

The Integrated Care for Kids (InCK) Model, Prevention, and Building a Culture of Health

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The InCK Model and Building a Culture of Health

Martha Davis, Robert Wood Johnson Foundation



I am passionate about healthy and safe families, and about opportunities to build viable, cross-system strategies that ensure a level playing field so that everyone has a fair and just opportunity to be as healthy as possible.

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The InCK Model and Prevention

Charles Bruner, InCKMarks Resource Manager



A common thread across my four decade's experience in child health, early education, child safety and welfare, and family economic security is that society and government do best when they support parents in being the best parents they can be, starting from where parents are, and building upon their dreams for their children to grow up and succeed.

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Building a Culture of Health in America


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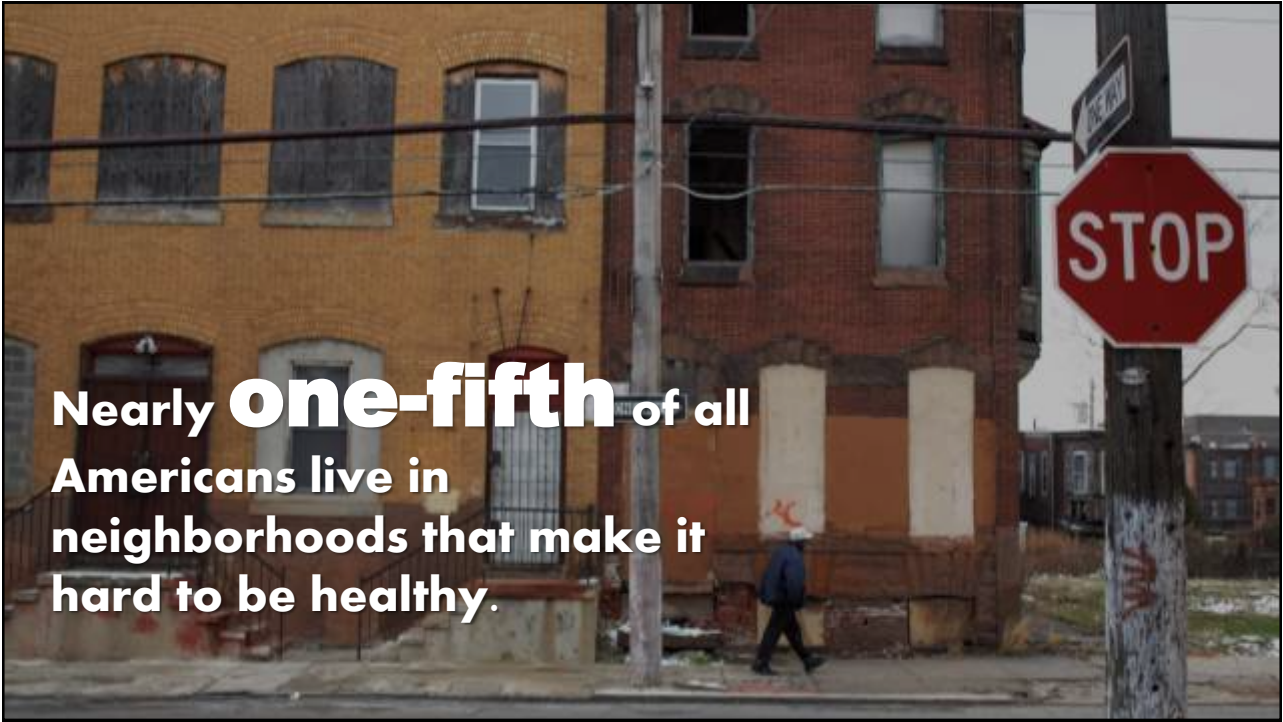
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What is a Culture of Health?

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WHERE YOU LIVE AFFECTS
HOW LONG YOU LIVE



Nearly **one-fifth** of all Americans live in neighborhoods that make it hard to be healthy.





Do more than **THINK BIG.**
ACT.

