Breakout session

Lessons Learned from Implementation of a Pediatric Medicaid Innovation Model

Ohio Integrated Care for Kids

Lessons learned from implementation of a pediatric Medicaid innovation model aimed at improved health outcomes and cost savings in rural and Appalachian Ohio

October 2024

Integrated Care For Kids

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Introductions

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  - Project Manager, Ohio InCK, Center for Child Health Equity and Outcomes Research
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- Mylynda Drake, MPH – Ohio Department of Medicaid
  - Section Chief of Maternal, Child and Family Wellness, Office of Strategic Initiatives
- Mitch Tom – Licking Heights Local School District
  - Director of Pupil Services

Learning Objectives

- Increased knowledge of the components of the Integrated Care for Kids Model and how Ohio is implementing the project with a pediatric Medicaid population in two rural and Appalachian counties.
- Increased knowledge of how project partners have aligned model components with existing local services and Ohio's next generation Medicaid managed care program.
- Increased awareness of similar models that could be expanded across Ohio to better support the behavioral health needs of Medicaid youth and their families.

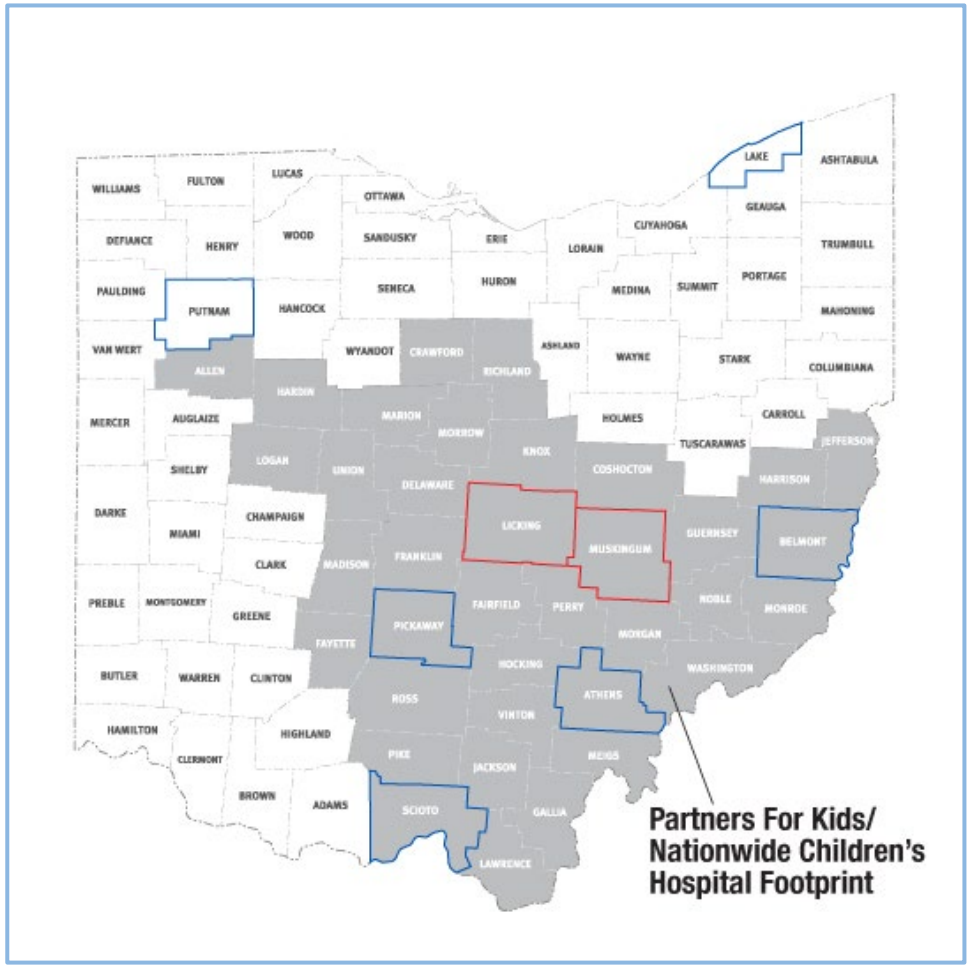
What is Integrated Care for Kids (InCK)?

A pediatric innovation model developed by the federal Centers for Medicare and Medicaid Services (CMS) to test the potential of alternative payment models supporting integrated delivery of child services to reduce costs and improve quality of care

InCK Goals

- For children age 0-20 in Licking and Muskingum County:
  1. Improve child health
  2. Prevent unnecessary out of home placement (OOHP) or reduce the length of stay when OOHP is appropriate
  3. Reduce unnecessary inpatient stays and inappropriate ED utilization
  4. Create sustainable Alternative Payment Models (APMs)

Pilot & Comparison Counties



Pilot

Comparison counties

Partners For Kids footprint

Criteria used to select Ohio pilot and comparison counties

Population demographics and community characteristics
e.g., Member density, utilization of IP/ED, rural vs. urban

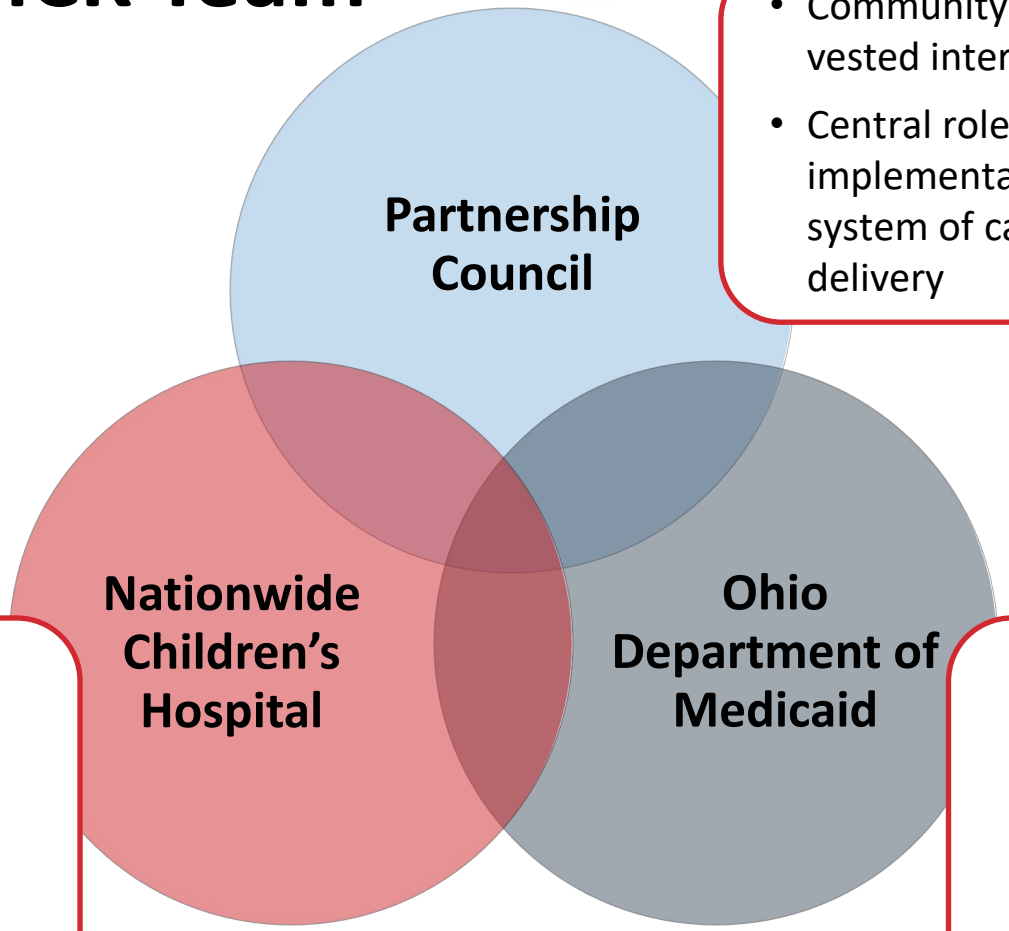
Lead partner reach
Pilot sites within Partners For Kids footprint

