michelle Alletto
Health and Human Services Commission

Aliya Hussani
Michael and Susan Dell Foundation

Ann Barnes
Episcopal Health Foundation

MCO NMDOH Survey Findings and Year 6 Goals

Laurie Vanhoose
Treaty Oak Strategies

MCO NMDOH Survey Results

Laurie Vanhoose, Principal,
Treaty Oak Strategies

TREATY OAK
STRATEGIES

Background

- The Learning Collaborative was established based on the initial Texas MCO NMDOH survey in 2018
  - Survey findings published in a 2019 Health Affairs blog
  - Survey revealed that while Texas MCOs are committed to addressing NMDOH, financial challenges and a lack of understanding of Texas Medicaid policies that authorize MCOs to advance NMDOH activities
- A second survey conducted in 2020 highlighted that during the COVID-19 pandemic, MCOs saw an increased need to address NMDOH and MCOs also observed that many CBOs were overwhelmed with increased social service needs but were short on funding resources
- A third survey in 2023 highlighted that all MCOs were screening Members for NMDOH but using various types of screening tools and made it clear that MCOs have now, more than ever, integrated NMDOH issues as they consider strategies to improve the health outcomes of their Members
- EHF and Learning Collaborative partners decided to initiate a 4th survey to identify continued work in the NMDOH space

2024 Survey

- All MCOs are screening pregnant women using a standard screening tools due to HB 1575 and have expanded the screening to other populations
  - Every plan is using a subset of HB 1575 questions and the only reason for deviating is that the screening is focused on pregnant women
- 10 health plans have some type of arrangement or initiative with a provider to screen for NMDOH but health plans continue to cite lack of reimbursement, provider burden as main reasons they do not require providers to screen for NMDOH
  - The majority of the screening is taking place in a specific type of program or part of an initiative like an APM
- All plans are investing in CBOs and have some type of relationship with CBOs across the state but still struggle with identifying opportunities to categorize that relationship in FSRs
  - Since not a provider type it is also difficult to have an APM relationship directly with a CBO but many APMs integrate work with a CBO in some capacity – for example for referrals when NMDOH needs are identified
- There are six health plans that either have an arrangement with or are working to implement an APM with a CIN
  - All health plans expressed interest in working with the CIN and appreciate the work going into developing new CINs in Texas

Year 6

- Explore best practices and opportunities around NMDOH screening in Medicaid
- Data sharing between MCOs, providers and CBOs
- Building CBO networks and MCO contracting
- Highlighting EHF and MCO initiatives
- Assist with implementation of any Medicaid NMDOH bills
- Continue to support implementation of HB 1575
- Support APM development that includes NMDOH interventions and/or CBOs
- Highlight MCO case studies as identified by EHF
- Other topics of interest?

Update on National Policy Changes and Federal Discussions

Matt Salo
Salo Health Strategies

HHSC and DSHS Updates

Emily Sentilles
Health and Human Services Commission

Michelle Erwin
Health and Human Services Commission

Joelle Jung
Health and Human Services Commission

Summer Stringer
Health and Human Services Commission

Lori Gabbert Charney
Department of State Health Services

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Health and Human Services

Texas Medicaid Updates

Medicaid & CHIP Services

Texas Health & Human Services

March 2025

Texas Medicaid Managed Care Quality Strategy

Emily Sentilles, Deputy Associate Commissioner
Quality and Program Improvement

What is the Quality Strategy?

- Each state contracting with a managed care organization (MCO) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by MCOs.
- The quality strategy is reviewed each year by the External Quality Review Organization.
- At least every three years, Texas must review and update its quality strategy.
- HHSC uses its Quality Strategy to assess and improve the quality of health care and services provided through the managed care system, setting priorities through goals and objectives.

Quality Strategy Requirements

- Applicable to CHIP and Medicaid.
- State must identify goals and objectives for continuous quality improvement.
- Goals and objectives must be measurable.
- Must consider the health status of all populations served by the state's contracted managed care plans.
- State must make the quality strategy available for public comment, including obtaining input from its Medical Care Advisory Committee.
- Must post the quality strategy on the state website.

Changes from Prior Quality Strategy

- Goals streamlined and revised
- Additional objectives
- New Appendix mapping measures to objectives
- Connecting goals and HHSC initiatives

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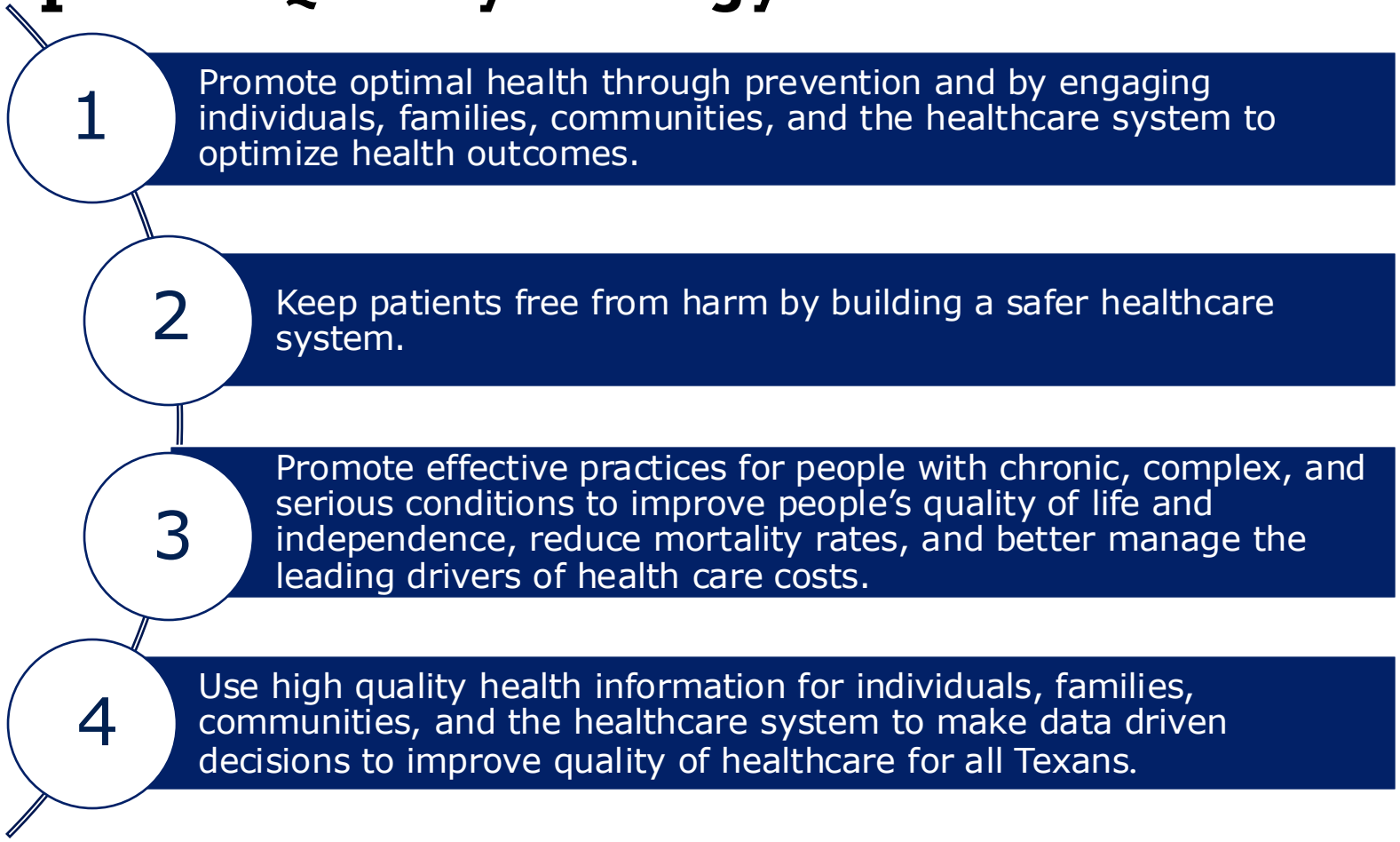
Updated Quality Strategy Goals



