



Strengthening Health Care Delivery Systems for Children with Special Health Care Needs and the Role of Quality Measurement

Wednesday, November 28
2:00 - 3:00pm ET

*Funded by a grant from the Lucile Packard Foundation for Children's Health,
Palo Alto, California.*

Logistics



- Webinar Audio
 - Audio will be coming through your computer speakers
 - If you are experiencing audio difficulties, you may dial in via your phone:
 - **Call-in:** 800-289-0462
 - **Passcode:** 017133
- Q&A
 - Please submit all questions via the chat box

Agenda



Welcome, Introductions, and Overview

- **Karen VanLandeghem**, Senior Program Director, NASHP

Delaware: Managing the Health Care Needs of Children with Medical Complexity

- **Kimberly Xavier** and **Glyne Williams**, Delaware Division of Medicaid and Medical Assistance

Massachusetts: Serving CYSHCN in an Accountable Care Organization Model

- **Jill Morrow-Gorton**, MassHealth

Rhode Island: Understanding the Care Coordination System for CYSHCN

- **Colleen Polselli**, Rhode Island Department of Health
- **Maura Taylor**, Hasbro Children's Hospital/Rhode Island Hospital

Questions and Discussion

Wrap Up

About NASHP



- An independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.
- As a non-profit, nonpartisan organization, NASHP is dedicated to helping states achieve excellence in health policy and practice by:
 - Convening state leaders to solve problems and share solutions
 - Conducting policy analyses and research
 - Disseminating information on state policies and programs
 - Providing technical assistance to states



Delaware Health and Social Services

Delaware's Plan

for Managing the Health Care Needs of

CHILDREN WITH MEDICAL COMPLEXITY

Division of Medicaid and Medical Assistance



LEGISLATURE



- House Substitute No. 1 for House Bill No. 275
- Budget Epilogue Section 141: Address the needs of Children with Medical Complexity (CMC)
- Comprehensive Plan for CMC
- Public Process



CMC STEERING COMMITTEE



- Community Partners
- Sister Divisions
- Parents
- Caregivers
- Community Advocates



Delaware CMC Steering Committee Key Planning Questions

- What do we want to achieve?
- What are the visions and goals that drive our work?
- What barriers limit CMC's ability to receive appropriate care?
- What are some possible solutions?



A COMPREHENSIVE APPROACH TO CARE



GOALS



- Clearly define and identify the population.
- Assess access to services.
- Evaluate models of care.
- Analyze the relationships between insurance payers.



CHILDREN WITH MEDICAL COMPLEXITY

Children with medical complexity are a subset of children and youth with special health care needs because of their extensive health care utilization. For the purpose of this plan, a child is considered medically complex if she/he falls into two or more of the following categories:

- ❖ Having one or more chronic health condition(s) associated with significant morbidity or mortality;
- ❖ High risk or vulnerable populations with functional limitations impacting their ability to perform Activities of Daily Living (ADLs);
- ❖ Having high health care needs or utilization patterns, including requiring multiple (3 or more) sub-specialties, therapists, and/or surgeries;
- ❖ A continuous dependence on technology to overcome functional limitations and maintain basic quality of life.