Community supports
e.g., Education partnerships, CMHCs, BH board synergies, PCSA partnerships/ juvenile justice

Ongoing activities that are complementary (e.g., existing APMs, CPC saturation) and not duplicative

SOURCE: Claims data, population data, 2013 CDC NCHS Urban-Rural classification scheme, County Health Rankings Model © 2014 UWPHI, U.S. Census data

The Ohio InCK Team

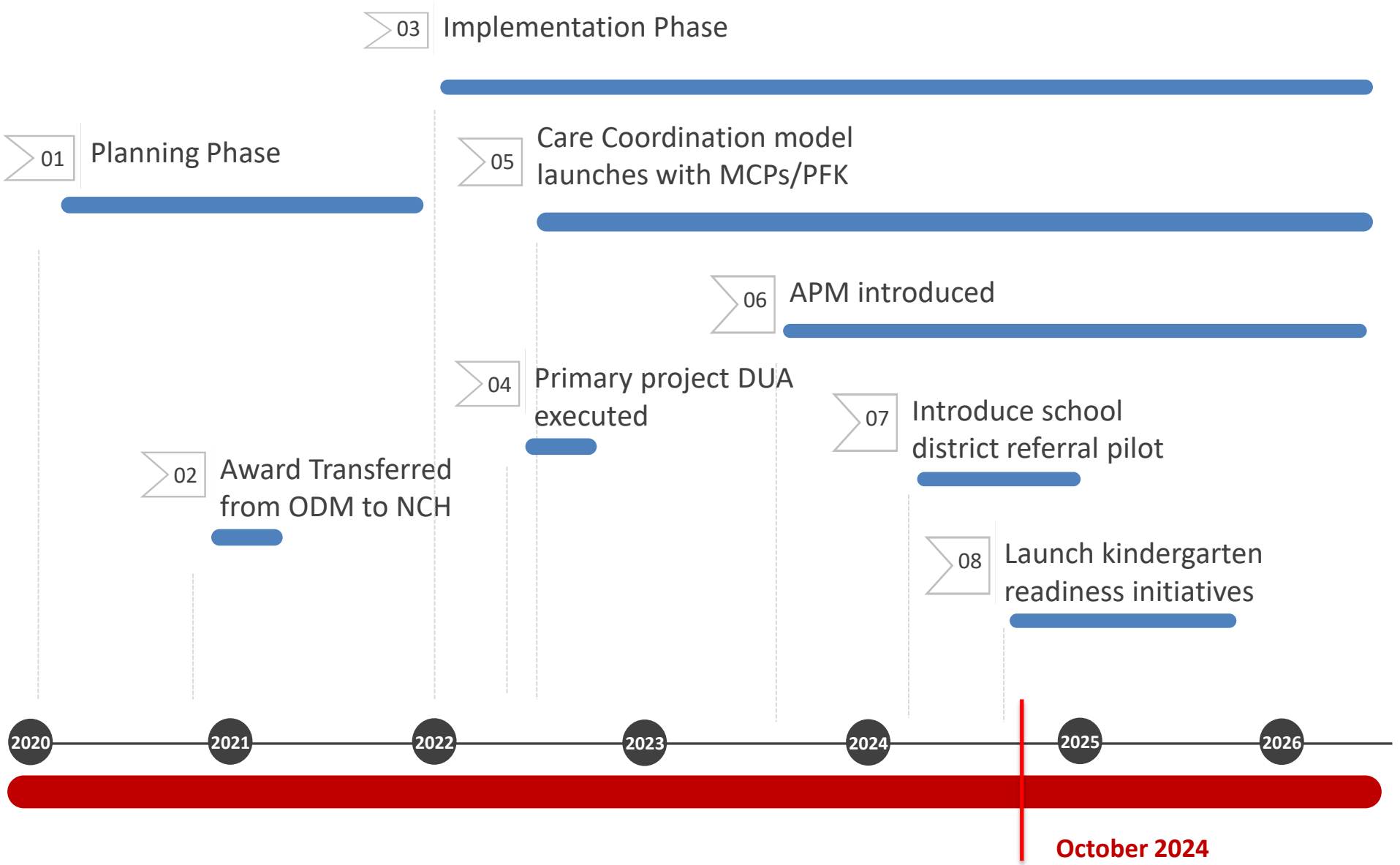


- Community stakeholders with vested interest in child welfare
- Central role in design & implementation of improved system of care and service delivery

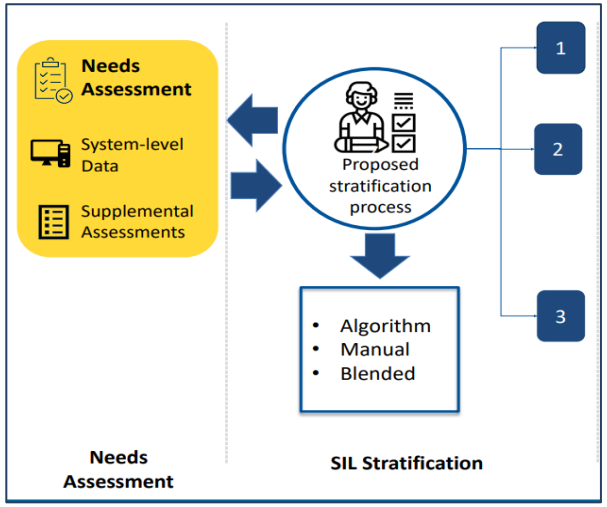
- Manage CMS award
- Engage and convene Partnership Council
- Partner with state Medicaid to design & implement InCK model

- Support APM design and advise implementation
- Engage community stakeholders
- Support data sharing infrastructure