Texas Health Care Quality Goals	Objectives
 Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.	a. Increase access to and use of preventive and primary care, including through telehealth b. Increase screening for chronic disease, behavioral health conditions, and substance use disorders c. Address non-medical drivers of health d. Increase the rate of preconception, early prenatal, and postpartum care and other preventive health utilization e. Promote a positive experience of care for Medicaid and CHIP members and providers f. Reduce avoidable hospital admissions and emergency department visits

New Program Additions

- Nonemergency Medical Transportation
- Non-Medical Drivers of Health Action Plan
- Directed Payment Programs
- Aligning Technology by Linking Interoperable Systems (ATLIS)

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Appendix A: Mapping Objectives, Quality Measures, and HHSC Initiatives

Appendix A. Crosswalk of Quality Objectives and Measures in HHSC Initiatives

1.c) Address non-medical drivers of health

Measure	HHSC Initiatives
Food Insecurity Screening and Follow-Up Plan	CHIRP, TIPPS
Non-Medical Drivers of Health Screening and Follow-up Plan Best Practices	CHIRP, RAPPS, DPP BHS
Social Need Screening and Intervention (SNS-E*)	Performance Indicator Dashboard

Resources

- Managed Care Quality Strategy
- EQRO Annual Technical Report
- CMS National Quality Strategy

House Bill 1575 (2023) Update

Michelle Erwin, Deputy Associate Commissioner, Office of Policy

Jolle Jung, Project Manager, Quality & Program Improvement

House Bill (H.B.) 1575 Summary

- Medicaid Managed Care Organizations (MCOs) and Thriving Texas Families (TTF) screen pregnant women for non-medical health-related needs and coordinate services
- Pregnant women must opt-in

- MCOs and TTF share results with HHSC

- Community Health Workers (CHW) and Doulas as new providers of Medicaid case management for Children and Pregnant Women (CPW) case management services
- Revised provider training for CPW services

- Report sent to the Legislature every two years

New Provider Updates

CPW policy guidelines in the *Behavioral Health and Case Management Services Handbook* of the TMPPM updated on December 1, 2024, to include:

- Health-related non-medical conditions question as part of the intake process
- Doulas and Community Health Workers (CHWs) as eligible to enroll as case managers
- Additional details relating to services, benefits, limitations, documentation, and billing and reimbursement

Effective December 1, 2024, CHWs and Doulas are eligible to enroll as CPW case managers in the Provider Enrollment and Management System (PEMS).

Texas Administrative Code

Texas Administrative Code (TAC) rules proposal to:

- Repeal rules in TAC, Title 25, Part 1, Chapter 27
- Establish new rules in TAC, Title 26, Part 1, Chapter 257
- Proposed rules published in the *Texas Register* on February 21, 2025
  - Public comment ends March 24, 2025
- Tentative effective date of June 2025

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Continued Outreach

HHSC will continue providing training and assistance for the new provider types

- Continued work with external partners
  - November 2024 meeting
  - Exploring future opportunities
- Trainings and assistance offered by TMHP
  - February 2025
- Providing guidance to MCOs and providers
  - Professional liability insurance
  - Continuity of care requirements

"Non-Medical Health-Related Needs of Certain Pregnant Women Report"

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Home > Search Regulations > Reports and Presentations

Reports and Presentations

Note: These files are in PDF format unless otherwise noted.

Search for reports and presentations Go

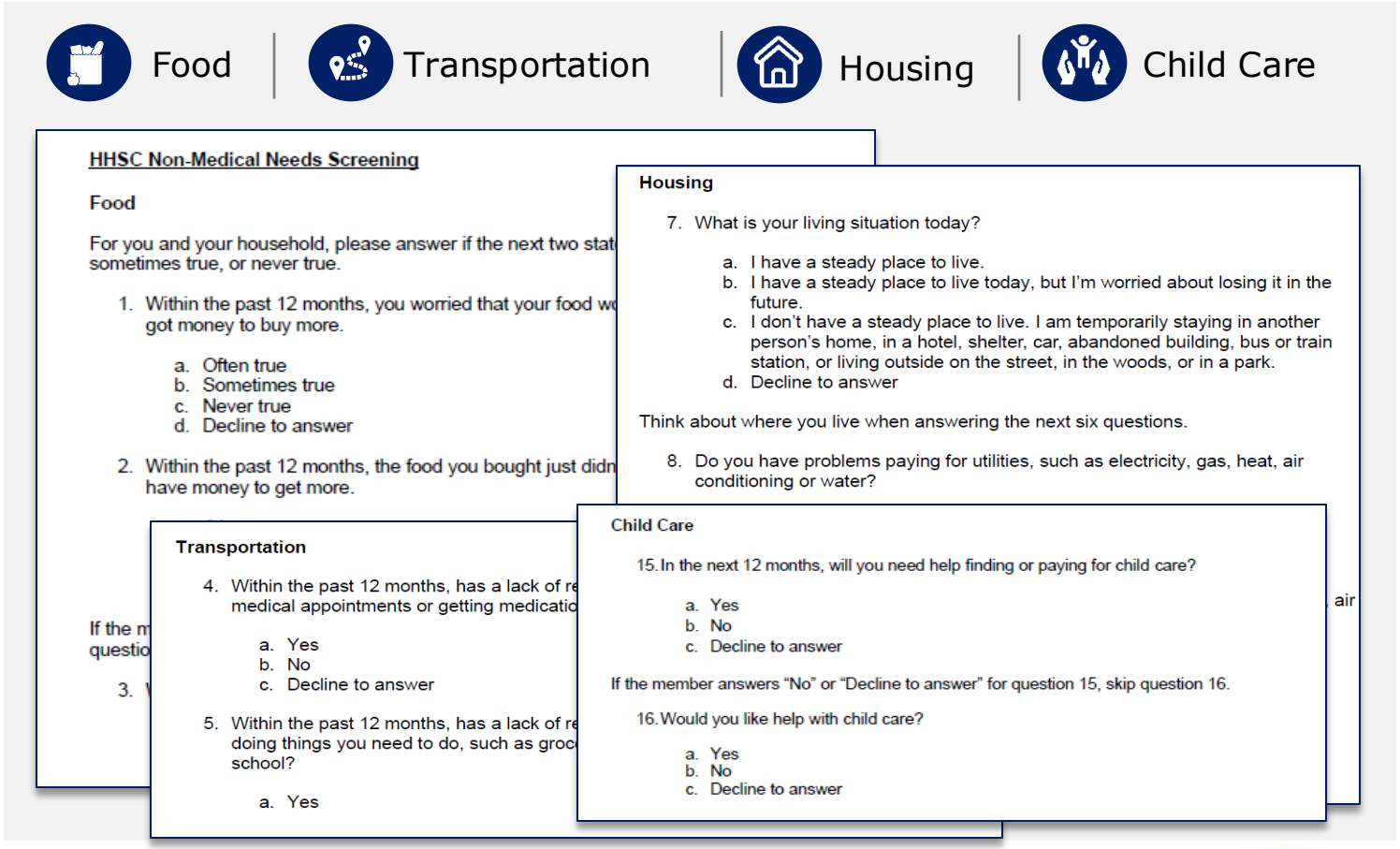
December 9, 2024

Non-Medical Health-Related Needs of Certain Pregnant Women Report - 2024

Relates to improving health outcomes for pregnant women under Medicaid and the Thriving Texas Families program. A one-time status report on bill implementation and the first of the biennial reports summarizing the non-medical health-related needs of pregnant women screening data collected by MCOs and TTF providers during the previous biennium. HHSC consolidated the two required reports that relate to the same subject matter.

HHSC Non-Medical Needs Screening

Food | Transportation | Housing | Child Care



HHSC Non-Medical Needs Screening

Food

For you and your household, please answer if the next two stat
sometimes true, or never true.