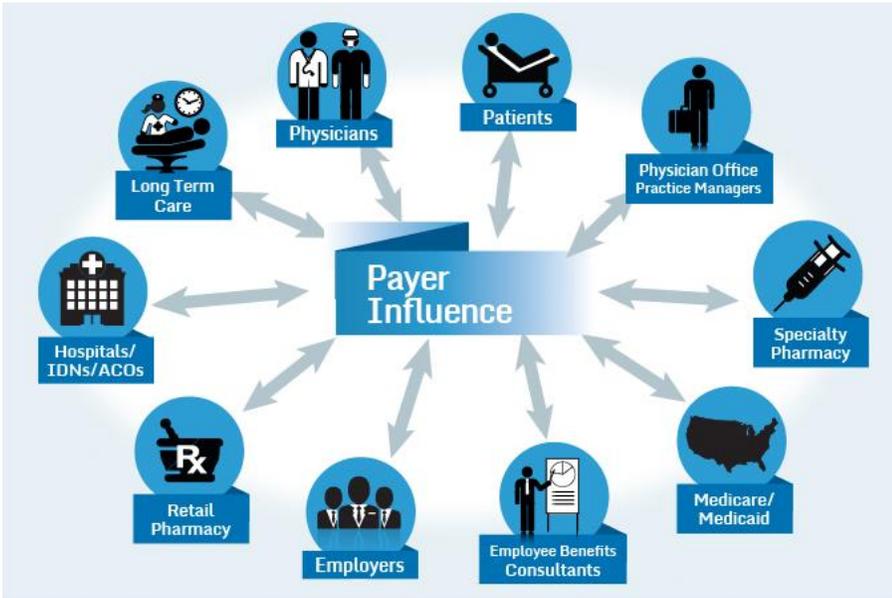


A COMPREHENSIVE APPROACH TO CARE

ACCESS

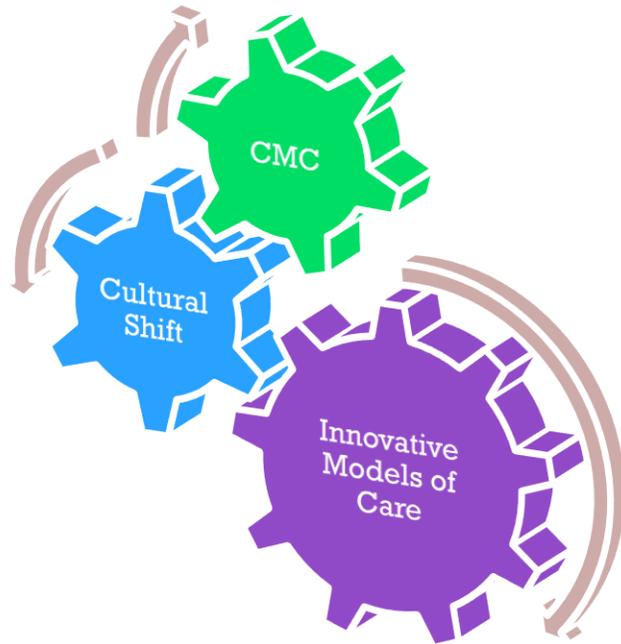


PAYERS

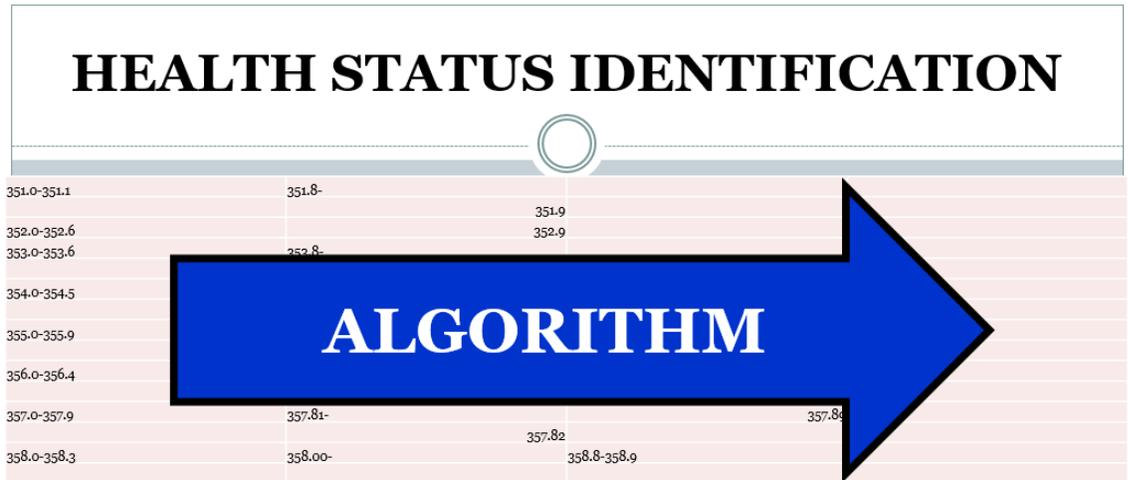


A COMPREHENSIVE APPROACH TO CARE

MODELS OF CARE



DATA





VISIONS AND GOALS



DATA WORKGROUP

❖ Nearly 20 percent of all US children have a chronic and/or complex health care need requiring physical and behavioral health care services and supports beyond what children normally require.

❖ A smaller group of children, which is increasing in number, have complex health care needs, with about 4 percent estimated to be medically complex.



