Reflecting on Learnings from the Oregon's Integrated Care for Kids (InCK) Applicable to APMs

Collaborative Discussion
1/12/22

OPIP

Agenda

1. Hearing from OHA about what they learned and areas they are focusing on
   - High level overview
   - Outstanding questions
2. Punchline of Key Priority Area from OPIP's Vantage Point Given Where We Are, Levers that Exist, Levers that Don't

Fodder Slides & Summary of Broader Points and Full Set of Factors for OHA:

a) Lack of requirement for explicit inclusion of children in other required APMs for CCOs, Reason for Advocacy within Primary Care Payment Reform Collaborative
b) PCPCH APMS – Learnings relative to current levers and current requirements
c) THW – within PCPCH vs in Community
d) Metrics – APMS Tied to Metrics
e) Behavioral health
f) HIE – is an APM or other mechanism needed

Hearing from OHA about What they Learned and Areas they are Focusing On

- High level overview
- Outstanding questions

Punchline of Key Priority Area from OPIP's Vantage Point Given Where We Are, Levers that Exist, Levers that Don't

There are no APMs (including metrics) focused on the following and levers and innovative approaches that go beyond traditional FFS are needed given the current state of quality, impact on health equity, and federal requirements for Medicaid Managed Care:

1. **Complex <u>health</u>** management (we intentionally don't use care coordination only)
   - At a community level FOR the targeted health complex population identified in CCO 2.0 Policies
   - For medically complex children who receive a majority of care from specialists
2. **Behavioral Health** provided by specialty behavioral health
3. Pilots of **Dyadic and/or Family Case Rates**
   - **Recommend a pilot of children identified by 2B: Parent Medicaid Insured, Parent has 1 of three factors (Parental incarceration, Parent SUD, Parent MH).**

1) APM Focused on Complex Health Management

- Metrics that gauge population reach for these services, Incentives tied to these metric
  - .019% of the InCK Population in a program
- Metrics specific to complex chronic children.
- Payment models that support the outreach, engagement, strength-based approach and trust building that will work for health complex populations already called in the priorities
  - Non-telephone based care
  - Team comprised of social work, nurses, providers, navigators
  - Ability to meet the child/parent in trusted plan
- Payment models that support the asset mapping and connections to services that are the right match with the knowledge in place
- Parent guidance and input – once case manager across services who also knows LOCAL landscape
- NOTE: This does not live within PCPCH

CCO 2.0 Requirements We Observed Were Not Designed for the Population of Focus, Not At Magnitude that Met the Need, And At Fidelity in Rural Regions

- ICC elements include assessment and assistance with:
  - timely access to and management of medical providers including physical health, behavioral health, oral health, remedial, and supportive care and services coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;
  - coordination of capitated services and discharge planning;
  - coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.
- **Behavioral Health CCO 2.0 Priority:** *Require wraparound is available to all children and young adults who meet criteria. Given it is a county based program, fidelity of the program in each county that CCO serves*
- Policy -27 Require wraparound is available to all children and young adults who meet criteria, Wraparound is provided at a county level.
- Policy 27 - System of Care (SOC) to be fully implemented for the children's system
- Electronic HIE for care coordination offers significant benefits to families and caregivers of children, especially those with complex medical needs.
  - It can eliminate the need to fax, mail or hand-carry medical records when seeing a new specialist, ensure all members of the child's care team can access the child's up-to-date health information at appointments, and provide real-time notifications to care team members that the child is being seen at the emergency department (ED) to facilitate follow-up – or even allow care team members to reach out to the family before they leave the ED

2) Behavioral Health APMs

- Need for APMs that
  - Support engagement: meaningful patient-centered outreach and strength-based engagement
  - Support closed loop communication and coordination with others.
    - PMPMs for core function
  - Culturally & linguistically appropriate care
  - Access in rural locations
- For Wraparound
  - For the work, time and resources that it really takes to provide wraparound services
  - Assurance of fidelity of services in <u>each county</u> given it is a county based program
- APMs that support life building skills by right level staff
- APMS that support time to go to the patient – meet them where they are