1. Within the past 12 months, you worried that your food w
got money to buy more.
   a. Often true
   b. Sometimes true
   c. Never true
   d. Decline to answer
2. Within the past 12 months, the food you bought just didn
have money to get more.

If the m
questio

3. V

Transportation

4. Within the past 12 months, has a lack of re
medical appointments or getting medicatio
   a. Yes
   b. No
   c. Decline to answer
5. Within the past 12 months, has a lack of re
doing things you need to do, such as groc
school?
   a. Yes

Housing

7. What is your living situation today?
   a. I have a steady place to live.
   b. I have a steady place to live today, but I'm worried about losing it in the future.
   c. I don't have a steady place to live. I am temporarily staying in another person's home, in a hotel, shelter, car, abandoned building, bus or train station, or living outside on the street, in the woods, or in a park.
   d. Decline to answer

Think about where you live when answering the next six questions.

8. Do you have problems paying for utilities, such as electricity, gas, heat, air conditioning or water?

air

Child Care

15. In the next 12 months, will you need help finding or paying for child care?
   a. Yes
   b. No
   c. Decline to answer

If the member answers "No" or "Decline to answer" for question 15, skip question 16.

16. Would you like help with child care?
   a. Yes
   b. No
   c. Decline to answer

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Report Highlights: MCO Pilot (1 of 2)

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MCO Pilot Overview

- Voluntary pilot with 11/16 MCOs
- Use final non-medical needs screening for a subset of pregnant members
- June 2024 - July 2024
- 1,159 completed screenings during pilot

MCO Pilot Screening Results

- Every type of non-medical need (food, transportation, housing, and child care) was identified across all MCOs
- **Food insecurity was most common need, followed by child care.**
- **Members with child care needs were more likely to respond they wanted help with that need.**

Appendix Table B-2. Percentage of Medicaid Pregnant Women with Positive Screening Results During the Pilot, Based on Non-Medical Need and Wanting Help with that Type of Need [pg. 34]

Appendix Table B-2 [report pg. 34]

Table B-2. Percentage of Medicaid Pregnant Women with Positive Screening Results During the Pilot, Based on Non-Medical Need and Wanting Help with that Type of Need

Type of Non-Medical Need	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G	MCO H	MCO I	MCO J	MCO K
n	*34*	*145*	*197*	*70*	*3*	*163*	*59*	*259*	*37*	*131*	*61*
Food Insecurity	27%	48%	12%	31%	-	22%	44%	42%	38%	24%	69%
Want Help, Food?	100%	91%	63%	36%	-	50%	46%	78%	57%	69%	67%
Transportation	24%	19%	4%	6%	-	8%	10%	14%	11%	8%	18%
Want Help, Transport?	100%	93%	25%	0%	-	62%	33%	75%	50%	73%	64%
Experiencing Homelessness	0%	2%	2%	3%	-	13%	0%	4%	8%	2%	7%
Housing Insecurity	12%	6%	0%	0%	-	1%	2%	5%	5%	7%	15%
Paying Utilities	24%	7%	8%	6%	-	7%	15%	15%	5%	10%	31%
Housing Quality	3%	10%	4%	14%	-	20%	25%	13%	19%	5%	18%
Want Help, Housing?	73%	57%	43%	0%	-	14%	6%	57%	56%	48%	43%
Child Care	18%	17%	25%	9%	-	17%	19%	26%	30%	18%	33%
Want Help, Child Care?	100%	100%	70%	50%	-	86%	91%	90%	82%	87%	85%

Data Source: MCO pilot data June-July 2024. Analysis by HHSC-DAP.

Report Highlights: MCO Pilot (2 of 2)

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Implementation Insights

- 10/11 MCOs conducted outreach and screenings over the phone, usually done by a CHW or administrative staff.
- 1 MCO piloted screenings via digital care management app.
- A mix of CHWs, social workers, or nurses made up the staff working with members to address identified non-medical needs that a member wanted help with.

Implementation Challenges

- Successfully reaching a pregnant member to conduct screening
- Additional time to complete screening over the phone.
- Additional time not a challenge for the MCO using the digital app since members could complete the screening on their own time.

Legislative Report Content Plan

Even-numbered year reporting to the legislature will summarize the data collected from the non-medical needs screening, and data about women receiving CPW, during the previous biennium

December 1, 2024

Initial Report

H.B. 1575 implementation activities

Summary of non-medical needs data from MCO pilot

Medicaid Pregnant Population Data, State Fiscal Year 2023

December 1, 2026

Ongoing Reporting

Summary of the screening data

For women receiving CPW:

- Data on non-medical needs
- # and types of non-medical referrals
- Birth outcomes for the women

Thank you!

Questions about the Quality Strategy, H.B. 1575 non-medical needs screening requirements and MCO Pilot:

DSQI@hhs.texas.gov

Questions about H.B. 1575 doula and CHW requirements for CPW case management:

askcm@hhs.texas.gov

Provider and MCO Panel and Facilitated Discussion on NMDOH Screening

Laura Freeman
Therapy 2000

Lindsey Tippit
Lone Star Circle of Care

Sandra Frasser, MD, FAA
People's Community Clinic

Nathan Hoover
Superior Health Plan

Jessica Rios
Community First Health Plans

Introduction to the Community Paramedicine Model

Cristina Garcia, PhD, MHS
Department of State Health Services

Community Conversations on Health

Rural Community Health Program

Cristina Garcia, PhD, MHS
Center for Public Health Policy & Practice
Texas Department of State Health Services
March 7, 2025

What is Community Paramedicine?

- **Community paramedicine** is the practice of allowing qualified personnel (EMTs, paramedics, social workers, RNs, CHWs, etc.) to assist with public health education and preventative services to underserved populations.
- **Goals:**
  - Increase access to primary and preventive care
  - Provide wellness interventions
  - Decrease emergency department utilization
  - Reduce healthcare costs
  - Improve client health outcomes

Rural Community Health Program

Rural Community Health Program (RCHP): In partnership with DSHS, the State Office of Rural Health's (SORH) pilot community paramedicine (CP) program aims to improve preventive care services and health education in rural communities in the Texas Panhandle via the training and provision of community paramedicine in selected partner counties.

Pilot Implementation Period: April 2022 to May 2026

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Texas Department of State
Health Services

S O
R H

Texas Department of Agriculture
Rural Community
Health Program

RCHP: Program Goals

- **ENGAGE**: Engage communities on the benefits of community paramedicine
- **TRAIN**: Train personnel to improve skills and knowledge
- **PROVIDE**: Provide resources and supplies to implement a sustainable community paramedicine program
- **FAST**: Utilize resources from the Fire, Ambulance, and Services Truck (FAST) fund in an effective manner
- **DEVELOP**: Develop strategies to increase rural access to healthcare and decrease costs
- **IMPROVE**: Improve community health and quality of care

Slide courtesy of the State Office of Rural Health (SORH)

RCHP Implementation Partners

Current Partners:

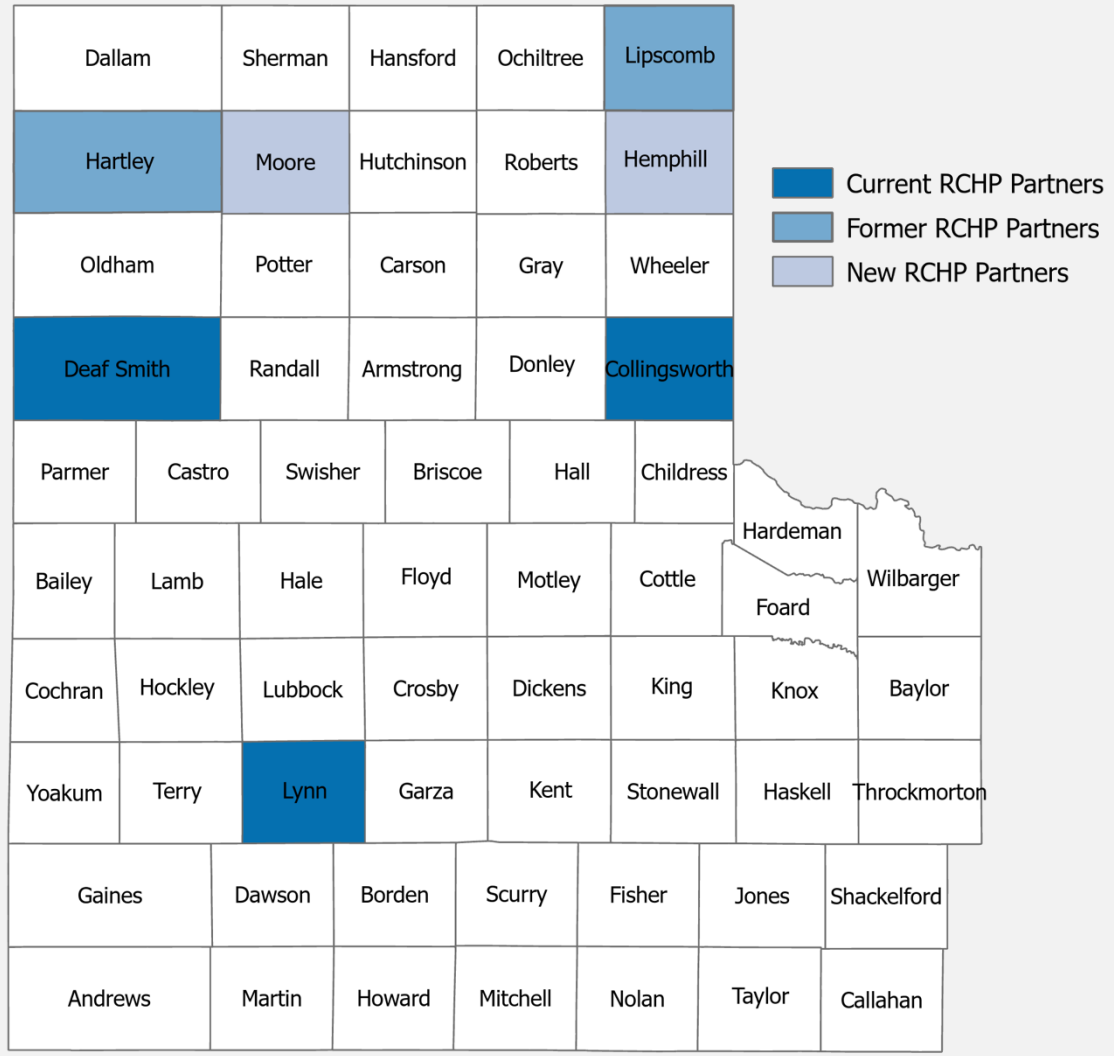
- *Deaf Smith County:* Hereford Regional Medical Center
- *Collingsworth County:* Wellington EMS
- *Lynn County:* Lynn County Hospital District

Former Partners: (ended May 2024)

- *Hartley County:* Hartley EMS and Volunteer Fire Department
- *Lipscomb County:* Darrouzett EMS

New Partners: (starting Spring 2025)

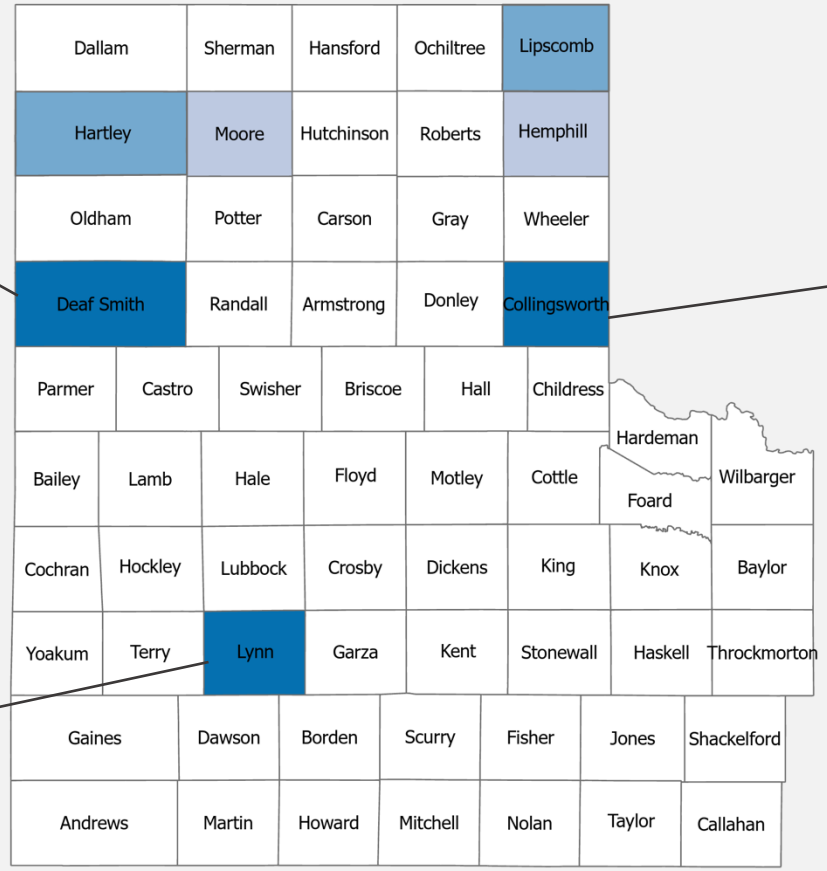
- *Moore County:* Moore County Hospital District
- *Hemphill County:* Hemphill County Hospital District



RCHP Partner Demographics

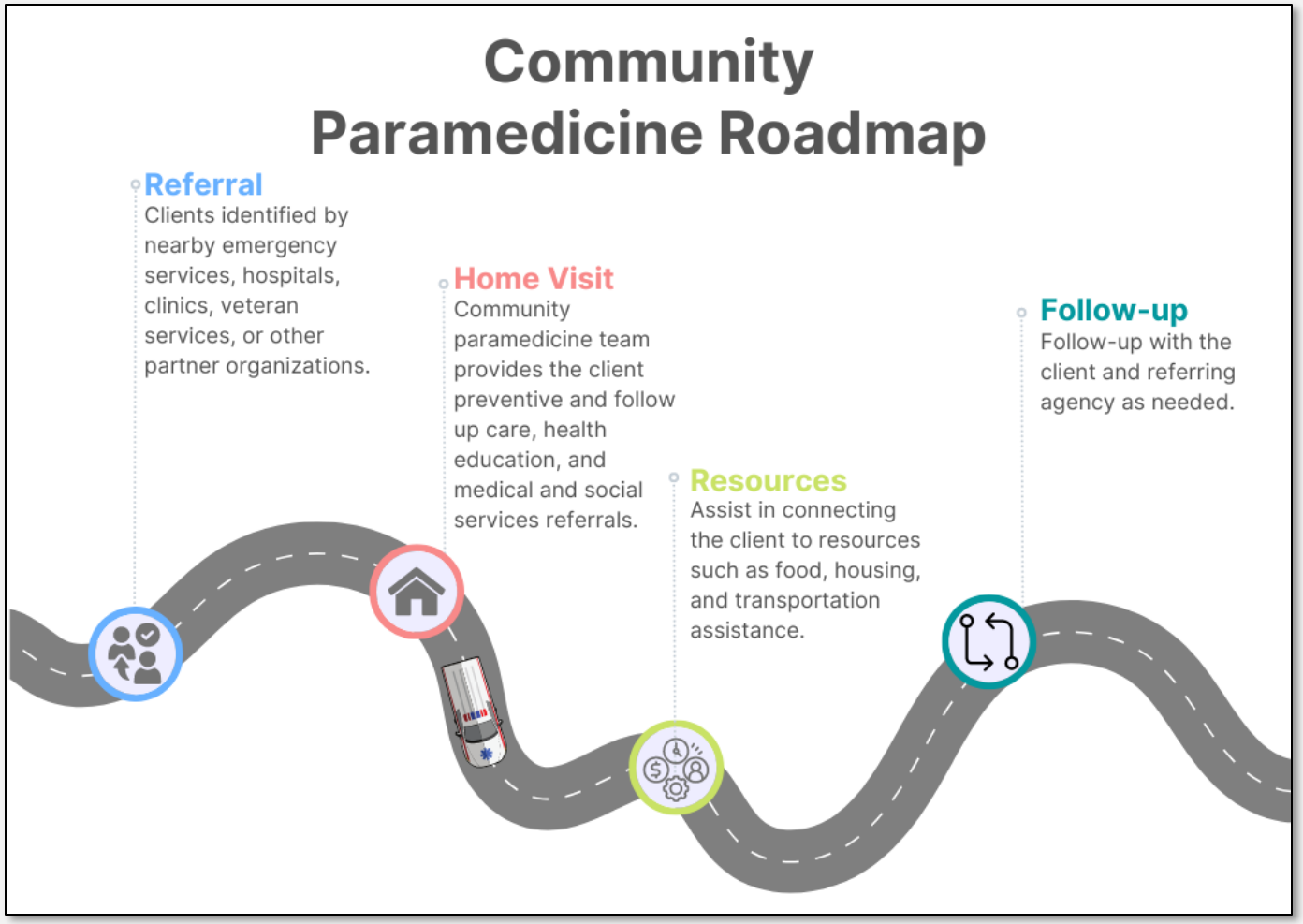
Hereford Regional Medical Center
- Serves a population of 18,377
- 1,497 sq mi service area
- 17.3% of the population lives below the poverty line

