Integrated Care for Kids (InCK) Model Evaluation: Report 1

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Abt
ASSOCIATES

About this Report

Integrated Care for Kids (InCK) Model Evaluation: Report 1

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List of Acronyms and Abbreviations

AHHN	All Hands Health Network	InCK Model	Integrated Care for Kids Model
APM	Alternative Payment Model	IHH	Integrated Health Homes
AR	Award recipient	NCH	Nationwide Children's Hospital
BE-InCK NY	Bronx Equity InCK New York	NOFO	Notice of funding opportunity
CMS	Centers for Medicare & Medicaid Services	OhioRISE	Ohio Resilience through Integrated Systems and Excellence
CHIP	Children's Health Insurance Program	OHA	Oregon Health Authority
CCO	Coordinated care organization	OOHP	Out-of-home placements
CCS	Core Child Services	OPIP	Oregon Pediatric Improvement Project
CGFS	Comparison Group Feasibility Study	PHE	Public health emergency
DUA	Data use agreement	RQ	Research question
EHD	Egyptian Health Department	SIC	Service integration consultant
HOP	Healthy Opportunities Pilot	SIL	Service integration level
HPSA	Health professional shortage area	SMA	State Medicaid agency
		T-MSIS	Transformed Medicaid Statistical Information System

Key Terms

Term	Definition
Alternative Payment Model (APM)	A payment approach that gives added incentive payments to provide high-quality and cost-efficient care, usually targeted to a specific clinical condition, care episode, or population. InCK Model APMs are designed to incentivize and facilitate quality improvements in care, reductions in Medicaid expenditures, and reductions in avoidable out-of-home placements among children.
Award recipient	An organization awarded a cooperative agreement from CMS to participate in the InCK Model: either a Lead Organization or state Medicaid agency.
Core Child Services	Non-health services included in the InCK Model, including early childhood care, education, food, housing, Title V, child welfare, and mobile crisis response; also referred to as social services or services that impact social drivers of health.
Health equity	The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.
Implementation period	Model Years 3-7 of the InCK Model (2022-2025), in which award recipients implemented the InCK Model.
Lead Organization	An organization designated to administer their local InCK Model in partnership with their state Medicaid agency.
Local model	The model approach designed and implemented by an InCK Model award recipient in accordance with general CMS model requirements and tailored to their local community's needs and capabilities.
Out-of-home placement	For the purposes of the InCK Model: placement in a psychiatric hospital, residential care center, skilled nursing facility, correctional facility, foster care (including groups homes and therapeutic foster care), or juvenile detention.
Partnership Council	A group comprised of representatives from local Core Child Services organizations, Medicaid payers, physical and behavioral health providers, beneficiaries, caregivers, and families, created by the Lead Organization for the purposes of collecting stakeholder input and devising strategies to achieve local coordination across services.
Pre-implementation period	Model Years 1 and 2 of the InCK Model (2020-2021), in which award recipients engaged in activities in preparation for the InCK Model implementation period (Model Years 3-7, 2022–2027).

Term	Definition
Service integration coordinator	An individual who serves as, or facilitates, the main point of contact for a beneficiary's integrated care coordination and/or case management of all health and Core Child Services.
Service integration level	The level of InCK Model services a beneficiary is eligible to receive based on results from their local model's needs assessment and screening processes, with more intense integrated care coordination and case management available for beneficiaries in SILs 2 and 3.
Two-generation approach	A care delivery approach that combines interventions for children and their caregivers or other family members, recognizing that the health and well-being of children and their caregivers are inextricably linked.

Abstract

This first evaluation report for the Integrated Care for Kids (InCK) Model describes findings from the pre-implementation period (2020-2021). The InCK Model, funded by the Centers for Medicare & Medicaid Services' Center for Medicare & Medicaid Innovation, aims to improve outcomes for Medicaid-enrolled children, with a particular focus on those with complex physical and behavioral health needs who require a broad range of health and health-related services. Limited coordination within and across sectors in the U.S. makes service navigation daunting, creating challenges for families and children. Physical and behavioral health provider shortages and persistent disparities in access, screening, and use of services exacerbate challenges, particularly among children from disadvantaged communities. Other environmental factors, such as rurality and transportation infrastructure, inhibit children's access to key services for improving health.

As Medicaid is the primary payer of health care for children in the U.S., CMS developed the InCK Model to address challenges faced by state Medicaid agencies, providers, and the families they serve. Specifically, CMS awarded InCK Model funding to implement locally designed child-and-family-centered delivery models and pediatric Alternative Payment Models. Delivery models intend to expand care coordination beyond health care to include Core Child Services (such as schools, housing, and food services) and address unmet service needs. Other goals include incentivizing and facilitating quality improvements in care, reducing Medicaid expenditures, and reducing avoidable out-of-home placements among children.