InCK Model and Prevention

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**Building a
Culture of Health
in America**

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The InCK Model and Prevention

1. About InCK and InCK Marks
2. What the InCK Model (NOFO) Says About Prevention and What It Requires in Applications
3. How InCK Marks Approaches Prevention
4. How and Where Prevention Might Be Incorporated into InCK Applications – Root Cause Analysis and Risk Stratification
5. What Child Health Champions Can Do to Advance Prevention
6. Next Steps for InCK Marks

About InCK and InCK Marks

- The **Integrated Care for Kids (InCK) Model** is a \$128 million, 7-year federal initiative of the Center for Medicare and Medicaid Innovation (CMMI) designed specifically for children (prenatal to 21), with a competitive application process involving the state Medicaid agency and a Local Lead Partner and Partnership Council
- The **InCK Marks Resource Network** is a resource network providing state-of-the-field resources to child health advocates, experts, family and community leaders, practitioner innovators, Medicaid administrators, and policy makers in reviewing and developing strategies to improve child health through more integrated care for kids.

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InCK Marks Partner Resource Network

SUPPORTING CHILD HEALTH CHAMPIONS

ADVANCE MEDICAID TO IMPROVE CHILD HEALTH



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Purpose of Federal InCK Model

The Integrated Care for Kids (InCK) Model will test whether:

- combining a local service delivery model coordinating integrated child health services and a state-specific alternative payment model (APM) to support coordination of those integrated services reduces health care expenditures and improves the quality of care for pediatric Medicaid and CHIP beneficiaries.
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What are the MUSTs in the InCK Model?

- Conduct **root cause analysis** for out-of-home placements.
- **Risk stratify child population** into service integration levels (SILs) based upon child condition/risks and multiple service system involvement.
- Provide **care coordination** for risk stratified populations and care coordination and team-based care for children in out-of-home or at risk of out-of-home placements/hospitalizations.
- Focus on a set of **core services** and establish mobile crisis response teams as part of core services.
- Provide **health outcomes** and **cost savings** projections.

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What the InCK Model Says About Prevention and Early Intervention

- Behavioral health conditions such as substance use disorders have a serious impact on the health and wellbeing of the American population. **Early detection and intervention is critical for the prevention** and treatment of behavioral health and substance use disorders. (p. 6)
- **Preventive measures delivered during the earliest years of life** can mitigate the effects of childhood trauma or adverse childhood experiences (ACEs) that contribute to increased risk of high rates of behavioral health diagnoses in adolescence and adulthood. (p. 7-8)
- Estimates show that more than one in three Medicaid-covered children have emotional or behavioral challenges. Less than one-third of these children currently receive behavioral health care. (p. 8)
- Preference will be given to applicants proposing **two-generational strategies**/approaches to assessing and stratifying young children. (p. 23 and 46).

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What the InCK Model and InCK Marks Say About Prevention

InCK Model – Paraphrasing

- Applicants may focus on prevention, and applicants should develop two-generation strategies at least for children birth to six
- Applicants MUST develop integrated approaches to reduce placements/ hospitalizations and project Medicaid savings as a result

InCK Marks – Guiding Framework

- Biggest gains in child health (and long-term ROIs) are in more preventive approaches that respond to social determinants of health
- These should be part of InCK application AND/OR the focus of state Medicaid improvement actions.

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InCK Marks Guiding Framework Tenets

1. The Importance of an Integrated Approach to Child Health Care Based Upon Child Health Definition;
2. Medicaid's Critical Role;
3. The Different Needs and Opportunities by Developmental Stage;
4. The **Importance of Both New Preventive and Treatment Responses**;
5. The **Presence of High Value, Evidenced-Based Practices to Guide Change**;
6. The Definition of **Value-Based Care as Broader than "Cost-Containment" Care**; and
7. The Importance of Measuring Child Health Based Upon its Broad Definition.

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InCK Marks HIGH VALUE/PERFORMING MEDICAL HOMES

Well-Child Visits

- Comprehensive well child visits as required under EPSDT.
- Adherence to AAP Bright Futures scope and schedule.
- Screening for physical, developmental, social-emotional-behavioral health, maternal depression and other social determinants of health.
- Anticipatory guidance and parent education, as required in EPSDT and Bright Futures.
- Family engagement, focused on two-generation approaches to ensuring child health
- Other primary care practice augmentations (e.g., Reach Out and Read).

Care Coordination / Case Management

- Individualized, with intensity commensurate with need.
- Routine care coordination for all as part of medical home.
- Intensive care coordination/case management for those with higher needs identified.
- Structured, family-focused approach to assess and respond to medical and non-medical health-related needs.
- Linkages to community resources, with active identification and engagement of those resources.