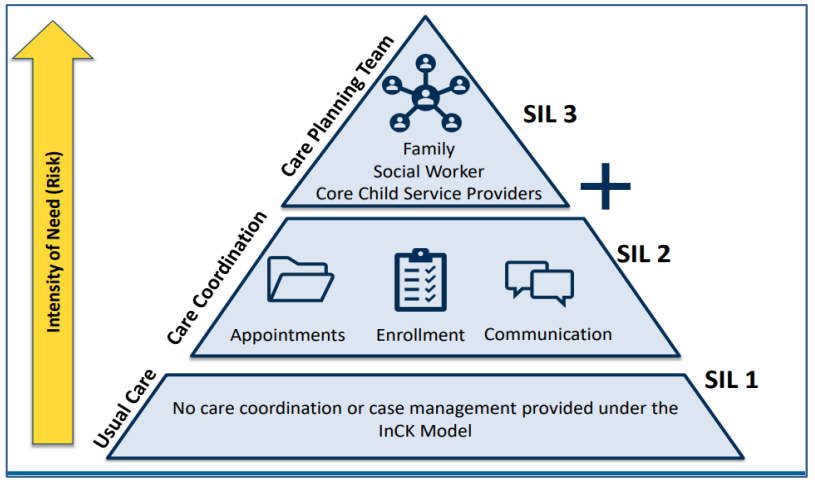
Project Timeline



Population-level Needs Assessment and Risk Stratification

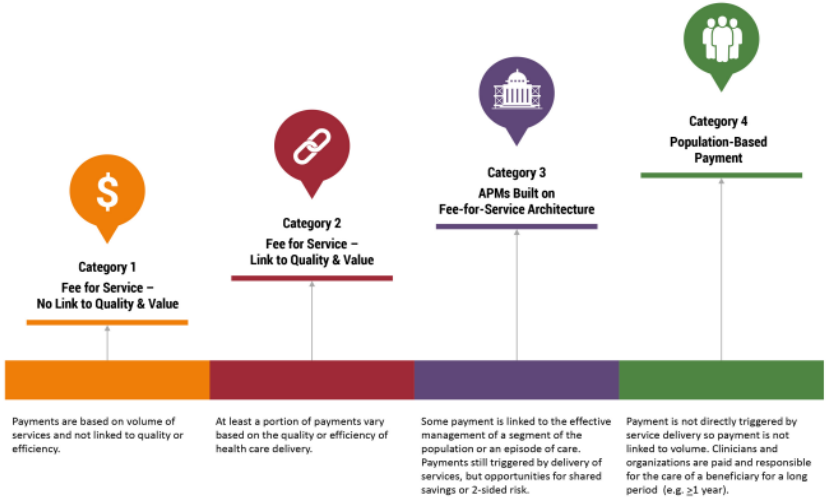


Integrated care coordination and case management



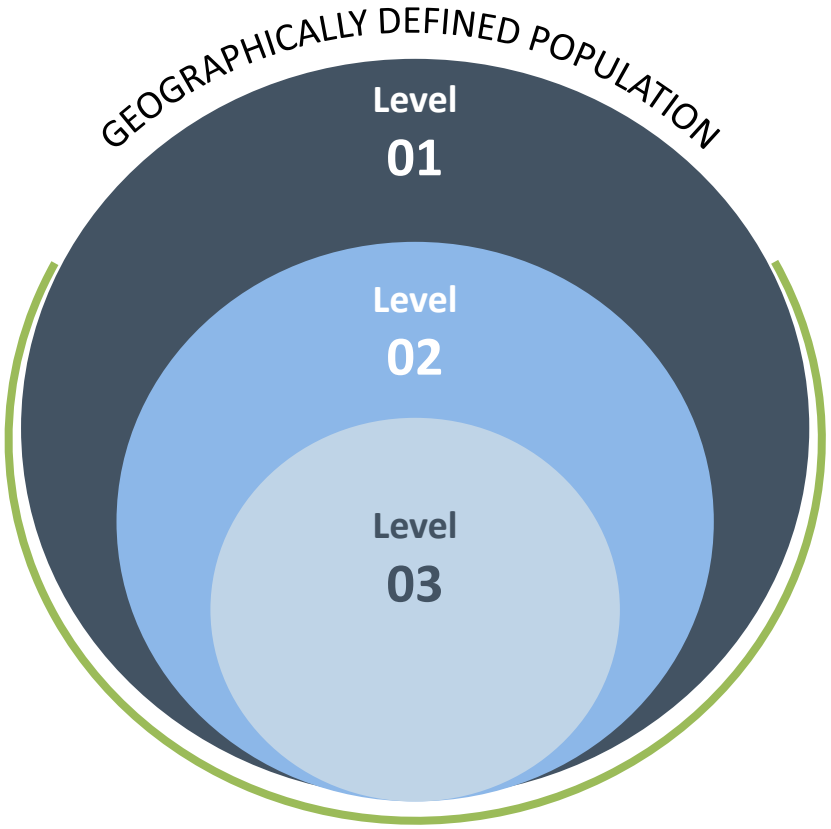
Early Identification and Prevention/Intervention Services for Children At Risk

Community-driven alternative payment model



InCK Model Components

Population-level Needs Assessment Risk Stratification



Ohio InCK Service Integration Levels

1

- Includes the entire target population
- Basic, preventive care and active surveillance for developing needs and functional impairments

2

- Includes children with needs involving more than one service type & who exhibit a functional symptom or impairment
- Comprehensive needs assessments and integrated care coordination

3

- Includes children who meet Level 2 criteria who are currently, or are at imminent risk, of being placed outside the home (e.g., multi-system youth)
- Child-centered care planning, integrated case management, and home and community-based services