At the start of the pre-implementation period, eight Lead Organizations received funding to implement the InCK Model. By the end of the pre-implementation period, seven organizations progressed to the five year implementation period: Ann & Robert H. Lurie Children's Hospital (Chicago, Illinois); Montefiore Medical Center (Bronx, New York); Clifford W. Beers Guidance Clinic (New Haven, Connecticut); Duke University, in partnership with University of North Carolina (select counties in North Carolina); Hackensack Meridian Health, in partnership with Visiting Nurse Association of Central New Jersey and the New Jersey Health Care Quality Institute (Central New Jersey); Nationwide Children's Hospital (Eastern Ohio); and Egyptian Health Department (Southern Illinois).

During the pre-implementation period, the evaluation team characterized model pre-implementation activities and provider, staff, patient, and caregiver experiences; captured information about local context; provided tailored support on model requirements; created measure specification and data templates for data collection; and determined a comparison group for each award recipient.

All award recipients cited the need to improve systems of care for children and caregivers as the primary reason for applying to the model, and each created individualized approaches based on needs in their communities and their local context. During the pre-implementation period, award recipients created or enhanced community partnerships, developed needs assessment and screening procedures to identify unmet needs, centralized care coordination efforts and communications, developed data sharing agreements and platforms to better integrate care, and drafted Alternative Payment Model plans. Despite differences in geographic regions and community characteristics, award recipients achieved common successes in building their programs and faced shared challenges. Seven cross-cutting findings emerged from the evaluation team's pre-implementation period activities.

Cross-Cutting Findings

1. While all ARs responded to the same NOFO, each AR designed individualized approaches based on their InCK Model region's and community's needs.

2. Across ARs, families faced common challenges accessing and engaging in needed services. Barriers include inadequate provider and care availability, reliable transportation to providers and other services, and behavioral health stigma. ARs aim to overcome challenges through coordinating care, educating providers and communities, integrating data, and improving service delivery.

3. Over the course of the pre-implementation period, ARs refined plans for model activities. Changes usually happened in response to clarification provided by CMS, increased understanding of model requirements, and greater awareness of the complexity involved in system transformation.

4. ARs successfully established and engaged Partnership Councils in model design, planning, and pre-implementation period activities.

5. The COVID PHE exacerbated the demands on health care and CCS systems, which limited the attention available to contribute to the InCK Model planning activities.

6. ARs navigated complex legal and regulatory environments as they worked to establish data sharing processes and agreements with CCS organizations.

7. Most ARs developed new data platforms to share information to support service integration.

Chapter 1.

Integrated Care for Kids Model and Evaluation Overview

1. Integrated Care for Kids Model and Evaluation Overview

Chapter 1 provides an overview of the Integrated Care for Kids (InCK) Model, describes the InCK Model award recipients, and discusses the role of the evaluation to document the implementation approaches and impact of the InCK Model on Medicaid-eligible beneficiaries in seven communities.

1.1 BACKGROUND

Among children with complex behavioral and physical health needs in the United States, Medicaid is the primary insurer. Children with behavioral and physical health needs rely on a complex network of medical and supportive service providers. Providers manage chronic conditions, address key social drivers of health, and identify and respond to risk factors (e.g., parental/caregiver substance use, child neglect). However, limited formal coordination for service delivery exists and often families and caregivers must manage and coordinate these services for their child. The burden and responsibility of coordination on families and caregivers creates risks related to the appropriateness and timeliness of service identification and receipt.

Further, workforce shortages limit the availability of providers to serve children and adolescents. Physical and behavioral health provider supply varies significantly within and across states. Recent estimates suggest that about 30 percent of the U.S. population lives in a county that the Health Resources and Services Administration designates as a health professional shortage area (HPSA) for mental health providers. Shortages of child and adolescent psychiatrists, in particular, are a major challenge to providing appropriate pediatric behavioral health services.[1-2] Moreover, 96 percent of U.S. counties are either wholly or partially considered primary care HPSAs.[3]

Contextual factors such as rurality; transportation infrastructure; air, housing, and water quality; and exposure to community violence shape health outcomes. Each of these factors impacts health service access and the health of local populations.[4-7]

Disparities in access to services, screening for service and treatment needs, and use of services by under-resourced populations are well-documented. Research suggests that racial and ethnic minority children with select conditions (e.g., autism spectrum disorder, attention deficit disorder/attention deficit hyperactivity disorder) remain under-diagnosed despite universally accepted screening guidelines.[8-9] Prior research on child maltreatment and referral to the child welfare system has found consistent disproportionate representation of children from racial/ethnic minority backgrounds despite similar rates of substantiated abuse and neglect across all race/ethnicity groups.[10] This differential representation of black, indigenous and people of color (BIPOC) children and youth in the child welfare system is reflective of the intersectionality of race and poverty, requiring a

systems-level approach to address the root causes of poverty to support families to achieve their optimal level of health and well-being.

