Presentation Goals

- Highlight key elements of health care delivery transformation that impact children with chronic and complex health care needs (aka CYSHCN).
- Discuss some policy levers that states are using to transform health care delivery systems for CYSHCN.
- Stimulate discussion and exchange among participants about key challenges and opportunities, and lessons learned in transforming systems of care for CYSHCN.
Why health care transformation?

- Changes unparalleled since passage of Medicaid and Medicare
- All states have initiatives underway to reform the health care delivery system including Medicaid, for example:
  - Patient Centered Medical Homes (PCMH)
  - Health Homes (Section 2703 of the ACA)
  - Accountable Care Organizations
  - Medicaid Managed Care
- Significant implications for CYSHCN, including:
  - Comprehensive coverage
  - Access to and continuity of care and coverage (e.g., moving between coverage types)
  - Access to specialty providers
  - Network adequacy
  - Many other considerations...
- How are states addressing the unique needs of CYSHCN and their families as part of health care transformation?

What are Some of the Top Trends?

- Heightened focus on integrated care through a medical home for adults and children, particularly enrollees with special needs (e.g., behavioral health)
- New models of care and service delivery systems (e.g., Accountable Care Organizations)
- Value-based payment models, such as...
  - Bundled payments for episodes of care (e.g., maternity care)
  - Bonuses/withholds tied to performance on defined quality metrics or care coordination standards
- Shifts of Medicaid enrollees into managed care
The road to integrated delivery systems begins with medical homes.

Background Image by Dave Cutler, Vanderbilt Medical Center
(http://www.mc.vanderbilt.edu/lens/article/?id=216

States with medical home activity for Medicaid/CHIP (current)

Source: National Academy for State Health Policy
"State Delivery System and Payment Reform Map.
Available at: http://nashp.org/state-delivery-system-payment-reform-map/
How medical homes are supporting pediatric populations: Connecticut snapshot

- Medicaid PCMH since 2012
- Enhanced fee-for-service payments for certain primary care codes for practices that meet NCQA PCMH level 2 or 3 and meet Federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements
  - NCQA PCMH must pass standards include: referral tracking and follow-up; care planning and self-care support, continuous QI
- Performance payments
  - Pediatric: Developmental Screenings, Recommended well-care visits, Connection to dental services, Emergency department utilization
- Glide path for practices to become PCMH level 2 or 3 to help with start-up transformation costs

Section 2703 (ACA) Health Homes

- Medicaid State Plan Option to provide comprehensive system of care coordination for Medicaid enrollees with chronic conditions.
- Health home providers to integrate and coordinate all primary, acute, behavioral health and LTSS.
- Health home services include:
  - Comprehensive care management, care coordination, health promotion, transitional care/follow-up, patient and family support, and referral to community and support services.
- Eligible Medicaid beneficiaries must have: 1) two or more chronic conditions, 2) one chronic condition and at risk for a second, or 3) a serious and persistent mental health condition.
- States can target geographic areas and propose service definitions
- Providers of services can include individual or teams of health professionals (pediatricians included).
- Eight-quarter 90% enhanced federal Medicaid match for health home services.

19 States & DC have 28 total approved Medicaid Health Homes as of December 2015

How Health Homes are supporting pediatric populations: Rhode Island Snapshot

- 3 Health Home SPAs, the 1st in 2011 focused on CYSHCN
- Designated providers: CEDARR Family Centers
- About 95% of CEDARR clients meet health home criteria
- Payment: flat service $350-400 rates for initial needs assessment & annual family care plan removed; plus $9.50 - $16.63 per 15 minutes for additional services (based on provider education level)
- Standards: state certification standards (i.e. family centeredness, community focus, coordination), establish protocol to gather, store and transmit data, meet 11 Health Home functions required by CMS
What are Accountable Care Organizations?