Other Services

- Child/family support programs, including those designed to be collocated in primary care (e.g., Healthy Steps, Project DULCE).
- Integrated behavioral health in primary care setting.
- Referrals to and integration with other services such as home visiting, family support, early intervention, early childhood mental health, and other programs.

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Incorporating Prevention (and Culture of Health) into Responding to NOFO: Root Cause Analysis and Risk Stratification

- Root Cause Analysis and Risk Stratification are central to federal InCK Model Application and service delivery changes
- Both have explicit directions and require narratives and data analysis in applications
- Both weigh heavily into scoring for application (root cause 15 points, risk stratification in 25 point section, of total 110 points)
- Root Cause Analysis and Risk Stratification are the places where applications can describe preventive approaches

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Root Cause Analysis – NOFO Description

- Applicants must identify health conditions that are the root causes of 1) out-of-home placements (institutional or residential setting of care, foster care, and juvenile detention) and 2) prolonged or multiple inpatient admissions.
- Applicants must discuss the prevalence of substance use disorders and other behavioral and mental health conditions in addition to other health conditions they identify as root causes.
- Applicants should use the root cause analysis to develop risk stratification (and response) strategies

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Root Cause Analysis – States must provide:

- Detailed information on the size and characteristics of the pediatric Medicaid population living in the model service area.
- Details on rates of out-of-home placement, inpatient admissions, and emergency department visits and any subpopulations with special health needs and estimates of the portion who are at-risk for these.
- Prevalence of conditions, including behavioral and mental health conditions, associated with the out-of-home placement or multiple inpatient admissions.
- Narrative with data explaining how health conditions identified in the analysis impact rates of out-of-home placement/inpatient admission.
- Identified gaps in service integration for the overall population, and for the subpopulations with the highest rates of out-of-home placement/inpatient admission.

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CMS Schematic Around (Root) Causes/Challenges

EXISTING CHALLENGES

Risk factors for behavioral health challenges start early in life

Child health services exist in silos; late diagnoses are often treated in higher cost settings

Limited infrastructure investments to coordinate across sectors and develop pediatric APMs

MODEL INTERVENTIONS

Early identification and treatment of health needs and risk factors by assessing children's needs

Integrated care coordination and case management of physical, behavioral, and other health services

Funding and support for development of state-specific APMs and infrastructure

MODEL GOALS

Improving performance on priority measures of child health, like mental illness and substance use

Reduce avoidable out-of-home placement and inpatient stays

Align payment to quality and outcomes to drive child health transformation



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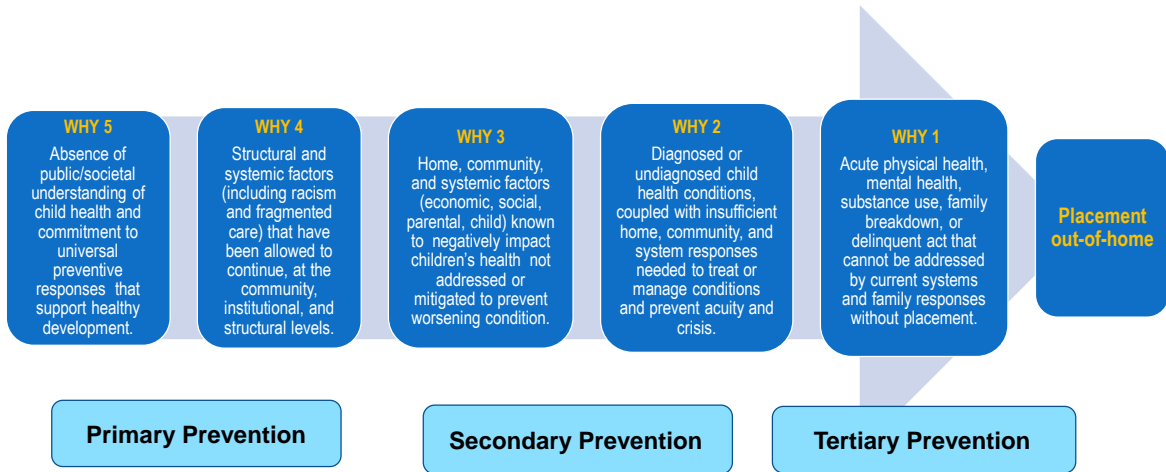
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Root Cause Analysis – Getting to Prevention