For decades, state Medicaid agencies have leveraged flexibilities offered by Medicaid waivers—1915(c) Home and Community Based Services waivers[11] and 1115 Demonstration Waivers[12-13]—to implement delivery system reforms and/or expand service coverage to children and families covered by Medicaid. Medicaid innovation models provide opportunities to transform the system that provides services to more than half of children with complex needs in the United States.

1.2 INTEGRATED CARE FOR KIDS (InCK) MODEL OVERVIEW

Model Goals and Intended Outcomes

The Centers for Medicare & Medicaid Services (CMS) developed the InCK Model in response to the challenges of coordinating and providing comprehensive holistic care to children and their caregivers.[14-19]

The InCK Model addresses infrastructure changes, incentivizes care delivery transformation, and encourages coordination across systems of care from Medicaid beneficiaries'[19] birth until they reach age 21. Some local InCK Model programs also include Children's Health Insurance Program (CHIP) beneficiaries and pregnant people age 21 and over who are covered by Medicaid.

The InCK Model intends to improve quality of care and reduce healthcare costs through prevention, early identification, and treatment of behavioral and physical health needs. InCK Model award recipients (ARs) developed and will implement locally designed child and family-centered delivery models focused on the areas defined in the notice of funding opportunity (NOFO) and shown in **Exhibit 1.1**. Each AR must also operationalize a pediatric Alternative Payment Model[20] (APM) to incentivize and facilitate quality improvements in care, reductions in Medicaid expenditures, and reductions in avoidable out-of-home placements[21] (OOHPs) among children. Other services include the following Core Child Services (CCS) domains: early childhood care, education, food, housing, Title V, child welfare, and mobile crisis response. ARs have the flexibility to augment the core domains to address the local context and needs of their InCK Model population.

Exhibit 1.1.   The InCK Model's Population-wide Approach, Providing Targeted Services as Required by the Child and Family

Inherent in the InCK Model design are components necessary to

- Enhance community partnerships to expand healthcare and CCS networks;

- Incentivize screening, care coordination, and quality of care through APMs specific to populations and providers;

- Conduct universal needs assessments and screenings to identify unmet physical health, behavioral health, and CCS needs;

- Stratify children by their needs, referring to and providing tailored, family-centered health and CCS services;

- Centralize care coordination and communication for individuals and their caregivers;

- Develop mechanisms to share and integrate health and CCS data across providers, organizations, and systems; and

- Improve outcomes related to health care utilization and costs, behavioral health, OOHP,[22] and child healthcare quality.

The InCK Model design includes two stages: a pre-implementation period (2020–2021; Model Years 1 and 2) and an implementation period (2022–2027; Model Years 3-7). CMS awarded up to $16 million in funding for the duration of the model to each of the eight ARs via cooperative agreement.

In their applications, ARs demonstrated partnership with their state Medicaid Agencies—if the AR is not a Medicaid agency—and formed Partnership Councils comprised of representatives of local CCS organizations. Throughout the model's pre-implementation period, these partners provided critical input, connections, understanding of available data, and planning for service delivery.

During the pre-implementation period, ARs refined their approaches to implementing the model requirements, built or changed local infrastructure to support InCK Model activities, hired and trained staff, identified and solidified partnerships and conducted other activities necessary to enroll beneficiaries in the InCK Model beginning in January 2022.[23] ARs invested significant effort in pursuing data use agreements and in developing stratification and screening approaches to identify an individual beneficiary's service integration level (SIL).[24] During the pre-implementation period, ARs also engaged in group learning through CMS-sponsored and informal activities and collaborative conversations.

This report discusses the evaluation team's activities, results, and findings of the pre-implementation period. Throughout the report, the evaluation team provides illustrative quotations and examples captured through evaluation activities. The illustrations are not exhaustive of all data or experiences.

- This chapter provides an overview of the InCK Model, each AR, the role of equity in shaping model design, and the evaluation team's activities during the pre-implementation period.

- **Chapter 2** discusses each AR's planned approach to implement core model elements and activities built during the pre-implementation period.