SOURCE: InCK NOFO, InCK website and webinars

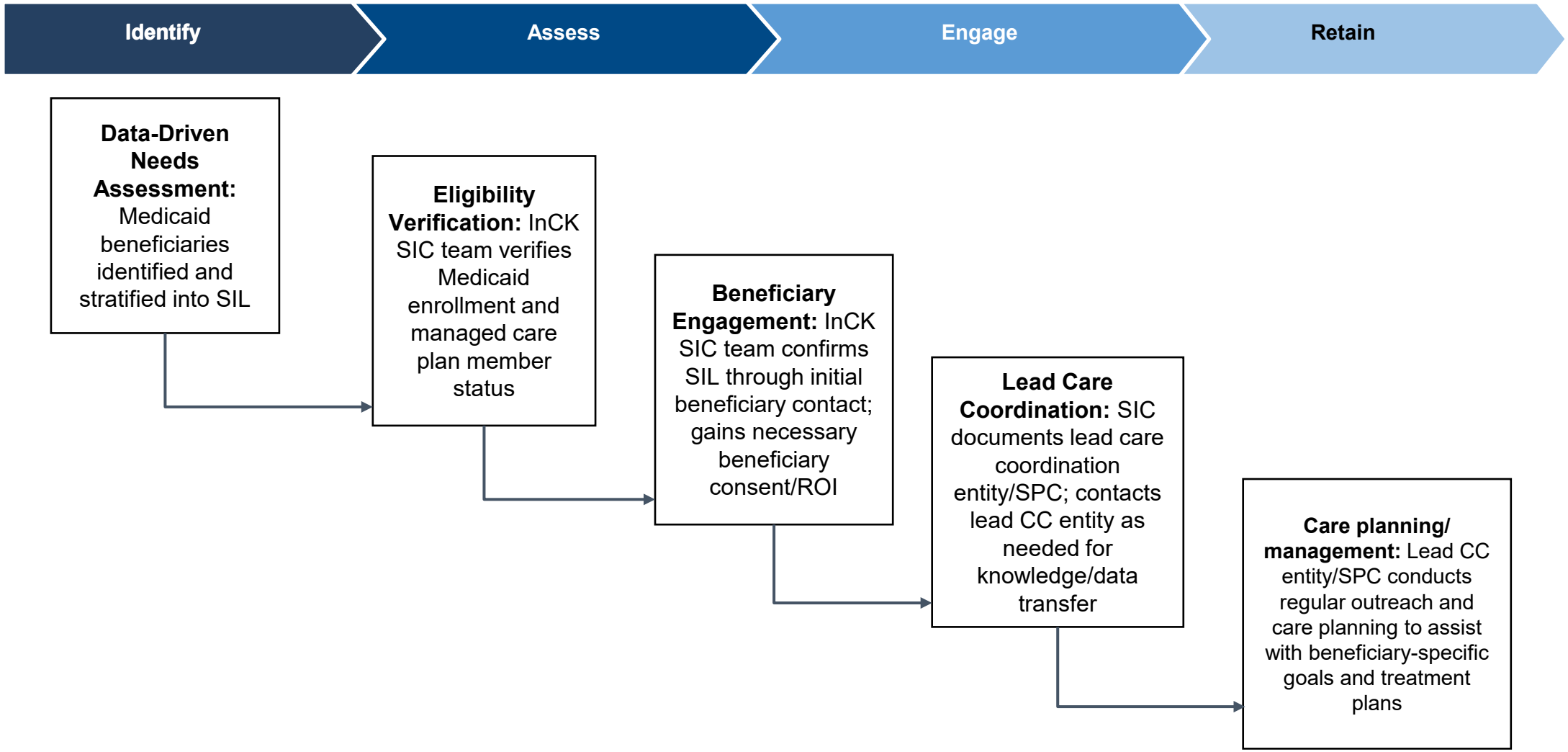
Care Coordination Model: Key Components

- Needs Assessment and Risk Stratification by the Service Integration Coordinator (SIC)
- Designation of a Single Point of Contact (SPC)
- SPC Care Coordination Competencies
- Intervention tracking
- Care Planning Team participation

Care Coordination: Purpose and Goals

- Work collaboratively with the patient, family, physician, and other providers to meet the individual's needs
- Maximize efficiency of available resources
- Ensure connection to services
- Encouraging patients/ families in self advocacy
- Enhance safety; build and strengthen family and community support
- Decrease fragmented healthcare
- Increase continuity of care

InCK Care Coordination Process Flow

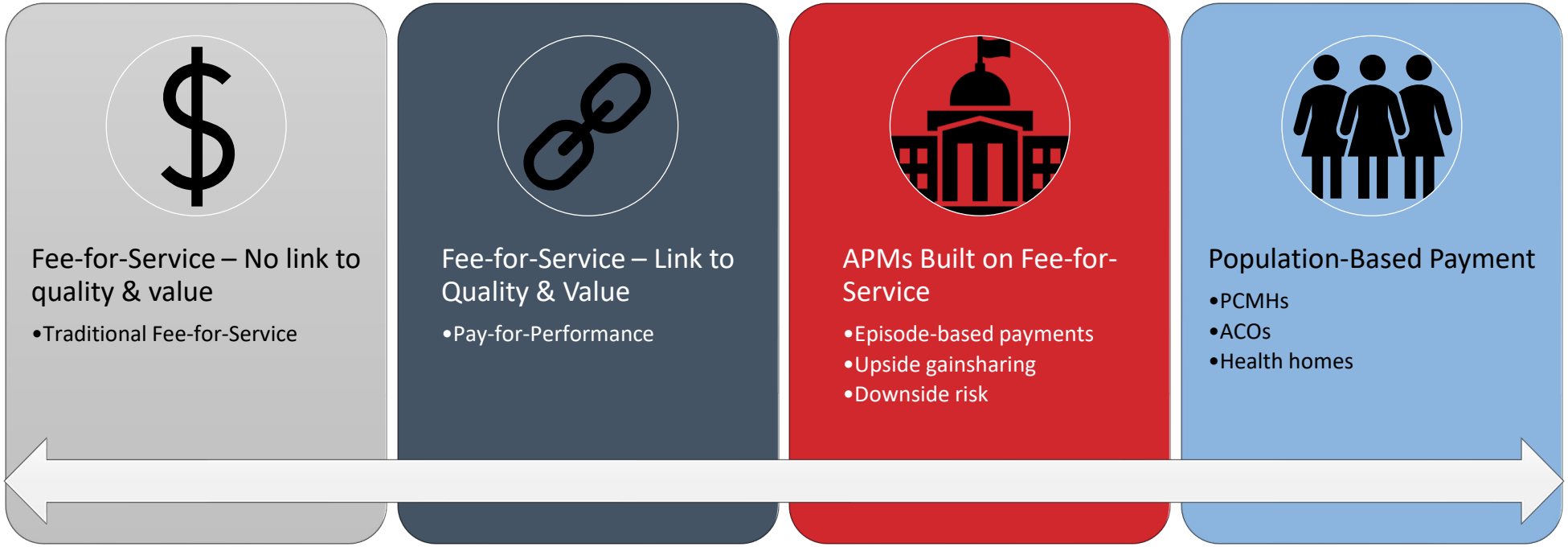


Intervention Strategies by SIL

Intervention	Description
Service Integration Level 1 – Primary prevention	
Mobile Crisis	Build additional capacity (e.g., staffing) within existing units, offering immediate mental health evaluations and referrals
24-hour hotline	Pilot how to optimize existing crisis hotlines to address the needs of the attributed population and ensure 24/7/365 coverage
School-based health services	Provide select healthcare services for students with no medical home, who do not seek routine care, and/or who do not or are unable to adhere to caregivers' order (i.e. asthma)
Signs of Suicide (SOS)	Trains teachers, parents, and peers to recognize warning signs for depression and other BH conditions
PAX Good Behavior Game	Provides educators with an evidenced based model to reduce interruptions and aggressive behavior thereby creating a more productive learning environment
Spark early childhood literacy	Pilot a monthly home visiting program implemented by retired teachers who teach parents how to read with their child
Evidence-based home visiting	Test impact of scaling evidence-based home visiting models included Healthy Families America, which decreases OOHP and promotes pregnancy health, child health, and parenting skills
Whole Child Partnerships Program	A model that addresses the student's social, emotional, education, and health needs
Service Integration Level 2 and 3 – Coordination care across systems	
Specialty SUD and BH Telehealth	Provide local primary care providers with the training and support from medical and BH subspecialists to allow patients receive care in their communities
Integrated Care Coordination	Single point of contact to coordinate existing care coordinators for children with medical complexity
Service Integration Level 3 – Reducing out of home placement	
Fostering Connections Expansion	Train providers to implement enhanced services aligned with FC clinic model, serving as a medical home for children in OOHP (e.g., assessments following OOHP, trauma informed model)
Positive Parenting Program	Pilot a parenting skills program focused on helping parents of children with BH conditions manage their behavior and avoid escalations that may lead to OOHP
Care Planning Teams	Additional care planning teams in cases where children experiencing medical/social complexity and involved in multiple systems of care are already covered under other Ohio programs

Alternative Payment Model (APM)

InCK awardees required to design payment innovations that create added incentives to provide high-quality and cost-efficient care. APM designs can apply to a specific clinical condition, a care episode, or a population.