CCO 2.0 Requirements We Didn't Observe Are In Place to Fidelity

- Require behavioral health services are accessible and available to all members throughout their lifespan (policy 25) and CCOs will ensure **care coordinators** are identified for families of children and youth with special health care needs (policy 24).
- Policy 21 prioritizes access to behavioral health services and early intervention for pregnant women, parents, families and **young children to prevent poor long-term outcomes and reduce costs**. CCOs can ensure children and families have access to **evidence-based treatment approaches for families that help children with symptoms of emotional disorders**. Additionally, CCOs will be expected to prioritize access to substance use disorder services for pregnant women, parents, families and their children to provide the best outcomes for young children and their caregivers
- Require CCOs utilize best practices **to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce that can provide culturally and linguistically appropriate care (including utilization of THWs)
- Policy -27 Require wraparound is available to all children and young adults who meet criteria, Wraparound is provided at a county level.
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3) APM Pilot of **Dyadic and/or Family Case Rates**

- Provision of data that allows this to be possible
- Pilots of **Dyadic and/or Family Case Rates**
  - Recommend a pilot of children identified by 2B: Parent Medicaid Insured, Parent has 1 of three factors (Parental incarceration, Parent SUD, Parent MH).
    1. Include outreach
    2. Strength based assessments of priorities and needs
    3. Assurance of access to and receipt of
       - Physical
       - Behavioral (assessment at a minimum)
       - Oral & Dental if Need Identified
       - Social determinant of health needs are met
    4. Dyad or family complex health management plan

Key Opportunities Informed or Reinforced in InCK Pre-Implementation

a) Rate Setting at OHA Level
b) Lack of requirement for explicit inclusion of children in other required APMs for CCOs, Reason for Advocacy within Primary Care Payment Reform Collaborative
c) PCPCH APMS – Learnings and Opportunity
d) THW – within PCPCH vs in Community
e) Metrics – APMS Tied to Metrics
f) Behavioral health
    - Costs of meaningful wraparound services
    - PMPM to support care coordination and community
g) HIE – is an APM or other mechanism needed.

Key Opportunities Informed or Reinforced in InCK Pre-Implementation

Punchline:

- **Current rates don't provide rates for health complex children that incentivize or would cover the level of access, engagement service and complex health management needed for children.**
- **If the rates don't change, then a focus on these populations within CCO 2.0 broad policies is unlikely.**
- **Rates are not at family/dyad unit – a contributor to lack of focus on the family/dyad**

Solutions:

- Better incorporate child-specific medical complexity & social complexity into rate setting that incentivizes outreach, engagement and provision of care.
  - ***Medical Complexity:***
    - ✓ Strong literature that CYSHCN account for 80% of the costs
    - ✓ Intended to address the blind spots of the commonly used CDPS methodology
  - ***Social Complexity***
    - ✓ Each factor associated with costs individually in child's lifetime.
    - ✓ Also a cumulative effect – more factors, more costs over time (So consideration of model that potential weights more)
    - ✓ With a focus on equity and upstream, providing rates that would incentivize and support the engagement, integration and provision of THW, behavioral and other social services seems critical
- **Pilot of Dyadic Rates** (for Child/Parent Enrolled): Opportunity to "have a go" with the "2B" Population and Dyadic Service Pilots to Examine Total Costs of Care and Impact
- Pilot of **FAMILY Rates** (For Children and Family Unit) & Family Complex Health Managament Pilots to Examine Total Costs of Care and Impact

CCO 2.0 APM Requirements

- Value of when a priority on children is explicitly called out, **unintended consequences of then lack of inclusion of a focus on children in other priority areas**.
  - "By Year 2 (2021), CCOs will be required to implement new VBPs in at least two of the five care delivery focus areas with hospital and/or maternity care required in Year 2 or 3. The remaining care delivery focus areas include: children's health care, behavioral health and oral health. "

  Solutions:
  - Consideration for priority areas of focus for the APMs focused on children given the other topic areas
  - Accountability and concrete questions in other priority areas of whether it impacts children given children are the largest age demographic
- Exec Summary on VBPs for Children: "In addition, through their children's health care VBPs, CCOs will begin to develop payment models that address social determinants of health (including trauma related to adverse childhood experiences), thus supporting long-term positive health outcomes
  - Executive summary implies no focus on children with medical complexity

  Solutions that Could be Part of Future Clarifications and TQS
  - Need for a focus on complex health management
  - Need for a focus beyond access to & screening given existing metrics and levers already in PCPCH

PCPCH: Learnings

Learnings from InCK:

- APM negotiations for **IPA's and multi-site entities**
  - APMs are set for group, which may mean that sites are getting APMs high than their actual PCPCH tiering
    - Lose incentive to be transparent about and improve tiering if already being paid at highest tier
    - Questionable validity of behavioral health supports solely based in centralized setting without presence at trusted place.
  - Only one IPA focused exclusively on children
    - Therefore, within IPA variable focus
- **Smaller practices, practice that serve children in rural regions continue to be left out of APMs** due to "administrative burden"
  - If "equity is the work" how can we ensure that all PCPCH locations have access to APM opportunities

PCPCH: Learnings

- Attribution
  - Attribution not anchored to patient choice, children are attributed to places they haven't been
  - Leaves quality work to focus on those that come in and can be engaged, the rest fall through cracks
    - Non-Engaged Patients with PCPCH, but Medically Complex
    - Non-Engaged Patients with PCPCH, But Socially Complex
- PCPCH
  - Unintended consequence of general PCPCH model and all PMPMs tied to that
    - Lack of validity and reliability of PCPCH tier for complex health management and integrated behavioral health
    - More pronounced lack of validity and reliability of PCPCH tier if family medicine for children
  - Limitations to practice-level reported metrics given denominator
    - Limitations of current metrics in PCPCH for children, largely focused on access and screening
  - THW within the site. Vs THW in the Community
  - **Lack of clarity on algorithms used to designate PMPMs, Rates don't seem to pencil out for practices with high rates of health complex children**
  - **Lack of consideration of practice population when designing PMPM rates**
    - ✓ For PCPCH
    - ✓ For Behavioral Health
- No PCPCH model for Specialist or Hospital Discharge, No APM, No Metric
  - Complex chronic account for 80% of costs, yet our models don't address this population well

THW – within PCPCH vs in Community

- Please see OPIP's comment to the THW model
- Concerned we are seeing a myopic focus on THW **within** Primary Care
- Concerned this doesn't address where **health complex** children have trust and park their cars and root causes of health
  - Medical Complexity
    - Hospital
    - Specialty
  - Socially complex with factors that are aligned with DHS reports
  - Housing supports
  - Non-engaged and not going to PCPCH

Solution:

- APM models for THW from Medicaid to CBOs

Power of Metrics – Lack of Metrics on CYSHN, Health Complex or Behavioral Health

Part 1: If Waiver Proposal of Incentivizing Quality Care Remains As Is.

If Maintain Current Downstream Focus Proposed in Waiver

Solution: Consideration of incentives tied to health complexity

- Related to access
- Related to quality
  - Problem is few within Core Set are quality
  - So even if equity gap is a focus, still stuck with topic areas in Core Set

If Maintain DHS Metric in Upstream:

Solution: Go beyond access to assessment visits

- Metric focused on how many GOT SERVICES that addressed the needs identified by the assessments
- Include metrics focused on steps to reunify the child with the bio parent or bio parent support

Power of Metrics – Lack of Metrics on CYSHN, Health Complex or Behavioral Health

Part 2:

- Significant concern with **LACK OF INCENTIVIZED** metrics related to **behavioral health** and **complex health management**
  - Current status of behavioral health metric committee
  - Priorities outlined for HPQMC and Metrics Scoring
  - Potential behavioral health metrics:
    - Reach metric for socially complex children with specific factors aligned with aces
    - Proportion of health complex children that received ICC or wraparound
    - Proportion of children whose parents receiving SUD or have SED, that are receiving therapy themselves or dyadic services.
- Consequence of no metrics or APM models tied to hospitalization/specialty care

Solution:

- Address the priority areas that HPQMC had identified as gaps in the set focused on metrics that address:
  - CYSHCN care coordination, complex health management
  - Behavioral health adequacy, access, and quality

Behavioral Health APMs

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HIE – Value of an APM?

- Landscape of practices that serve children, or focus on children with systems that serve multiple populations
- Access to & engagement on Collective
- Populations loaded to Collective, Who Uses It
- Proposed use of Connect Oregon and Gaps
- Potential value of targeted focus for “3A” and “3B”

Solutions:

- Create incentives for quality of engagement and tracking WHICH populations are of focus (age and demographic)

CCO 2.0 Requirements We Didn’t Observe Are In Place to Fidelity

- Policy 33 requires CCOs to ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology.
- Electronic HIE for care coordination offers significant benefits to families and caregivers of children, especially those with complex medical needs.
- It can eliminate the need to fax, mail or hand-carry medical records when seeing a new specialist, ensure all members of the child’s care team can access the child’s up-to-date health information at appointments, and provide real-time notifications to care team members that the child is being seen at the emergency department (ED) to facilitate follow-up – or even allow care team members to reach out to the family before they leave the ED