Lynn County Hospital District
- Serves Lynn, Garza, and Borden counties
- Serves a population of 12,168
- 2,717 sq mi service area
- 18.8% of the population lives below the poverty line



Wellington EMS
- Private, non-profit EMS serving Collingsworth and part of Childress counties
- Mostly volunteer staff
- Serves a population of ~3,000
- 919 sq mi service area
- 16.9% of the population lives below the poverty line

Program Implementation



Implementation Considerations

APPROPRIATE STAFFING

REFERRALS INTO THE PROGRAM

DATA REPORTING

AWARENESS AND EDUCATION

What happens during a CP visit?

Community Paramedicine Home Visits

Education
- Diabetes Management
- Fall Prevention
- Adult Vaccines

Services
- Vitals Check
- BP Monitoring
- Medication Inventory
- Behavioral/Mental Health Assessment

Referrals
- Case Management
- Specialty Care
- Medication Access
- Food & Housing Resources

Program Impact on Texans

EMS/Hospital Partners:

- Conducted about 1,500 home visits since April 2022
- Hereford Regional Medical Center reported:
  - Readmission rate dropped from 34% in 2021 to 5.4% in 2022 and 0% in 2023
  - Decrease in frequent ER visits
  - Increase in clinic follow-up compliance
- Decrease in non-emergency 911 calls
- Improved rapport with providers
- Increased trust with communities

Clients:

- Clients thought the CP visits prevented ER visits (53%) and unnecessary hospital readmissions (50%)
- Improved quality of life
- High patient satisfaction with the program
- Increased knowledge of when to call 911

Lessons Learned

- Staff education and buy-in is essential.
- Program promotion and community education is needed for awareness and buy-in.
- Tailor the program to community needs. Each program is unique.
  - Composition of the CP team
  - Cross-sector partnerships
- Effective data management and reporting is essential to demonstrate value.
- Sustainable funding remains a challenge.
  - Limited staff capacity and resources
  - No standardized reimbursement model
  - Rural vs. urban solutions

Next Steps

- Hosted a Community Paramedicine Roundtable in Nov 2024.
- Establish topical workgroups and peer support subgroups (e.g., rural implementation).
- Engage implementation partners.
  - Philanthropy
  - Health plans
  - Health Information Exchanges
  - Hospitals and other providers
  - Community leaders
- What data or outcomes are needed for decision making?

The Community Paramedicine Roundtable was hosted by the Texas Department of State Health Services, Episcopal Health Foundation and Texas Department of Agriculture's State Office of Rural Health.

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For more information on the program email:
Cristina.Garcia@dshs.texas.gov
healthdisparities@dshs.texas.gov

DFW ARPA-H Project Overview

Cameron Combs
Dallas Federal Funding Accelerator

North Texas Maternal Health Accelerator (NTX-MHA)

Discussion with MCO NMDOH Learning Collaborative

March 2025

Questions?
Cameron Combs (cameron@cpal.org)
Heather Stansell-Morris (h.morris@tcu.edu)

NTX-MHA | Who we are and what we are doing

Multisectoral coalition comprises leading providers, researchers, data experts, and community partners

Shared goal is to **reduce severe obstetric complications** in Dallas and Tarrant Counties

Convened Spring 2024 to apply for federal outcome-based funding through **ARPA-H's HEROES program**

Launched the month it submitted application to APRA-H (Dec 2024) with **$17.5M in foundation commitments**

Current priorities:

- Begin prepartum iron distribution
- Formalize relationships with foundation, government, and MCO partners
- Prepare launch of other preventive care interventions while awaiting ARPA-H response

Two co-primes provide administrative and clinical leadership

Application coordinator convenes and manages coalition

Five health systems scale evidence-based preventive care

Leaders in analytics and community-based care work with systems to provide targeted, comprehensive support

- Texas' second-largest community center
- Leader in advanced health analytics
- Developer of Parent Pass navigation app

+ dozens of operational, foundation, and MCO partners

ARPA-H HEROES | Program sets two ambitious goals to expand preventive health care

The problem

"Health care organizations in the U.S. today lack strong incentives to offer robust preventative care to their patients"[1]

This incentive problem is particularly acute in maternal health and leads to severe obstetric complications ("SOCs", aka. severe maternal morbidity)

The approach

ARPA-H HEROES sets **two goals** to sustainably expand preventive care:

(#1) Reduce SOC rate by 20%+ in a population of 5 million patients

(#2) Create self-sustaining financial models for preventive care that last beyond the program period

Detail on how NTX-MHA delivers on these two goals to follow

Example of patient impact due to incentive challenges in maternal health

Texas Health Cleburne To Lose Labor and Delivery Department

July 2024

"Obstetrical services will [remain] available at nearby locations such as Texas Health Harris Methodist Hospital Fort Worth, Texas Health Harris Methodist Hospital Southwest Fort Worth, and Texas Health Huguley Hospital Fort Worth South.

Those facilities are all about 30 minutes from Cleburne's hospital."

One patient advocate: "People have babies every day, and it's usually not an emergency, but it is when someone has to drive another 30 or 40 minutes or an hour to get to a labor and delivery unit"