ACCESS



- Provider Capacity
- Nursing and other Support Services
- Transportation
- Durable Medical Equipment and Supplies
- Pharmacy



PAYERS

- Redundant Documentation
- Appeals and Fair Hearings
- Coordination between Payers



MODELS OF CARE



- Patient and Family Centered Care
- Care Coordination
- Transitioning to the Adult System of Care





RECOMMENDATIONS



RECOMMENDATIONS FROM THE CMC STEERING COMMITTEE

- ❖ Keep the Children with Medical Complexity Steering Committee in place
- ❖ Perform a comprehensive data analysis as it relates to children with medical complexity
- ❖ Strengthen systems of care for children with medical complexity



RECOMMENDATIONS FROM THE CMC STEERING COMMITTEE

- ❖ Be clear in contracts about the role of managed care organizations in identifying and providing services to children with medical complexity
- ❖ Develop and/or strengthen existing resources for caregivers, providers, and the larger community involved in the care of children with medical complexity
- ❖ Strengthen the network of home health providers for children with medical complexity





PLAN AND PROGRESS TO DATE



THE PLAN & PROGRESS TO DATE

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THE PLAN & PROGRESS TO DATE

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NEXT STEPS



THANK YOU!

https://dhss.delaware.gov/dhss/dmma/files/de_plan_cmc.pdf

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MassHealth Accountable Care Organizations (ACOs): A Potential Model for Supporting Transition of Care for Youth with Special Healthcare Needs



NASHP Webinar: Strengthening Health Care Delivery Systems for Children with Special Health Care Needs and the Role of Quality Measurement

November 28, 2018

MassHealth ACOs Timeline

- MassHealth has historically used the 1115 Waiver to authorize managed care delivery systems for members under age 65
- Prior to March 2018, MassHealth's managed care system included Managed Care Organizations (MCOs) and the Primary Care Clinician Plan (PCCP), including a managed behavioral health vendor (MBHP)
- The Waiver, approved November 2016, created MassHealth's new managed care structure and choices for members, including implementation of ACOS. Seventeen ACOs in three models of ACOs were developed: Accountable Care Partnership Plan (Partnership Plan—a partnership between an ACO and a single MCO)-13, the Primary Care ACO (an ACO with MassHealth)-3, and the MCO-Administered ACO (an ACO that may contract with multiple MCOs)-1.

MassHealth ACOs Timeline, cont.

- Of the 1.8 million MassHealth members, 1.19 million were eligible for ACO participation. Eligibility includes age less than 65 years and the absence of other insurance coverage such as Medicare. Since March 1, 2018, MassHealth has transitioned more than 850,000 members to Accountable Care Organizations (ACOs), and more than 200,000 to two Managed Care Organizations (MCOs).
- Since launching, ACOs have been actively engaging with their membership to understand their needs, and addressing them through a variety of programs (e.g. disease management, complex care management, community base supports).
- As of July 1, 2018, Community Partners are working with ACOs and MCOs to provide specialized wraparound supports and care coordination for members with complex long-term medical and/or behavioral health needs. CPs are estimated to work with around 60,000 members when fully implemented. They will actively outreach and engage individual/ families, assess needs, provide options and refer to services, coordinate with individual and providers to develop and maintain a care plan and help members navigate medical, behavioral health, disability, social services

MassHealth Accountable Care Organizations: Treating the Whole Person

MassHealth engaged extensively with hundreds of health care providers, advocates and other stakeholders throughout the ACO design and transition process. This has included the creation of a Delivery System Reform Implementation Advisory Council, three Technical Advisory Groups, and a monthly advocates forum.

ACOs are rewarded for *value* – **better health outcomes and lower cost**– not volume. ACOs:

- Are a network of primary care providers who work in partnership with hospitals and specialists to coordinate all of a member's medical and behavioral health care.
- **Strengthen members' relationship with their primary care provider**, who engage members in their care and coordinate to help them navigate all the services they need.
- Focus on **better coordinating care** and **engaging members in their care** to improve health outcomes and reduce preventable costs (e.g., avoidable hospitalizations).
- **Integrate all care a person needs, including behavioral health and physical health care**, especially in the primary care setting, as well as **long-term services and supports**.
- Develop **innovative approaches to address social needs** (e.g., housing, food insecurity) that impact health.
- Are **accountable for the quality, member experience and cost of care** for members.