- **Cause for children currently in or at imminent risk of placement:**
 - Lack of options for keeping child safe and receiving care without placement
 - Absence of crisis response team and capacity for triage and stabilization without placement
 - Complexity of needs and fragmentation and lack of coordination among existing services
- **Cause for children with conditions getting to the point of being at imminent risk**
 - Child conditions (physical, social, emotional, developmental) not identified or responded to, resulting in worsening severity of behaviors or conditions or episodes placing child at imminent risk (e.g., parent substance use, depression, neglect)
- **Cause for children developing conditions in the first place**
 - Childhood trauma and adversity and/or other social determinants of health such as family stress, economic insecurity, and family instability and lack of nurturing
- **Cause for families being in compromised positions that can lead to trauma/stress**
 - Discrimination, unsafe neighborhoods, and parental segregation and marginalization leading to more barriers to providing a safe, stable, nurturing home environment

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Five Why's Approach to a Root Cause Analysis



Risk Stratification – NOFO Explanation

- Applicants must describe plan for child service integration level (SIL) stratification according to eligibility criteria.
- SILs consist of increasing intensity of integrated care coordination and case management:
 - **Level 1:** Includes the entire target population. Focuses on basic, preventive care and active surveillance for developing needs and functional impairments.
 - **Level 2:** Includes children with needs involving more than one service type and who exhibit a functional symptom or impairment. Focuses on comprehensive needs assessments and integrated care coordination.
 - **Level 3:** Includes children who meet Level 2 criteria who are currently, or are at imminent risk of being, placed outside the home. Focuses on child-centered care planning, integrated case management, and home and community-based services.
- Applicants must discuss how their **stratification plan connects to their root cause analysis** findings and potential for health outcomes and cost savings.

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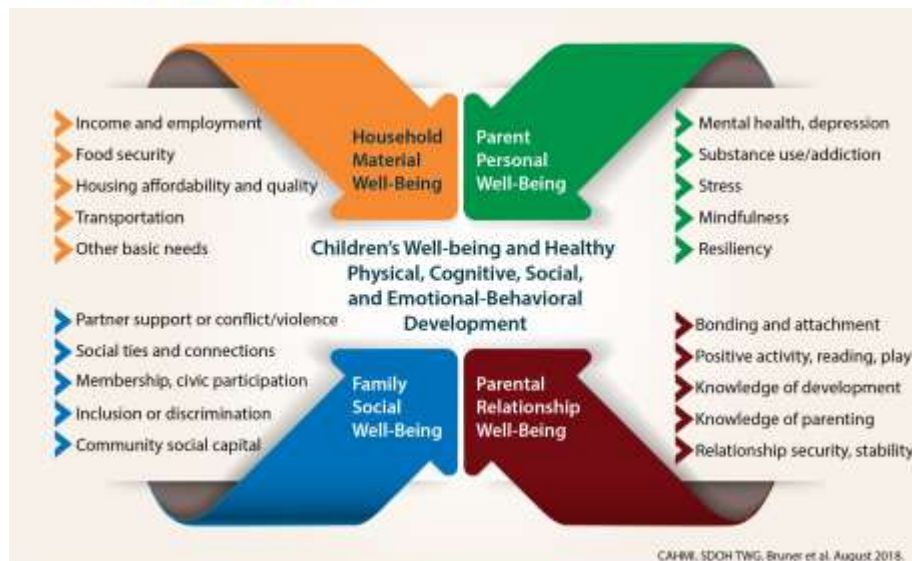
InCK Marks Risk Stratification from a Prevention Perspective

- Builds from a root cause analysis that looks for ROOT causes of out-home-placements and poor health trajectories
- Adopts the broad definition of health in NOFO
- Creates a risk stratification system that involves both identifying child-specific conditions and risks related to environment
- Strengthens primary/well-child care for children based upon risk stratification and *Bright Futures* and the EPSDT benefit
- Establishes payments for providers who provide such high value primary and preventive care (FFS or APM) to enable them to do so

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Ecology – Determinants of Child Health



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Risk Stratification: *Health Complexity* = Medical Complexity + Social Complexity

- Medical conditions (biological, physical, neurological)

Medical Complexity



- Social conditions (basic needs, environment, stress, SDOH)

Social Complexity



- Integrated and relational health responses needed

Health Complexity



Source: Reuland. Health Complexity in Children: A Statewide Summary Report. Oregon Pediatric Improvement Partnership. November, 2018.