What is an Alternative Payment Model (APM) in the InCK Model?

The InCK Model NOFO Defines an Alternative Payment Model (APM) as: A payment approach that ties payments to the delivery of high-quality and cost-efficient care.

- APMs can apply to a specific clinical condition, a care episode, or a population.
- It is not an Alternative Payment Model or Advanced Alternative Payment Program as defined by the Quality Payment Program created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

InCK Model APM Requirements

1. Include **integrated care coordination and case management** services using appropriate Medicaid and/or CHIP authorities to pay for the services

2. Utilize a clear **method of patient attribution** with a clear process for communicating patient attribution to providers; ideally, prospective patient attribution when feasible.

3. APM implementation must begin by model year 4. If including **downside financial risk** sharing (not required), this element may not be implemented until model year 5.

4. The APM must conform to one of the following approaches:
   - **Build on existing fee-for-service** architecture by providing mechanisms that connect payment to health care service quality and efficiency.
   - **Implement a population-based payment** approach to compensate providers for caring for a defined patient population over a fixed period of time.

What is the Social and Behavioral Health Complexity Pilot (InCK's APM)?

- ✓ Value-based payment pilot to improve quality of social needs data and treatment of conditions associated with child out of home placement
- ✓ Performance-based incentive aimed at:
  - Earlier detection of barriers to optimal child health
  - Medication/psychotherapy initiation and effective follow up after ADHD diagnosis

Eligible Patients

- **InCK Eligibility –**
  - Under the age of 21
  - Enrolled in Medicaid
  - County of residence is Licking or Muskingum
- **Financial Incentive Program Eligibility –**
  - Enrolled in managed Medicaid in Ohio
  - Under the age of 19 (if enrolled in CFC) and under the age of 21 (if enrolled in ABD or AFK)
  - County of residence is Licking or Muskingum
  - Patients will be attributed using Partners For Kids' current Provider Incentive Plan methodology, which accepts attribution from the payor provider eligibility files

CFC – Covered Families and Children; **ABD** – Aged, Blind, and Disabled; **AFK** – Adoption, Foster, and Kinship

Eligible Providers

- Initial implementation of the Social and Behavioral Health Complexity Pilot is limited to providers currently contracted with Partners For Kids and with attributed patients residing in Licking and/or Muskingum County

- Providers must be in good standing with Partners For Kids network requirements and eligible for Partners For Kids' primary care Provider Incentive Program

- Pilot providers include five pediatric primary care providers with attributed patients in Licking and Muskingum County

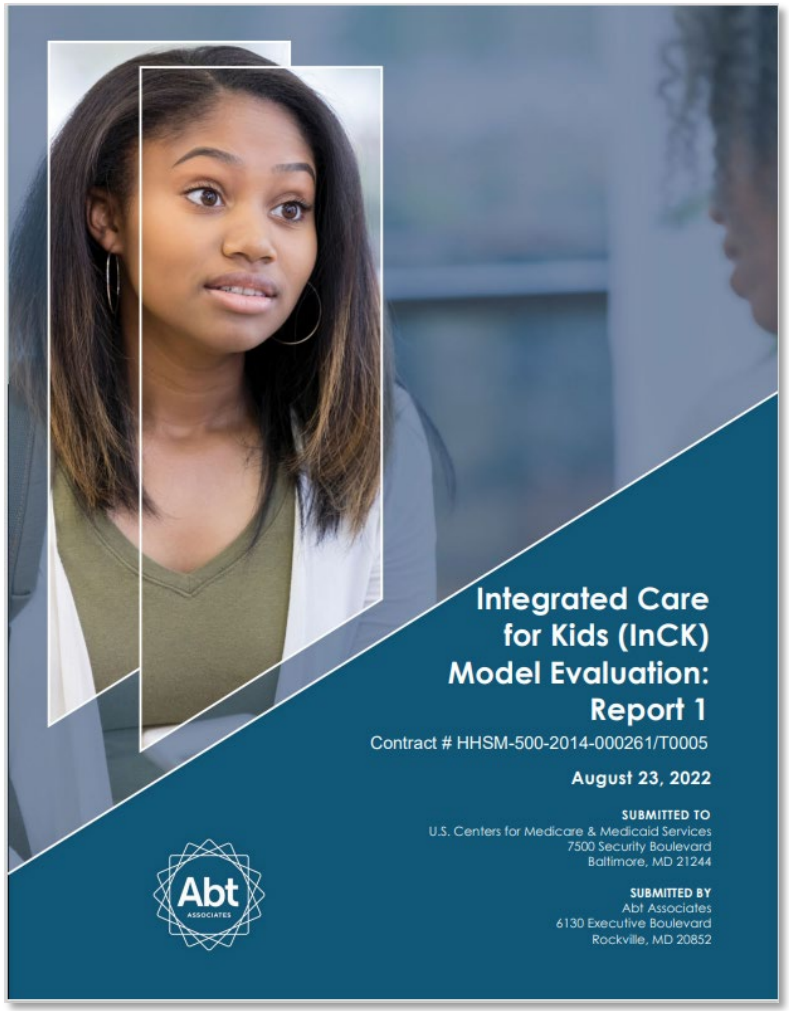
    - 6,510 members are collectively attributed to these eligible providers

Measures and Specifications

MEASURE	2023
ODM Health Risk Assessment • Successful completion of one Ohio Department of Medicaid health risk assessment • Limited to attributed patients without a completed HRA after 120 days of unsuccessful contact attempts by Partners For Kids Quality Outreach Coordinator staff	$10 PSP*
Follow up after ADHD medication initiation • Includes patients age 3-20 with a clinical diagnosis of ADHD who have a follow up visit for ADHD with a prescribing authority 45 days after medication initiation	$40 PSP*
Patient engagement in Psychosocial Services • Include patients age 3-20 with a clinical diagnosis of ADHD who have at least one psychotherapy visit within one year after a new diagnosis	$40 PSP*