- Organizations or structures that assume responsibility for a defined population of patients across a continuum of care, including across different institutional settings.
- Participants are held accountable through payments linked to value, emphasizing dual goals of improving quality and containing costs.
- Accountability is facilitated by reliable performance measurements that demonstrate savings are achieved in conjunction with improvements in care.

http://www.nashp.org/state-accountable-care-activity-map

Medicaid Accountable Care Organizations

State-Based Medicaid Accountable Care Organizations

How ACOs are including pediatric populations: Colorado snapshot

- Colorado Accountable Care Collaborative statewide primary care system for Medicaid enrollees.
  - Medical home for all Medicaid enrollees
  - Regional Care Collaborative Organizations (RCCOs) provide care coordination services.
  - In 2017, RCCO contracts will be rebid with more changes to improve the system of care (e.g., behavioral health integration, addressing enrollees unique needs, care coordination strategy, etc.)
  - The redesign of RCCOs (V2.0) is considering unique needs of CYSHCN with recommendations being advanced by the CO state Title V program

State Innovation Model (SIM) Initiative

**Purpose:** CMS funds to states to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states

**Goals:**
- Develop health systems to improve the patient experience of care (including quality and satisfaction), population health and reduce cost
- Demonstrate a return on investment in three years

**Criteria:**
- Include a broad array of stakeholders
- Engage multiple payers
- Affect a preponderance (80%) of care
- Leverage existing initiatives and investments
- State-wide, state-led, Governor-endorsed effort
39 SIM Design and Test Grants have been awarded since 2013


How SIM is supporting pediatric populations: Idaho SIM Snapshot

- Expanding access to primary care by building 180 NCQA recognized PCMH practices, including 75 virtual PCMH practices, to improve rural patient access to care
- Participation by Medicaid & three largest commercial insurers
- SIM data collected on cross-payer healthcare performance measures to assess and improve population health
  - Proposed measures include childhood immunization rates, asthma ER visits, and LBW rates
- SIM testing program and transformation of practices will include work of the state’s Children’s Health Improvement Coalition to develop PCMH practices for CYSHCN
SHIFTS OF CYSHCN INTO MEDICAID MANAGED CARE

- Many states are or have shifted children and adults with chronic and complex health care conditions into managed care
- 2/3 of all Medicaid enrollees were receiving all or most of their health care from managed care, as of October 2010
- 2/3 of states (32 states) reported mandatorily enrolling at least some CYSHCN in managed care, 20 states on a voluntary basis, and about half of states mandating managed care for at least some children who receive Supplemental Security Income (SSI)

Final Federal Rule for Medicaid and CHIP Managed Care: Highlights for CYSHCN

- Released by CMS on April 25, 2016 with ongoing analysis by many groups (1400 page rule)
- Establishes important changes, with a strong focus on access, while maintaining state flexibility
- **Enrollment**: States retain ability to determine which populations of children and adults to enroll in Medicaid managed care
- **Network Adequacy Standards**: Requires states to develop network adequacy standards, including time and distance standards, for certain types of providers including pediatric, specialty and behavioral health providers, hospitals, and long-term services and supports
Final Federal Rule for Medicaid and CHIP Managed Care: Highlights for CYSHCN (continued)

- **Care Coordination:** Requires health plans to complete an initial health risk assessment within 90 days of enrollment of new beneficiaries, and ensure that enrollees with special health care needs receive an assessment and treatment plan that is regularly updated.

- **Plan Enrollment:** States must take families’ needs into account when passively enrolling individuals and plans will be required to provide 90 days for families to change their plan assignment.

- **Quality Rating System:** Established by CMS (or states) to provide performance information to consumers on all managed care plans to promote transparency.

Texas Medicaid Managed Care Snapshot

- In Fall 2016, children and youth age 20 or younger who receive SSI Medicaid or were enrolled in the state’s Medically Dependent Children Program will receive all of their services through Texas STAR Kids Medicaid managed care program, which serves children who receive disability-related Medicaid.

- The STAR Kids health plans have specific network adequacy and access requirements for specialty providers and requirements to establish medical homes for enrollees.
CYSHCN and Health Care Delivery Transformation

- How are states structuring health care delivery systems to meet the unique needs of CYSHCN?
- Which groups of CYSHCN are enrolled in Medicaid managed care (e.g., all?, condition specific?, etc.)?
- How are states integrating health care delivery systems with other programs that support CYSHCN (e.g., public health, education, mental health)?
- How are states ensuring access and coordinating care?
- What quality improvement strategies and measures are states using to monitor quality of care?
- How are CYSHCN and their families faring as a result of rapid transformation in states?

Standards for Systems of Care for Children and Youth with Special Health Care Needs

A Product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project

For more information:
www.nashp.org
http://www.nashp.org/medical-homes-map/
www.nashp.org/state-accountable-care-activity-map
https://medicalhomeinfo.aap.org

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