Community Partners

- The Waiver authorizes MassHealth to create Community Partners (CPs) in order to better support members with complex behavioral health, long term services and supports (LTSS), and health-related social needs
- These community-based entities will help members navigate the complex system of care
- MCOs and ACOs will partner with MassHealth identified CPs with experience in behavioral health, LTSS, and health-related social needs

Community Partners, cont.

Objectives

- Improve member experience and quality of care for members with behavioral health and LTSS needs who are enrolled in MCOs and ACOs
- Improve continuity of care for members with behavioral health needs and ensure appropriate setting and level of care for members with LTSS needs
- Create opportunity for ACOs and MCOs to leverage the expertise and capabilities of existing community-based organizations servicing populations with behavioral health and LTSS needs
- Invest in the continued development of behavioral health and LTSS infrastructure (e.g., technology, information systems) that is sustainable over time
- Improve collaboration across MCOs and ACOs, CPs, community organizations addressing the social determinants of health, and the behavioral health, LTSS, and physical health delivery systems in order to break down existing silos and deliver integrated care
- Avoid duplication of care coordination and care management resources
- Support values of community-first and cultural competence, SAMHSA recovery principles, and independent living

Delivery System Reform Incentive Payment (DSRIP) Investments for Year 1

ACO Investments

ACO DSRIP Investment Category	Amount*	% of Total
Care Coordination & Care Management	\$124.1M	39%
Clinical Integration	\$34.0M	11%
Community-Based Care Initiatives	\$8.3M	3%
Culturally & Linguistically Appropriate Services	\$2.9M	1%
Data and Population Health Analytics	\$19.6M	6%
Health Information Technology	\$36.5M	12%
Health-Related Social Needs	\$4.9M	2%
Organizational Integration	\$43.4M	14%
Workforce Development	\$6.1M	2%
Other	\$37.3M	12%
TOTAL	\$317.1M	100%

Examples of innovative ACO investments:

- An Ambulatory Intensive Care Unit (ICU) Program that will care for members with serious medical conditions in their homes.
- Cell phones for members with complex medical and behavioral health care needs who need to keep in touch with their providers to help them follow treatment plans, which can reduce hospitalizations from poorly managed chronic disease.
- An intensive care management program that surrounds frequent ER users with a team dedicated to managing their health, wellness, and social needs.
- Implementing an Opioid Prescription Management Program that supports providers in facilitating safe and appropriate prescription of opioids and other pain management drugs.

CP Investments

Entity	Amount**
Behavioral Health Community Partners	\$30.9M
Long Term Services and Supports Community Partners	\$11.0M
CSA	\$5.3M
TOTAL	\$47.2M

Statewide Investments (SWI) – Key Contracts for CY18

Category	Vendor	Purpose	Amount
Capacity Building	Abt Associates	TA Program for ACOs, CPs, and CSAs	\$9.6M
Workforce Development: Capacity Increase	MassLeague	Community-focused workforce development programs	\$6.8M
Workforce Development: Training	Commonwealth Corporation	Workforce development programs focused on CHWs, peer specialists, and frontline healthcare workers	\$1.7M

* Prep Budget period funding of \$106.4M already disbursed, Performance Year 1 funding of \$210.7M being disbursed throughout 2018

** Infrastructure funding for Preparation Budget Period of \$15.8M already disbursed; PY1 funding of \$31.4M (Jun to Dec '18) under review

ACO and CP Quality and Integration Performance Measures

- ACOs and CPs are financially accountable for meeting specific quality measures and forfeit a portion of their funding if those measures are not met.
- Quality metrics include:
 - Providing **preventive care**
 - Managing **chronic diseases** like diabetes and heart failure
 - **Screening for behavioral health conditions** and initiating appropriate treatment for mental health, addictions, and co-occurring disorders
 - Ensuring appropriate **follow-up care** after a medical or behavioral health hospitalization
 - Maintaining **members with disabilities living in the community** rather than in nursing facilities
- Part of ACOs' quality score will be based on **member experience surveys conducted starting in early CY 2019** by Massachusetts Health Quality Partners (MHQP) an independent, objective 3rd party.