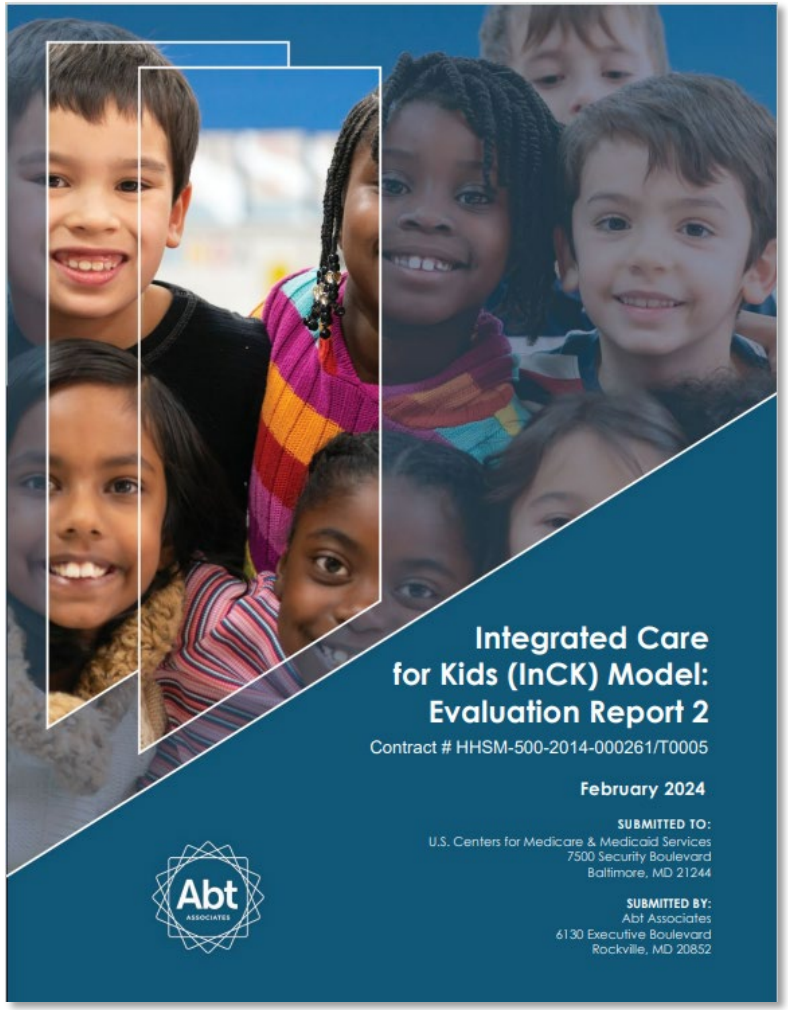
* PSP = Per Successful Patient

CMS Model-Wide Evaluation



Pre-Implementation Evaluation Report

First Year Implementation Evaluation Report



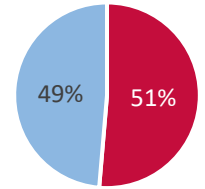
Presentations and Papers

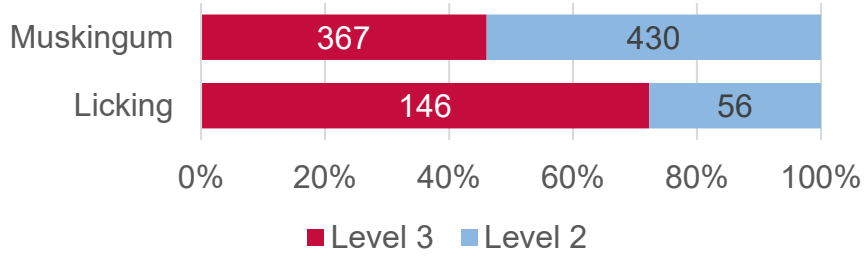
- The role of value-based purchasing in building neighborhood health. State of the Art Plenary: The evidence base for value-based purchasing. *Panel Presentation Pediatric Academic Societies Annual Meeting. Toronto, Canada May 2024*
- Comparison of Machine Learning Algorithms Identifying Children at Increased Risk of Out-of-Home Placement: Development and Practical Considerations. *Manuscript submitted to Health Services Research*
- Building Community-Academic Partnerships in Grant-Funded Projects: Perspectives from the Field In development; manuscript pending submission to *Progress in Community Health Partnerships: Research, Education, and Action*
- Community-Academic Collaboration and Partnership Councils: Lessons Learned While Working on a Federally-Funded Child Health Project in Rural and Appalachian Ohio; *poster accepted to ATRN Annual Health Research Summit 2024*
- A Data-Driven Approach to Identifying Medicaid Children at Risk of Out-of-Home-Placement: Validity, Value, and Data Sharing Considerations; *abstract accepted by Medical Care special issue on Building Data Capacity to Advance Health Equity for Patient-Centered Outcomes Research*

InCK SIL 2 and 3 Demographics Dashboard

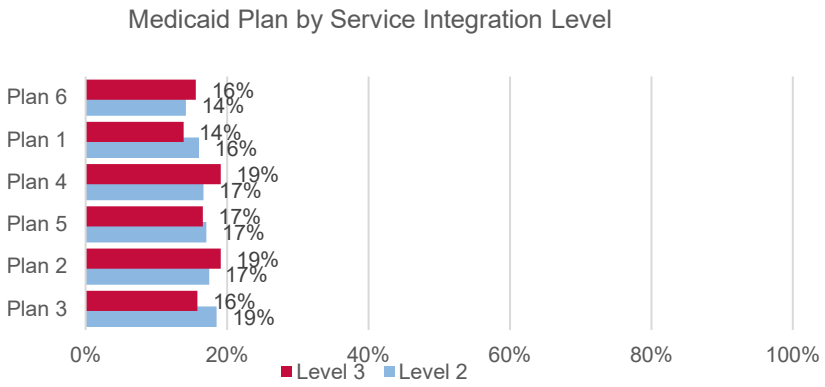
Total Medicaid Beneficiaries in Level 2: 501 **Total Medicaid Beneficiaries in Level 3:** 498

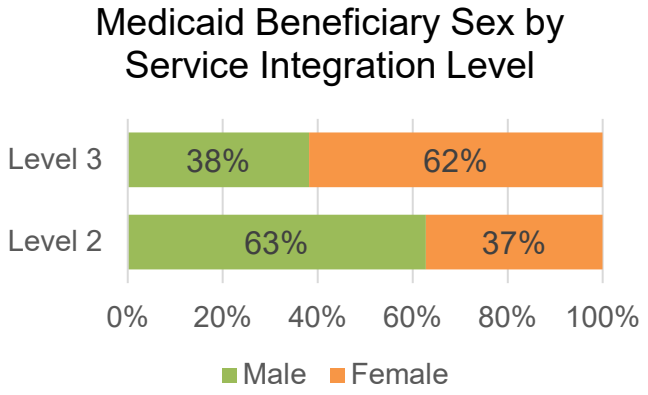
Total Medicaid Beneficiaries in Level 2 and Level 3: 999