1. ARPA-H direct quote.

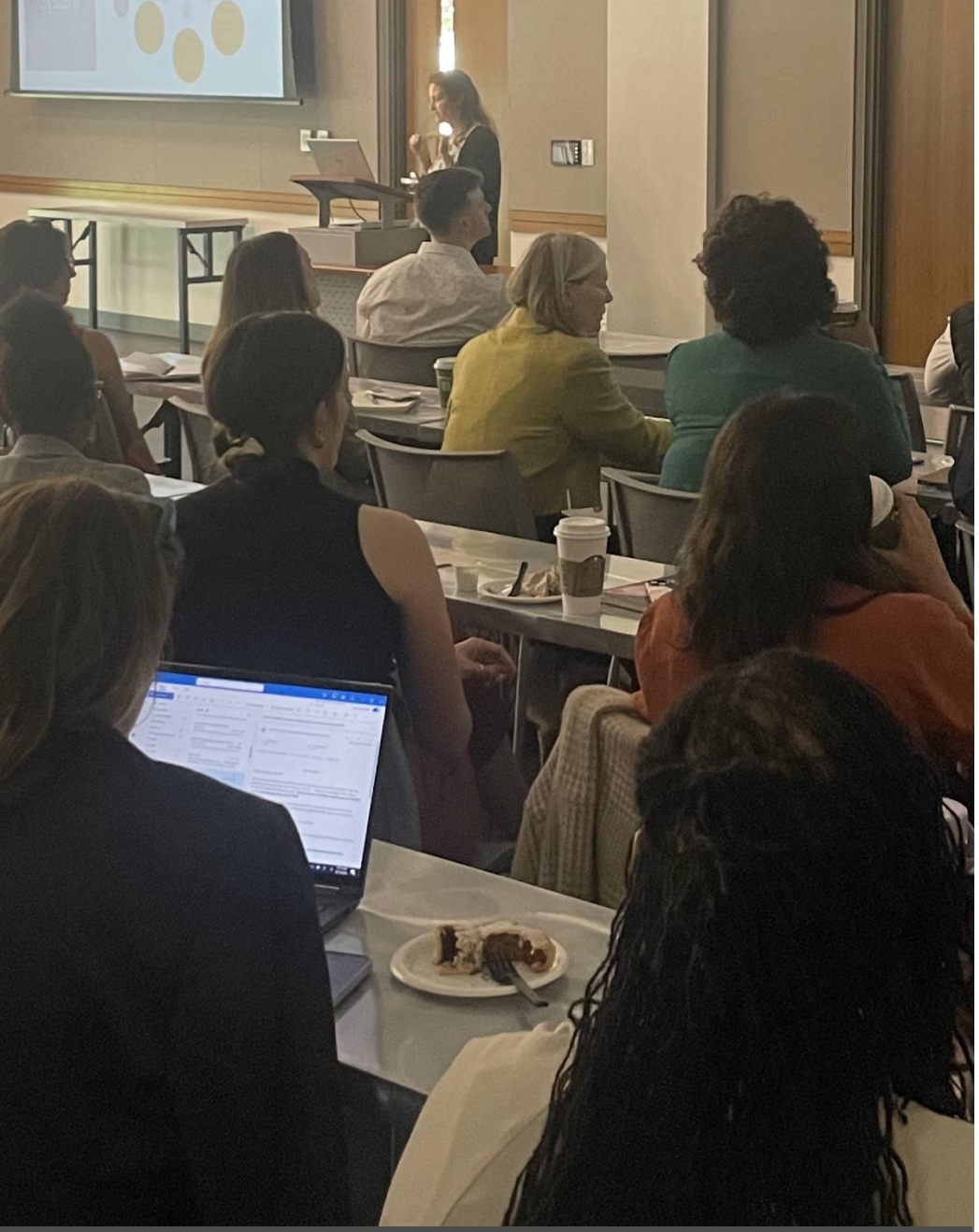
Sources: "Texas Health Cleburne To Lose Labor and Delivery Department," *D Magazine* (July 2024). "HEROES: Health Care Rewards to Achieve Improved Outcomes," *ARPA-H.gov* (2024).

Why Maternal Health in North Texas?

Because our patient population:

- Is larger than most states
- Is highly representative of the country as a whole
- Has one of the country's highest maternal morbidity burdens

And because we have the assets and evidence-based strategies to address these challenges



Laura Kender (MHMR) addresses 40+ attendees of NTX-MHA ideation workshop, April 2024

NTX-MHA harnesses North Texas' strengths through unprecedented regional coordination

Both Dallas and Tarrant Counties have existing strengths to bear, which happen to be highly complementary

Momentum towards system change, such as Mayor Parker's leadership with TCU to create the Tarrant County Maternal & Infant Health Coalition

Clinical evidence, UTSW literally writes the OB textbook and has extensive studies on maternal health in the DFW patient population

Technology capabilities to strengthen preventive healthcare, such as:

- DFW Hospital Council Foundation data, which covers 100% of hospital-based births in Dallas and Tarrant Counties
- Advanced analytics with Parkland Center for Clinical Innovation (PCCI)
- Ability to connect patients with hyperlocal resources, such as My Health My Resource's database of supports and the Parent Pass app

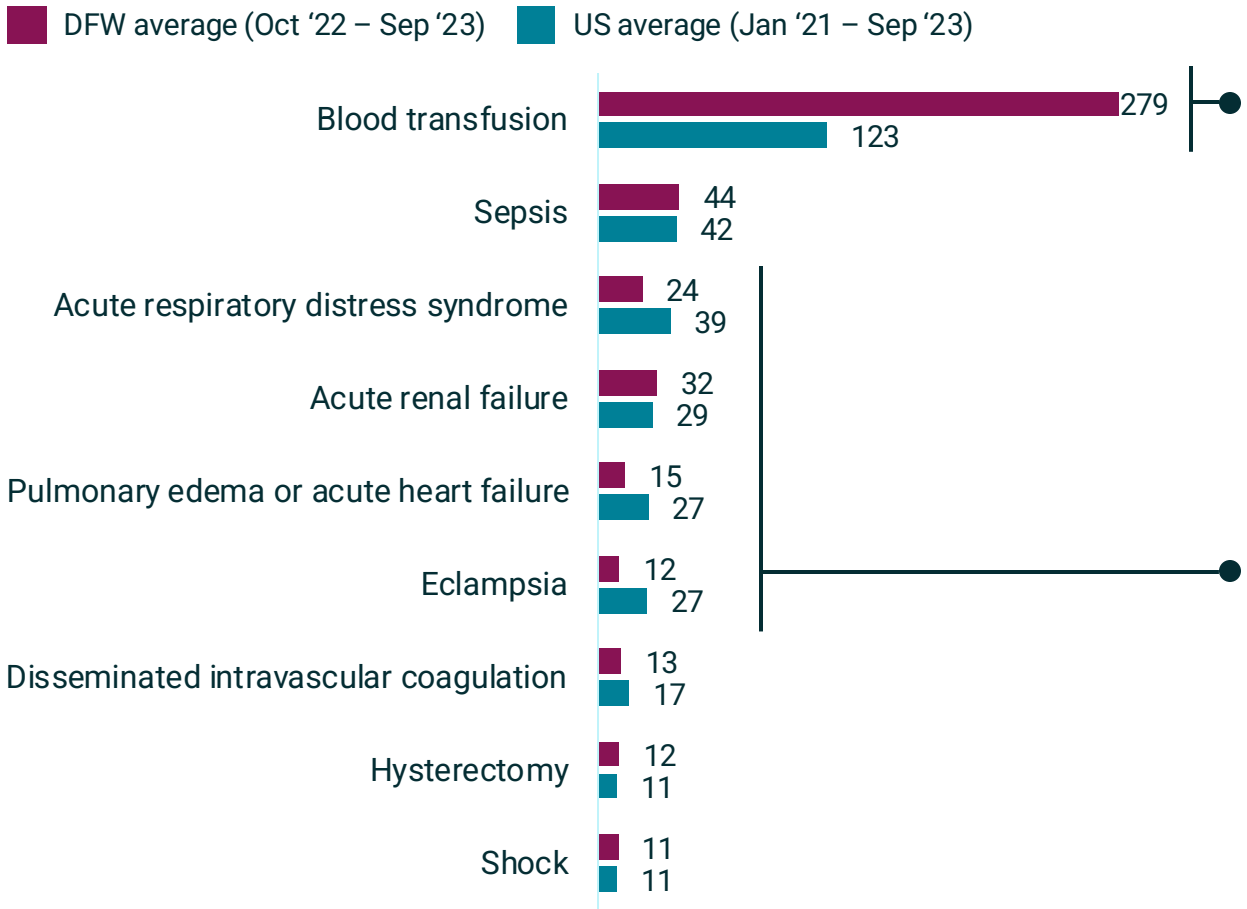
How NTX-MHA will deliver on ARPA-H's two goals:

1. **Reduce the SOC rate by 20%+ in a population of 5 million patients**
2. Create self-sustaining financial models for preventive care that last beyond the program period

PRELIMINARY DATA | NOT PEER-REVIEWED

Clinical primer | Transfusions and hypertension are key focus areas

Incidence of most common SOCs, Rate per 10k births



Headline clinical drivers of SOCs

Blood **transfusions** represent 65-70% of all SOC cases, generally categorized in two groups:

1. *Symptomatic anemia*: "Normal" blood loss necessitates transfusion due to mothers' iron deficiency
2. *Intrapartum hemorrhage*: "Catastrophic" blood loss due to a hemorrhage event (e.g., uterine atony)

Next largest clinical domain are complications driven by **hypertension** (wholly or in part)

Why is hypertension so important? Mothers double their volume of blood during pregnancy

NTX-MHA developed four evidence-based interventions to reduce transfusions and hypertensive-related complications

Source and notes: US data (~50% coverage) provided by HealthVerity, Inc data, as presented during HEROES Proposers' Day (Feb 14, 2024), classifications via Outcome Toolkit. DFW data generated by PCCI May 2024 using DFW Hospital Council data (~99% coverage).