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Risk Stratification – Oregon Data on Health Complexity in Child Medicaid Population

Analysis of 12 factors	Medical Complexity – Non-Chronic Healthy	Medical Complexity – Non-Complex Chronic	Medical Complexity – Complex Chronic
Social Complexity: No factors	16.6%	1.7%	0.7%
Social Complexity: 1-2 factors	32.6%	7.2%	2.4%
Social Complexity: ≥3 factors	26.5%	9.5%	3.0%

RED most likely in preventable placement/imminent risk; **PURPLE** most likely experiencing multiple stresses and early intervention; **GREEN** most likely benefiting from enhanced prevention.

Source: Reuland. Health Complexity in Children: A Statewide Summary Report. Oregon Pediatric Improvement Partnership. November, 2018.

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MACPAC 2011 Data Behavioral Needs/Costs

Medicaid Population	Number Children (millions)	Medicaid Costs (billions)	Annual per child cost	Percent of Medicaid Population	Percent of Medicaid Costs
All Children on Medicaid (including disability)	29.3 M	\$77.1 B	\$ 2,632	100%	100%
Disability (medically complex) & Behavioral Health	0.7 M	\$13.3 B	\$ 19,182	2.4%	17.3%
Disability (medically complex) & No Behavioral Health	0.7 M	\$ 7.9 B	\$ 11,399	2.4%	10.2%
Child Welfare & Behavioral Health	0.3 M	\$ 3.5 B	\$ 11,097	1.1%	4.6%
Other Populations – Behavioral Health	3.1 M	\$13.9 B	\$ 4,482	10.5%	18.0%
All Other Children	24.5M	\$38.5 B	\$ 1,571	83.7%	50.0%

RED most likely in preventable placement/imminent risk; **PURPLE** most likely experiencing multiple stresses/social complexity and early intervention; Subset of **GREEN** most likely benefiting from enhanced prevention.

Source: MACPAC 2015 Report to Congress (2011 Medicaid data).

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Implications of MACPAC Analysis

- Few (6%) children in Medicaid have high medical costs but they represent about 1/3 of costs (avg. \$14,527 per year)
 - Greatest potential for savings through reducing placement/hospitalization costs is among this small percentage of children.
- Medicaid costs are not high among those with behavioral health services but no child welfare or disability involvement
 - About 10% of children, 18% of costs (avg. \$4,482 per year) *Note these are identified kids who had billing for behavioral health services.*
- Many of those at social risk – another **25%** of other children-- likely not to be receiving many services but have conditions that cost in long run
 - Little potential for immediate cost savings, given low Medicaid costs (avg. \$1,561 yr.)

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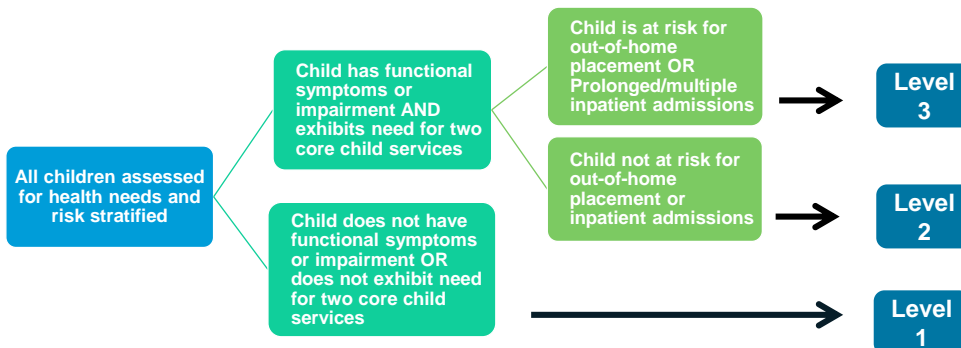
State-Specific Information on Child Population

- States are expected to do analysis of Medicaid data related to risk stratification
 - Both for the state as a whole and for selected local geographic area.
 - Oregon and MACPAC data involved special runs and analyses.
 - Also involves developing cost projections of savings, so includes current expenditures by groups.
- The method for this analysis will determine how useful it will be to really stratifying risk based upon both medical and social characteristics and complexities.