ACO Quarterly Performance Report

<ACO Name (ID#)> Q3: 01/01/2018 – 09/30/2018

The delivery date of this report is 06-30-2018, and the time periods referenced throughout the report are as follows:

Performance period (rolling 12 months):
Service dates 10-01-2017 – 09-30-2018, paid through 12-31-2018

Most recent year-to-date (YTD):
Service dates 01-01-2018 – 09-30-2018, paid through 12-31-2018

Comparison period (rolling 12 months):
Service dates 10-01-2016 – 09-30-2017, paid through 12-31-2017

Prior year's year-to-date (YTD):
Service dates 01-01-2017 – 09-30-2017, paid through 12-31-2017

Report Contents:

Page 1	Overall Performance Summary
Page 2	Cost Performance
Page 3-4	Key Population and Utilization Measures
Page 5-6	Cost Breakdown by Categories of Service
Page 7-8	Quality Measure Performance
Page 9	Community Partner and Community Service Agency Enrollment
Page 10	Additional Payment Breakdown

Excel Supplement Contents:

Tab 1	Risk Score, by Region and Rating Category
Tab 2	Categories of Service, by Region and Rating Category
Tab 3	Cost Performance, by Region and Rating Category
Tab 4	Care Delivery Patterns (Inpatient)

Strengthening Medicaid Managed Care for CYSHCN Learning Collaborative: Project Aim and Activities

- **Project Aim:**

- Focus on how an integrated care model such as the Accountable Care Organization (ACO) structure could support transition and transfer of care for Youth with Special Health Care Needs (YSHCN) from pediatric to adult healthcare settings.

- **Team Activities**

- Identify and collate value based purchasing strategies to identify ways to incentivize transition
- Learn about existing transition activities in the state
 - Pilot hybrid transition model occurring at Boston Children's Hospital (BCH) between pediatrics, pediatric neurology/developmental pediatrics and adult care
 - DPH to survey their case managers/care coordinators and families regarding the barriers to transition
- Study integrated care strategies used by others to achieve this goal
 - Conversation with Got Transition!

Potential Ways to Leverage Delivery System and Payment Reform for Transition of YSHCN to Adult Healthcare: What Did We Learn?

- **Infuse transition into clinical practices**
 - Use of a care needs screen to identify youth with special healthcare needs (YSHCN)
 - Transition readiness screen including assessment of youth's skills needed for successful transition (could be built into the care needs screen)
 - Incorporate core elements of transition into Plan of Care
 - Develop strategy to support transition to adult system (e.g. practitioner education in pediatric conditions)
 - Shared accountability between pediatric and adult systems
- **Value Based/Alternate Payment strategies**
 - Provide monetary incentives for adult practitioners to accept YSHCN
 - Increase pmpm for first year
 - Increase payment for care coordination or offer care coordination support
 - Overlap transition between the pediatric and adult practitioners
 - Quality payments for successful transition (need good quality measure)
 - Network requirements for adult practitioners willing to accept YSHCN

Summary

- Transition of YSHCN could be supported by integrated care models such as the ACOs using Value-Based and Alternative Payment methodologies.
- However, there are some barriers to overcome:
 - Gaps exist in capacity in the adult provider community to provide healthcare to these youth
 - Care complexity with both primary and specialty care
 - Lack of established process for transition to occur
 - YSHCN to gain needed skills for advocating for health as adults
 - Referral sources for YSHCN with knowledge about youth's condition(s)
 - Lack of validated quality and performance measures for successful transition
- Conclusion: We still have work to do to prepare the system for successful transition of YSHCN from pediatric to adult healthcare

Rhode Island: Understanding the Care Coordination System for CYSHCN

RI DEPARTMENT OF HEALTH

COLLEEN POLSELLI

CNDC @ HASBRO CHILDREN'S HOSPITAL

MAURA K. TAYLOR

RI's Existing State System of Care for CYSHCN

- Level I Risk Assessment
- Developmental Screening
- Cross-Departmental [KIDSNET](#) Data System
- Early Intervention Home/Community-based Program
- Pediatric Assessment Services

RI's Current Initiatives that Impact CYSHCN

Rhode Island State Priorities

- Population Health
- Payment Reform
- Leveraging Funds

Systems Initiatives in Place

- Centers for Medicare and Medicaid Services (CMS) State Innovation Model (SIM)
- Multi-payer [Care Transformation Collaborative \(CTC\)](#) program
- Patient-Centered Medical Home (PCMH) Kids
- Accountable Entities (AEs)

Understanding Care Coordination: Project Aim and Activities

Aim:

- To understand the care coordination system in the State of RI and identify the providers of care coordination of children and youth with special needs (CYSHCN)

Activities:

- Assembled key players in the CYSHCN system of care
- Held monthly meetings to review current state of care, identify available resources, and share experiences
- Identified a specific group of CYSHCN enrolled in MCO, Medicaid, PCMH- kids, & seen at the CNDC community specialty care (complex conditions)
- Conducted data analysis of CYSHCN meeting above criteria

Care Coordination Data Analysis

CYSHCN Profile

March 2015-December 2017 *Implementation of EMR

795 CYSHCN received medical/behavioral services at The Children's Neurodevelopment Center

And were enrolled in Case Management/Care Coordination Services from:

- Managed Care Organization
- RI Medicaid Program
- Designated Patient Centered Primary Care Medical Home

Care Coordination Data Analysis

Target Population: Demographics

795 CYSHCN

- ✦ 71% live in the Core Cities (Social Determinants)
- ✦ 63% Male, 37% Female
- ✦ Race and Ethnicity (self identified)
 - 54% Hispanic or Latino
 - 30% Caucasian
 - 22% Black African American
- ✦ Age range
 - 28% birth-5 years
 - 44% 6-12 years
 - 20% 13-18 years
 - 8% 19+ years

Care Coordination Data Analysis

*EMR

795 CYSHCN

9916 Total encounters with Lifespan Healthcare System

- 50% Primary Care
- 24% CNDC Specialty Center
- 19% ED visits
- 7% Behavior Health

Care Coordination Data Analysis

Patient Profile

- Unresolved issues on Problem List
 - 74% had 6 or more identified issues
 - 16% had 10 or more unresolved issues
- 14: Average number of hospital encounters with specialty providers
 - 51 children had 40 or more hospital encounters
 - 7 children had 90 or more encounters
- 24% were seen at the Children's Neurodevelopment Center
 - Clinical Assessment & FU Treatment
 - Development of Care Plan
 - Family Service Coordinator

CNDC: A.C.T. Clinic

Assessment, Clinical Triage, Treatment

- Supports PCP
- Performs clinical assessment for complex med/beh children & families
- Identifies needs of child and family
- Develops care plan
- Provides treatment & parent support
- Care Coordination Provided; **Not a Covered Service**

Takeaways and Future Activities

Key Takeaways

- Care Coordination is complex; occurs through multiple providers
 - Limited communication between care coordinators
- *PCMH Kids* practices receive **temporary** enhanced rate for care coordination

Unexpected Discoveries/ Road Blocks

- Care plans are segmented by care coordinator/provider
- Not all providers are designated care coordinators & are not eligible for enhanced rate
- Complicated authorization requirements exist:
 - Not all care coordinators have authority for approval- delaying services
- Existence of CNDC: ACT Clinic: Assessment, Clinical Triage, and Treatment for complex CYSHCN

Future Activities

- Specialty Care Coordination must be an integrated component of the Care Plan.
 - Specialty Care Plan must be linked to the Medical Home
- Identify a “Lead Care Coordinator” for complex CYSHCN

Q&A



Please enter your questions in the chat box.

New Resource: Measures Compendium



- Reference tool of quality measures aligned with key elements of a system of care for CYSHCN
 - Measures aligned with 10 domains, which are drawn from the *National Standards for Systems of Care for CYSHCN*
 - ✦ Ex: access to care, medical home and care coordination, transition to adulthood
 - Includes relevant measures from 13 existing measure sets
- To help states evaluate how their systems of care serve CYSHCN
- Available at <https://nashp.org/national-standards-compendium/>

Additional Resources



- [Toolkit: National Standards for Children and Youth with Special Health Care Needs](#)
- Learning Modules: Quality Measurement for CYSHCN (forthcoming)
- Medicaid Managed Long-Term Services and Supports for CYSHCN (forthcoming)
 - Webinar: Tuesday, Dec. 4 from 3:00-4:00pm ET
 - 50-State Scan
- [State Strategies for Medicaid Quality Improvement for Children and Youth with Special Health Care Needs](#)
- [State Strategies for Shared Plans of Care to Improve Care Coordination for Children and Youth with Special Health Care Needs](#)
- For more resources, visit NASHP's [CYSHCN Resources](#) webpage

Thank You



- Thank you for joining today's webinar!
- Please take a moment to complete a brief evaluation survey.