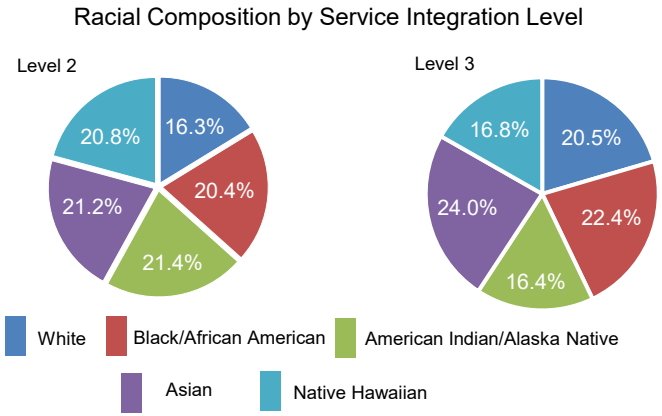




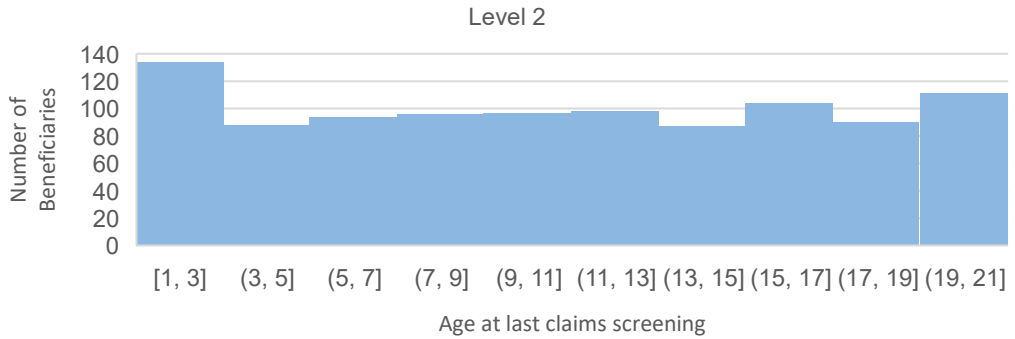
*Visualizations included do not reflect actual project data-for example purposes only

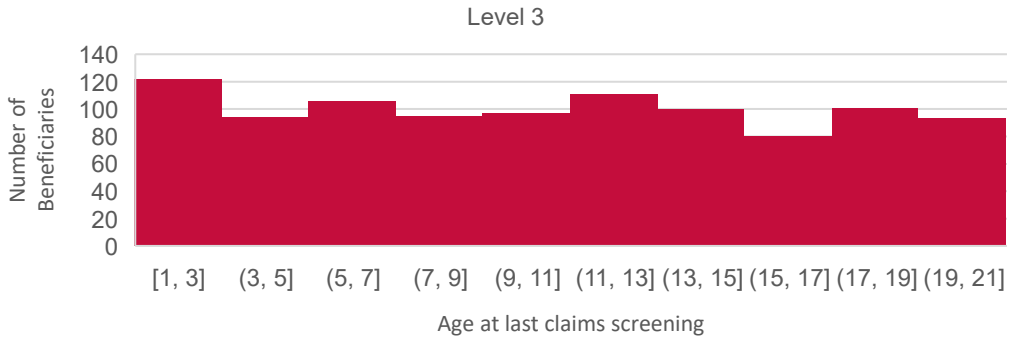






Age composition of Service Integration Levels 2 and 3





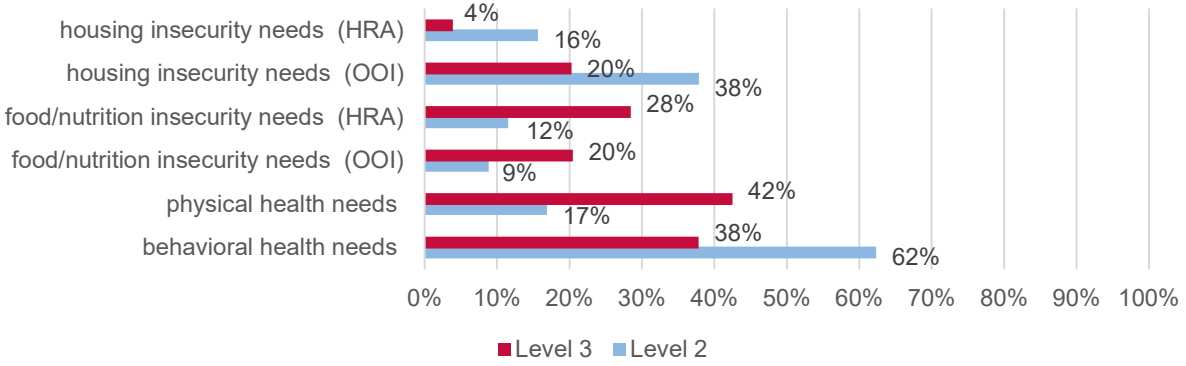
Trends in Needs among Level 2 and 3 Beneficiaries Dashboard

Total Medicaid Beneficiaries in Level 2: 501

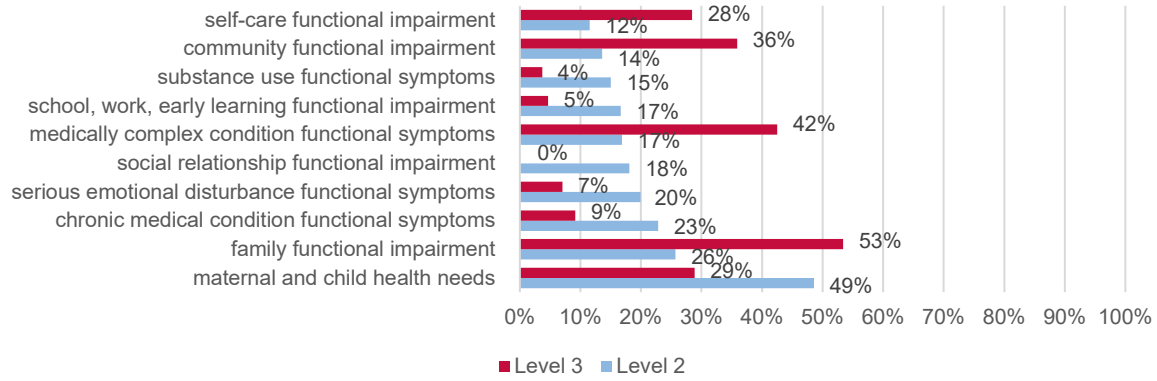
Total Medicaid Beneficiaries in Level 3: 498

Total Medicaid Beneficiaries in Level 2 and Level 3: 999

Physical Health, Food Insecurity, and Housing Needs in Levels 2 and 3



Functional Impairment and Functional Symptom Trends in Level 2 and Level 3



34% of Level 2 beneficiaries screened positive for child welfare involvement

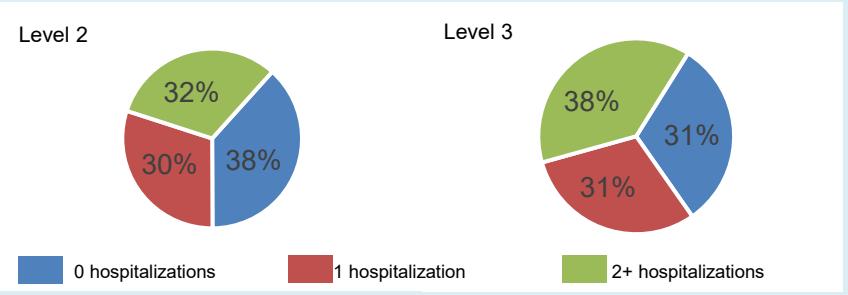
15% of Level 3 beneficiaries screened positive for child welfare involvement