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InCK Service Integration Level (SIL) Stratification



Options for Prevention/Early Intervention: (1) Use risk stratification to further differentiate and respond to children at Level 1 with preventive approaches based upon risk; (2) develop a risk stratification for Level 2 that includes child risk factors/SDOHs that lead to two generation strategies.

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Some Examples on SIL Risk Stratification

- A. 2-year-old developing normally with mother and father both in graduate school and with limited income but strong support system and grandparents who provide additional support
 - *SIL 1 – no special need/risk*
- B. Single mother of 6-month-old working and living in poor neighborhood, struggling to get by under substantial stress and with limited support, infant has no identified medical conditions/ trauma/ ACEs
 - *SIL 1 – social complexity who could benefit from preventive services and supports/risk*
- C. 3-year-old with some developmental delay (not enough for Part C but in CSHCN) and 2 ACEs, living in temporary substandard housing, mother may be depressed but is clearly stressed, struggling to hold it together, and not picking up on her child's cues for attention
 - *SIL 2 – social complexity, developmental delay, CSHCN, maternal mental health/support*
- D. 8-year-old missing school because of asthma, living in house with mold and cockroach infestations, but doesn't have other health conditions
 - *SIL 1 or 2 – medical complexity, may qualify with two core conditions (if housing counts)*
- E. 12-year-old acting out in school, school considering special education but child does not have specific mental health diagnosis, mother has mental health issue and provides limited guidance
 - *SIL 1 or 2 – some social/medical complexity, discretion in applicant's risk stratification where this fits*

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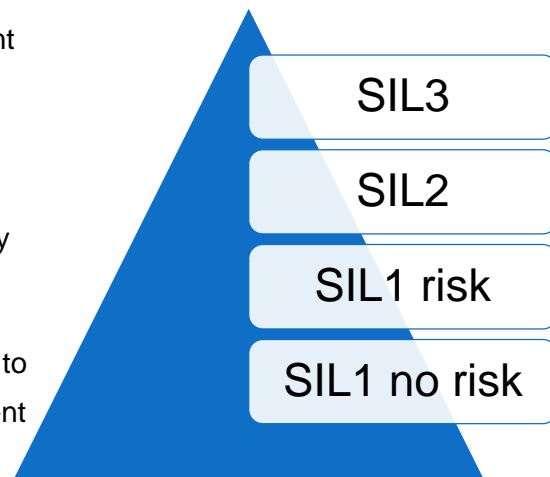
SILs and Improving Health/Reducing Costs

SIL3 (5-6% Medicaid child pop.) – Current high costs with greatest opportunity for immediate cost savings

SIL2 (10-20%) – Some higher cost with opportunity for some savings, others with long-term benefits but currently underserved

SIL1 risk (15-25%) – Greatest opportunity for improving health and long-term ROI, but often requires additional investment

40-50%+ evidenced-based opportunities to improve health (with long-term ROI), 5-15% with opportunities for reducing current costs and maintaining/improving health



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“High Value”/Long-term Impact vs. “Cost Savings”

- Risk stratification for sole purpose of cost savings would narrow size of SIL 2 population and do nothing different for those at risk in SIL1 population.
- Risk stratification for purpose of providing high value care and producing long-term health impacts would expand size of SIL 2 population and use risk stratification to further differentiate SIL1 population and provide additional responses to those with social complexity but no manifested child medical complexity.
- Medicaid and its EPSDT benefit require a broader developmental and preventive approach than is the standard of care today – many opportunities for providing additional responses within Medicaid to improve long-term health.
- Seminal “Triple Aim” article suggests achieving the Triple Aim requires investing more in primary, preventive, and developmental health care.