- **Chapters 3-5** highlight seven cross-cutting findings representing key themes uncovered through the pre-implementation period evaluation activities. **Chapter 3** describes findings related to ARs' local contexts, **Chapter 4** covers ARs' processes and activities in the pre-implementation period, and **Chapter 5** discusses data challenges.

- **Chapter 6** describes evaluation considerations and plans for the implementation period.

- **Chapter 7** presents individual snapshots sharing details of each AR's model, the community context, the planned approach to and progress with implementing the model, and outstanding questions to discuss during the implementation period.

- Four appendices offer supporting information on pre-implementation period evaluation activities (**Appendix A**), comparison group methodology (**Appendix B**), case study methods (**Appendix C**), and sample case study protocols (**Appendix D**).

1.3   INCK MODEL AWARD RECIPIENTS

CMS awarded InCK Model cooperative agreements to eight organizations. One AR, Oregon (OR) InCK, ceased participation at the end of the pre-implementation period. All eight ARs cited the need to improve systems of care for children and families as their primary reason for applying to the InCK Model. Other reasons included leveraging existing work in the state or by care delivery organizations; building or enhancing partnerships with CCS providers and organizations; and integrating primary, specialty, and behavioral health care.

Exhibits 1.2-1.4 provide key characteristics of the ARs; additional information is provided in **Chapter 7**.

1. **Exhibit 1.2** identifies the local InCK Model name, Lead Organization, location, and the designated InCK Model and comparison regions.

2. **Exhibit 1.3** presents characteristics on ARs' InCK Model regions. ARs intend to serve between 11,000 and 146,000 beneficiaries. Each AR's population represents the unique community within which the AR determined to focus its services. Six AR model regions had a considerable portion of non-White populations. Half included rural ZIP Codes or counties, while half did not. Social needs related to housing, food, and other areas were substantial in all ARs.

3. **Exhibit 1.4** provides brief descriptions of each AR's goals, targets, and stratification approaches. **Chapter 2** shares additional detail.

Exhibit 1.2.   ARs Funded by CMS to Implement the InCK Model

Local InCK Model Name	Lead Organization, Type of Organization	Location	InCK Model Region	Comparison Region
All Hands Health Network (AHHN)	Ann & Robert H. Lurie Children's Hospital (Lurie), hospital or health care network	Chicago, Illinois	2 ZIP Codes in the neighborhoods of Belmont-Cragin and Austin in Chicago's Cook County, Illinois: 60639 and 60651	6 ZIP Codes in select neighborhoods in Chicago's Cook County, Illinois: 60617, 60623, 60629, 60632, 60165, and 60426
Bronx Equity InCK New York (BE-InCK NY)	Montefiore Medical Center, hospital or health care network	Bronx, New York	3 ZIP Codes in North-Central Bronx, New York: 10461, 10467, and 10469	8 ZIP Codes in Brooklyn, New York: 11207, 11208, 11212, 11221, 11223, 11230, 11232, and 11234
Connecticut (CT) InCK Embrace New Haven	Clifford W. Beers Guidance Clinic, mental health community organization	New Haven, Connecticut	6 ZIP Codes in New Haven, Connecticut: 06510, 06511, 06512, 06513, 06515, and 06519	5 ZIP Codes in Bridgeport, Connecticut: 06604, 06605, 06606, 06608, and 06610

Local InCK Model Name	Lead Organization, Type of Organization	Location	InCK Model Region	Comparison Region
North Carolina (NC) InCK	Duke University, in partnership with University of North Carolina (UNC), university	Select counties in North Carolina	5 counties in North Carolina: three urban (Alamance, Orange, and Durham) and two rural (Granville and Vance)	11 counties in North Carolina: Camden, Catawba, Cumberland, Currituck, Forsyth, Lenoir, Richmond, Scotland, Wake, Washington, and Wilson
New Jersey (NJ) InCK	Hackensack Meridian Health (HMH), in partnership with Visiting Nurse Association of Central New Jersey and the New Jersey Health Care Quality Institute, hospital or health care network	Central New Jersey	2 adjacent coastal counties in central New Jersey: Monmouth and Ocean counties	2 counties in central New Jersey: Middlesex and Burlington counties
Ohio (OH) InCK	Nationwide Children's Hospital (NCH), hospital or health care network (Original Recipient: Ohio Department of Medicaid, state Medicaid Agency)	Eastern Ohio	2 counties in eastern Ohio: Licking and Muskingum counties	6 counties located throughout Ohio: Lake (northeast), Belmont (east), Athens (south), Scioto (south), Pickaway (central), and Putnam (northwest)
Village InCK	Egyptian Health Department (EHD), local health department	Southern Illinois	5 adjacent, rural counties in southern Illinois: Gallatin, Hamilton, Saline, Wayne, and White	12 counties in middle and southern Illinois: De Witt, Edwards, Franklin, Fulton, Greene, McDonough, Montgomery, Pike, Pope, Pulaski, Scott, and Shelby counties
Oregon (OR) InCKa	Oregon Health Authority (OHA), in partnership with Oregon Pediatric Improvement Project (OPIP), state Medicaid agency	West-Central Oregon	5 counties in West-Central Oregon: Jefferson, Deschutes, Crook, Marion, and Polk	11 counties in Oregon: Benton, Clatsop, Columbia, Hood River, Washington, Yamhill, Jackson, Josephine, Malheur, Umatilla and Lincoln