Among Level 3 Medicaid Beneficiaries,

32% screened positive for out of home placement in claims

54% screened positive for out of home placement using SACWIS

Hospitalizations among Level 2 and Level 3 beneficiaries



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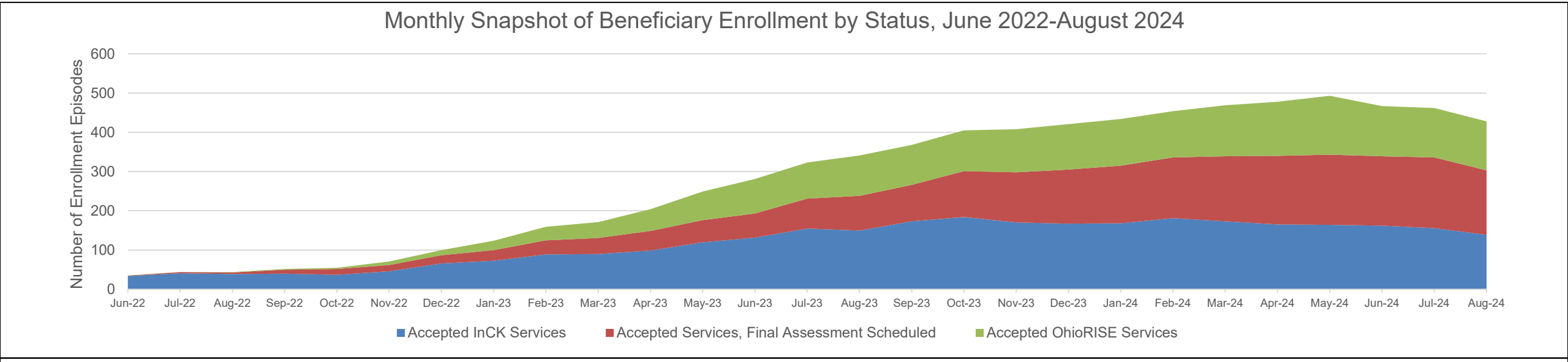
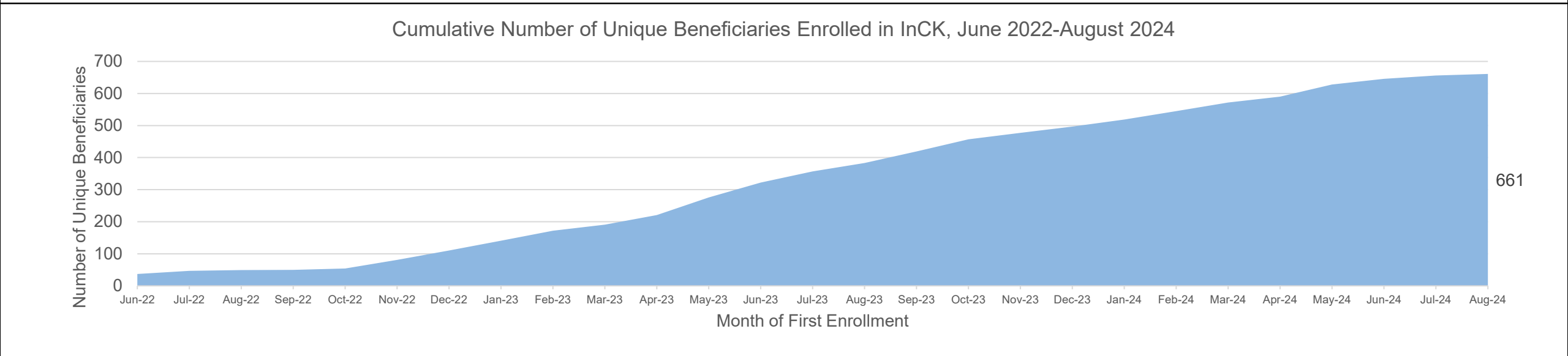
InCK Enrollment Over Time

Unique Beneficiaries with an Enrollment Initiated in the Last 12 Months: 415
Total Unique Beneficiaries with an Active Enrollment in the Last 12 Months: 634



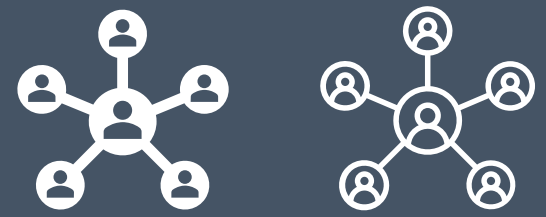


Building Community-Academic Partnerships in Grant-Funded Projects

Background: As community-academic partnerships (CAP) and community-based participatory research (CBPR) continues to grow, navigating the requirements of grant-funded projects while building trust and collaboration with partners can be challenging.

Objectives: Members of project leadership and a community Partnership Council reflect on building CAPs while implementing a large-scale Center for Medicare and Medicaid Services (CMS)-funded project and identify tensions and challenges to building CAPs within grant-funded work and offer recommendations to address these challenges.

Challenges to Community Collaboration

Funding Limitations 	Timeline and Structure 	Power and Resource Imbalances 
Measures of Success 	COVID-19 pandemic 	Shifting Health Policy Landscape 

Building and Sustaining Partnerships While Navigating Grant-funded Project Requirements

Partnerships require patience, trust, time, and intentional effort. We identified recommendations to navigate challenges and leverage funder requirements to enhance trust and collaboration.

- Focus on sustainability
- Leverage power and resources
- Allow for patient, frank conversations and meaningful feedback
- Include short-term and relational success outcomes

Partnerships in Rural Ohio

- Overcoming initial perceptions and building trust in partnerships that bring together rural, Appalachian, and urban stakeholders
- Designing an innovation model for implementation in two counties that share similar health needs but differ in geography and regional alignment
- Understanding beneficiary population needs and provider dynamics that differ widely even within specific counties

Big Wins

Negotiation of data sharing agreements across multiple state agencies

Operationalizing a project within a complex and active state health policy environment

Development of authentic community relationships

Increasing internal visibility

Emerging Challenges

Even more policy landscape change

Planning for sustainability

Defining success locally

Ohio-Specific Model Learning

Implementation Milestone	Key Insight
• Positioned model within Ohio's NextGen Medicaid managed care landscape, including within OhioRISE system	• Taking an adaptive approach was necessary given planning phase occurred during Ohio Medicaid's managed care re-procurement process
• Screening and risk stratifying ~29,000 Medicaid enrolled beneficiaries quarterly using data-driven algorithm	• Using a data-driven methodology has been a success, yet it came through extensive DUA negotiation and validity testing
• Leveraged hospital system capacity and community partner relationships to expand evidence-based interventions	• Introducing/expanding evidence-based interventions was possible due to unique positioning and experience of NCH
• Introduced new quality measures as part of an existing provider incentive plan administered by a pediatric ACO	• Quality measures still relatively new and are only one part of the InCK population health approach for our model

Questions

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Health Policy Institute of Ohio

OHIO HEALTH POLICY

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2024

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