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Risk Stratification and Real Families

- *In theory, theory and practice are the same. In practice, they are not.* – Yogi Berra

Impact of Risk (Consequences)	Major		Moderate		Minor	
	High	Low	High	Low	High	Low
Severe	Very High	High	High	Medium	Medium	Low
Moderate	High	Medium	Medium	Low	Low	Very Low
Minor	Medium	Low	Low	Very Low	Very Low	Very Low

RISK MANAGEMENT STEPS		COMMENTS	
BEFORE THE MEDICAL INTERVENTION	1. Identify the medical condition that requires attention.	2. Assess the child's current health status.	3. Determine the child's social complexity.
DURING THE MEDICAL INTERVENTION	4. Monitor the child's response to the medical intervention.	5. Provide additional support as needed.	6. Document the child's progress.
AFTER THE MEDICAL INTERVENTION	7. Evaluate the child's long-term health status.	8. Adjust the child's care plan as needed.	9. Provide ongoing support and monitoring.



Real families; More complicated, source of opportunity well beyond what risk stratification can measure. Hold key and knowledge needed for effective response.

Risk Stratification: Seemingly objective, especially if “validated.” Has a role, but only a role.

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From Risk Stratification to Identifying Child and Family Needs – A real world example

- **Surveillance** – At well-child visit, mother appears stressed and does not really pick up on six month-olds cues for attention; apple juice in child's bottle, mother has unkempt appearance
- **Screening** – No ACEs in child or identified developmental/physical delays; social screen indicates family moved and in temporary housing in poorest neighborhood in community, some food insecurity; self-reported stress and social isolation
- **Practitioner activity** – In Reach Out and Read session, mother reveals she did not know her baby liked listening to and looking at books; mother indicates infant has trouble breathing at times (first following first cold/virus), and is extremely fussy; practitioner orders tests related to asthma/allergies and blood lead level and recommends inter-periodic EPSDT visit in 2 weeks; brings in/refers to care coordination
- **Care coordination** – Follow-up with social worker/family advocate/community health worker/HMG call center; mother indicates she has moved to new community to get out of unsafe home/neighborhood situation and is staying with friend, working at a job where she is in trouble because she has missed work due to her baby's illnesses, and doesn't know where to go for help (is receiving SNAP, WIC, Medicaid for herself and child), doesn't have crib at home

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From Identified Needs to Response (T)

- **Care Coordination:** Care coordinator validates mother in her role (doing so much for her baby in stressful times) and helps, through Medical Legal Partnerships, to get her onto subsidized housing list, links her to church Stork's Nest program for crib and supplies and into family development program at local Community Action Agency (meetings and support group for new parents), including additional visit with WIC to develop food and nutrition plan
- **Services:** Practitioner identifies breathing/asthma as concern, prescribes home visit from nurse to identify and address contaminants in home, provides training on early response to episodes (as well as medication for the child); and mother enrolls in CenteringParenting/HealthySteps/DULCE/TripleP/home visiting/babieswithasthma support group for responding to infant's special/general needs

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Measurable Results from Activities – 18 month visit

- **Family:** Family in own apartment, clean and without environmental hazards; home has books and toys; mother and child in weekly family/library program; mother found employment that is more family-friendly and has friends from work, church, and library program who can provide help (including child care) for unexpected needs
- **Child:** No identified developmental delays, at normal weight, fewer episodes related to breathing/asthma, shows secure attachment with mother and grabs at new Reach Out and Read book and picks out pictures as mother reads and asks her questions.
- **Metrics:** Measure what you treasure – developing ways to capture such changes in a value-based care system (another webinar!)

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Implications for Prevention from Examples

- More integrated and **relational health services**, through “high value/high performing medical homes,” can improve child health through offering “high value” care
- Evidenced-based interventions exist and can address “root causes” for child health (at all levels of prevention/root cause/risk stratification)
- “Risk stratification” involves identifying both medical and social complexity
- Importance of care coordination and health-related services, including the core services in the InCK Model, extends beyond multi-system involved children
- Evidenced-based and best practices are often not part of current, standard practice nor reimbursed under Medicaid for their value -- in fee-for-service (FFS), managed care, or alternative payment models (APMs)

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What Child Health Advocates Can Do to Advance Prevention and a Culture of Health

- Contact state Medicaid agency and encourage state to give attention to prevention at both the service delivery and the planning/design level in reviewing InCK.
- Offer to participate in InCK model review and planning and identify other allies and experts who can contribute to planning process (and strategize on roles for them to play).
- Provide information on the current status of prevention in Medicaid for all children and for children with special needs, as well as opportunities for promoting healthy development over the life course through more preventive services

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What Child Health Advocates Can Do to Advance Prevention and a Culture of Health (cont.)