Scalable interventions | Four interventions spanning the care continuum

☐ Details to follow

NTX-MHA proposes **four interventions** that have shown evidence-based outcome improvements in the DFW patient population—but have not been scaled due to access barriers and inadequate preventive care incentives

Prepartum	Intrapartum	Postpartum
1. Universally provide prepartum iron supplementation (on-site, no charge) to reduce transfusions due to anemia	2. Standardize hospitals' simulation exercises for hemorrhage events and coding for postpartum acute kidney injury	3. Discharge hypertensive patients with blood pressure cuffs coupled with virtual nurse visits to ensure at-home readings are taking place

4. Deploy cutting-edge population- and patient-level analytics to focus these interventions and existing community supports on most underserved communities and highest-risk patients, leveraging programs such as Help Me Grow

Intervention 1 | Anemia is common, understudied, and has real patient burden

Patient need

80%+ of mothers develop iron deficiency by the third trimester, even if not previously anemic

DFW's transfusion rate is 2x US average (3x for Medicaid)

Anemia not only drives morbidity, it has adverse neonatal outcomes

Yet preventive care guidelines do not recommend iron supplementation due to "insufficient evidence"

August 2024

JAMA Network | EDITORIAL

Anemic Data for Preventive Screening and Supplementation to Address Iron Deficiency Anemia in Pregnancy

Elaine L. Duryea, MD; Catherine Y. Spong, MD

"US Preventive Services Task Force (USPSTF) recently released a Recommendation Statement examining the data to support screening for iron deficiency anemia in pregnancy and finding them lacking. It also found insufficient evidence to make a clear recommendation for or against preventive iron supplementation in pregnancy.

…USPSTF acknowledges that routine supplementation with iron in pregnancy carries minimal risk of harm and improves hematologic indices. However, no definitive evidence of the benefit of improved hematologic indices at delivery exists in the form of RCTs and likely never will."

Source : "Direct Dispensation of Prenatal Supplements With Iron and Anemia Among Pregnant People," *Jama Network Open* (July 2023). PCCI using DFWHCF data (May 2024). "Finally, a quality prospective study to support a proactive paradigm in anemia of pregnancy," editorial in *American Journal of Clinical Nutrition* (August 2024).

Intervention 1 | Direct dispensation of prenatal iron is evidence-based

JAMA Network | Open

July 2023

Direct Dispensation of Prenatal Supplements With Iron and Anemia Among Pregnant People

Lisa R. Thiele, MD, MPH; Elaine L. Duryea, MD; Alexandra S. Ragsdale, MD; Carrie A. Berge, MS, PharmD; Donald D. McIntire, PhD; David B. Nelson, MD; Catherine Y. Spong, MD

Table 2. Clinical Outcome Data

Outcome	Patients, No. (%)		
	Pre-providing supplements (January 1 to August 1, 2019)	Post-providing supplements (May 13 to December 13, 2020)	Adjusted RR (95% CI)[a]
Postpartum transfusion, No. (No. per 1000)[b]	71 (10.0)	46 (6.6)	0.62 (0.43-0.91)
Hematocrit 24-32 weeks, mean (SD)	34.7 (3.3)	35.2 (3.1)	0.45 (0.33-0.51)[c]
Anemia 24-32 weeks	377 (7)	278 (5)	0.68 (0.59-0.79)
Hematocrit at delivery admission, mean (SD)	34.0 (4.4)	35.3 (4.3)	1.27 (1.13-1.42)[c]
Anemia delivery admission	1237 (18)	782 (11)	0.61 (0.56-0.66)
Hematocrit at delivery discharge, mean (SD)	30.8 (3.7)	31.1 (3.7)	0.36 (0.23-0.48)[c]
Anemia delivery discharge	2810 (41)	2550 (36)	0.89 (0.85-0.93)

SMFM Pregnancy Meeting

February 2025

1042 | Direct Dispensation of Prenatal Supplements with Iron Among Pregnant People: a Cost-Effectiveness Analysis

Helen Samuel[1]; Megha Arora[2]; Ashley E. Benson[2]; Aaron B. Caughey[2]

Table 1. Outcomes associated with directly dispensing versus recommending prenatal iron in a theoretical cohort of 1,514,784 Medicaid-enrolled pregnant individuals.

	Directly Dispensed Prenatal Iron	Recommending Prenatal Iron	Differences
Preterm delivery	92,401	155,001	-62,600
Neurodevelopmental disability	353	405	-52
Maternal Postpartum Anemia	545,347	621,030	-75,683
Acute Blood Loss Transfusions at Postpartum	773,062	827,072	-54,010
Cost (USD)	$28,386,003,406	$905,732,057,844	-$62,187,202,377
Effectiveness (QALYs)	84,833,163	84,645,688	187,475

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Intervention 1 | Direct dispensation is underway thanks to angel funding

NTX-MHA approach, already underway

Distribute iron supplementation at prenatal visits (on-site, no charge) at 17+ partners that provide care to Medicaid and self-pay patients

Partner with frontline providers (e.g., FQHCs), public agencies (e.g., housing authorities), and outpatient clinics