- Focus on “what works” and provide state examples and enlist practitioner innovators and champions who are improving children’s health through more preventive service responses, starting with primary care.
- Emphasize that opportunities exist whether or not the state applies for or receives InCK designation – all states can and should do something within Medicaid to integrate services and build a culture of health from both a prevention and treatment perspective.

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Talking Points for Child Health Prevention Advocates and InCK Marks

- **Medicaid is part of the solution.**
 - Medicaid plays a key role in improving healthy development – physical, cognitive, social, developmental, and emotional/behavioral.
- **We know enough to act.**
 - More preventive and relational health responses provide high value/high performing primary care and medical homes consistent with *Bright Futures* and broad definition of health
 - Evidence-based practice augmentations (Healthy Steps, Help Me Grow, Project DULCE, Medical Legal Partnerships, etc.) share common attributes and show the way to success.
- **We must build upon what we know.**
 - Practitioner innovators, prevention advocates, and other child health experts are essential to guiding Medicaid reforms toward value-based care.

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Webinars:

- InCK Model Overview (*March 5 on website*)
- InCK Model and the Medicaid EPSDT Benefit (*March 19 on website*)
- InCK Model and Family Engagement (*April 2 on website*)
- InCK Model, Prevention, and Building a Culture of Health (today)
- InCK Model and Health Equity (Coming)
- InCK Model and the First 1000 Days (Coming)

InCK Marks Resource Briefs:

- Guiding Framework (with appendices by ages of development)
- The InCK Model, Adolescents, and Behavioral Health (with Mental Health America (forthcoming))
- The InCK Model, Medicaid and Child Welfare Coordination (with Center for the Study of Social Policy (forthcoming))
- The InCK Model and Risk/Strength Stratification (with Child and Adolescent Health Measurement Initiative (forthcoming))

• Key Issues Sections on www.inckmarks.org

- Medicaid and EPSDT
- Value-Based Care, Risk Stratification, and Preventive Health
- Exemplary Early Childhood Primary Care Practices
- Opioids and Child Health

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Word Cloud from CMMI InCK Fact Sheet

Next Steps: Champions

- Complete Survey on Webinar
- Sign Up for and Participate in Future Webinars
- Visit www.inckmarks.org
- Share State Experiences
- Provide Ideas for InCK Marks Activities



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Extra Slides: About the NOFO

- The Notice of Funding Opportunity (NOFO) provides the guidelines for applications for the InCK Model.
- The application guidelines are quite extensive, complex, and ambitious, but everyone is in the same boat in responding to them.
- The page requirements for the application will mean that applicants cannot go into detail on any aspect of the application (see next slide).
- The scoring places an emphasis upon the root cause analysis and risk stratification in describing what the practice transformation approach will be (see final slide).

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What MAY Applicants Do Who Want to Stress Prevention and Early Response?

- Review the Application Requirements (Notice of Funding Opportunity or NOFO) for Opportunities to Incorporate Prevention into Applications
- **NOFO EXPLANATION TO APPLICANTS:** Provides application guidelines for applicants to describe their plans to develop a local integrated care delivery plan across health and non-health core services and an alternative payment model (APM) at the state level for ALL Medicaid children in local area birth to 21 (and CHIP children and pregnant women over 21, at state discretion). (102 pages single-spaced)
- **NOFO REQUIREMENTS OF APPLICATION:** Must describe the approach, including local organization structure, care plan, risk stratification and root cause analysis, alternative payment model development, comparison local area for evaluation of impact, and cost savings and outcomes projections (maximum 55 page, double-spaced narrative).

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Elements and Scoring of the Application

- A Model Implementation Plan consisting of: (1) (20 points) state and community engagement, organizational capacity and Partnership Council descriptions, (2) (25 points) service integration plan including **a care map, a risk stratification plan**, and an information sharing infrastructure and, (3) (15 points) a Medicaid and CHIP authorities and payment model proposal;
- A Model Impact Analysis – consisting of: (1) (15 points) **a root cause analysis for out-of-home placements and hospitalizations**, and (2) (15) points health outcomes and cost saving projections; and
- A Budget Narrative and Program Duplication Questionnaire (20 points).
- Total of 110 points.

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