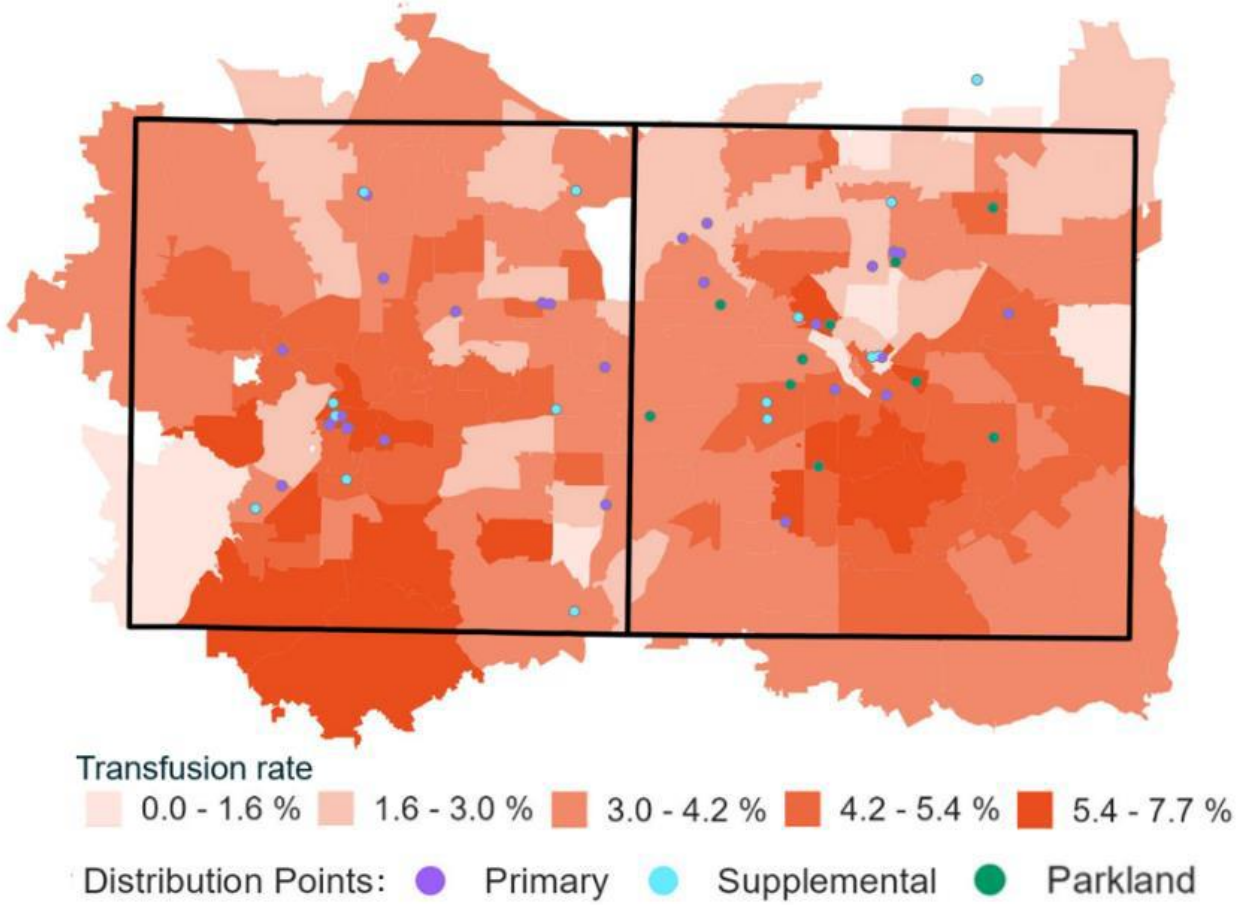
Select OTC supplementation likeliest to be well-tolerated and effective (i.e., reduced GI effect)

Logistics providers

Catholic Charities Dallas

Catholic Charities Fort Worth

Intrapartum transfusion rate in Dallas & Tarrant Counties,
% of births Oct '21 to Sep '23 by patient ZIP code



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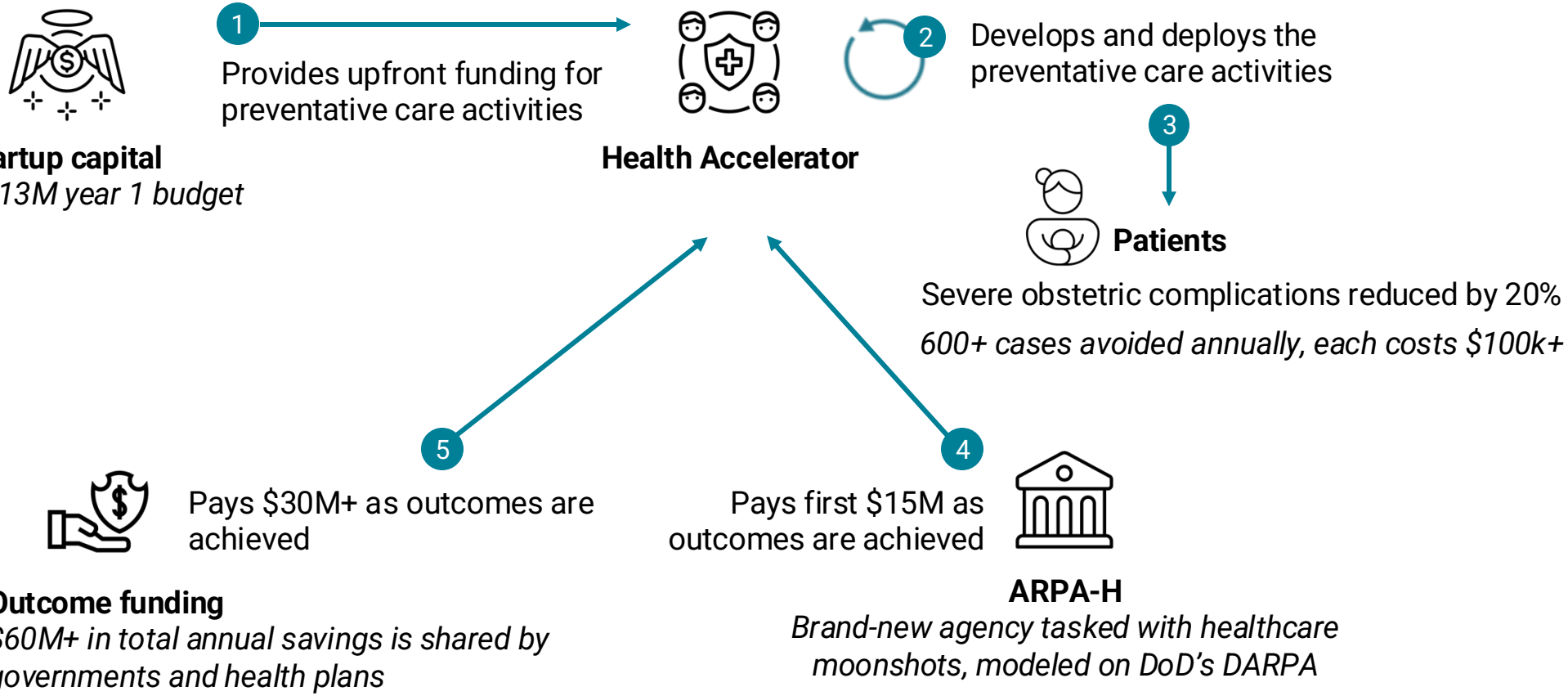
Source and notes: PCCI May 2024 using DFW Hospital Council data.

How NTX-MHA will deliver on ARPA-H's two goals:

1. Reduce the SOC rate by 20%+ in a population of 5 million patients
2. **Create self-sustaining financial models for preventive care that last beyond the program period**

Program design | High-level funding sequence



Financial strategy | Four groups of funders drive incentive model innovation

NTX-MHA will develop self-sustaining incentive models for preventive care by working with **four funder types**

Expire with program (year 3)

Self-sustaining

Funder type	Role in incentive model innovation
Foundations	Launch preventive care with $8.6M in upfront funding in year 1 Sustain operations with $4.45M in annual outcome-based funding in years 2-3
ARPA-H	Launch preventive care with $2M in upfront funding in year 1 Sustain operations with $13M in outcome-based funding in years 1 and 2
State & Local Governments	Provide funding for outcome-based maternal health programs (to be appropriated) Reward NTX-MHA for improving population health metrics in their jurisdiction
Health Payors	Develop “alternative payment models” that share savings from avoided obstetric complications and reward NTX-MHA for quality improvement in patient care

By year 3 of the program, NTX-MHA will finance its operations through self-sustaining outcome-based payment models

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NOTE: All figured are preliminary and require board approval, legislative approval, MCO negotiations, ARPA-H award, and other steps

Financial strategy | Two collaboration models under consideration with MCOs

NTX-MHA **worked with five MCOs** during its program design phase

Aetna Better Health® of Texas

BlueCross BlueShield of Texas

CookChildren's Health Plan

MOLINA HEALTHCARE

Parkland Community Health Plan

Collaboration models under consideration fall within **two archetypes**:

1.) Programmatic alignment including physician and patient education for prepartum iron supplementation; and/or

2.) Financial model innovation to develop APMs that:

- Share realized savings driven by NTX-MHA's preventive care interventions that lower maternal and infant costs (i.e., both SOCs and PTB)
- Improve key quality metrics such as PPC

NTX-MHA members **already collaborate individually with MCOs**, driving:

- 2pp reduction in PTB births (20% relative decrease)
- 20% reduction in PMPM infant costs
- 90% postpartum visit attendance
- 99% of clients completing EPDS screening


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Closing Remarks

Shao-Chee Sim
Episcopal Health Foundation