Note:

a. In October 2021, Oregon Health Authority informed CMS of their intent to withdraw from the model.

Exhibit 1.3. Characteristics of the InCK Model Population

Characteristics	AHHN	BE-InCK NY	CT InCK Embrace New Haven	NC InCK	NJ InCK	OH InCK	Village InCK	OR InCK[a]
Number of beneficiaries[b]	42,653	31,576	34,695	104,176	146,536	35,080	11,184	103,204[c]
Estimated number of beneficiaries in SIL 2[d]	4,000-4,800	4,800[e]	4,500-6,000	13,000	4,600	1,000	300-500	N/A
Estimated number of beneficiaries in SIL 3[d]	400-500		900-1,500	4,300	1,200	2,500	200	N/A
Characteristics of all Medicaid Enrollees in the InCK Model Region[f]								
Enrollees who are Black	27.7%	39.1%	58.7%	41.9%	9.7%	9.4%	4.6%	1.1%
Enrollees who are Hispanic	43.5%	33.9%	No data available[h]	26.4%	22.8%	1.8%	1.3%	55.8%
Enrollees who as Asian American/Pacific Islander	0.7%	14.6%	4.1%	1.8%	1.5%	2.7%	0.8%	1.8%
Enrollees who are 18-20 years old	8.6%	8.6%	8.4%	7.7%	7.3%	8.2%	6.7%	8.5%
Characteristics of All Residents in the InCK Model Region[g]								
Median household income[i]	$41,655	$49,975	$45,570	$55,879	$82,218	$56,905	$46,603	$57,902
Residents living in a rural ZIP Code/county[j]	0.0%	0.0%	0.0%	14.5%	0.0%	33.3%	100.0%	7.1%
Residents speaking limited English[i]	14.4%	13.0%	7.9%	3.5%	2.8%	0.4%	0.6%	3.2%
Residents who are food insecure[k]	12.0%	16.0%	12.1%	15.4%	8.5%	13.1%	12.4%	11.6%
Residents with some college or more[i]	37.9%	48.1%	53.1%	66.2%	63.6%	52.7%	54.3%	62.3%
Area deprivation index[l]	4.45	5.67	6.36	4.51	4.98	5.17	8.64	6.13
Residents who own homes[m]	56.9%	19.6%	61.9%	60.0%	76.8%	71.1%	75.7%	62.7%
Residents experiencing severe housing problems[n]	18.9%	31.7%	18.1%	14.8%	18.1%	11.0%	9.1%	15.0%

Notes:

a. In October 2021, Oregon Health Authority informed CMS of their intent to withdraw from the model.

b. Source: Each award recipient (AR) submits a retrospective attribution file (RAF) noting the number of individuals in the InCK Model population. The data in this row comes from the RAFs submitted in January 2022, with data as of December 31, 2021.

c. Source: Oregon InCK submitted its final RAF in August 2021, with data as of December 31, 2020.

d. Source: Each AR provided estimated numbers of individuals who would be assigned SIL 2 and SIL 3 in the original application.

e. BE-InCK NY provided a combined estimate for SILs 2 and 3 and did not differentiate between the two SILs.

f. Source: CMS. (2019). *Interim Transformed Medicaid Statistical Information System (T-MSIS)*.

g. Average across attribution ZIP Codes/counties weighted by the population of each ZIP Code/county.

h. Source: Census Bureau. (2018). *American Community Survey*. https://www.census.gov/programs-surveys/acs through the Agency for Healthcare Research and Quality. (2018). *Social Determinants of Health Database*. https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html. *Interim Transformed Medicaid Statistical Information System (T-MSIS)* is not usable for Connecticut.

i. Source: Census Bureau. (2018). *American Community Survey*. https://www.census.gov/programs-surveys/acs through the Agency for Healthcare Research and Quality. (2018). *Social Determinants of Health Database*. https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html.

j. Source: U.S. Department of Agriculture. (2010). *Rural-Urban Community Area Codes*. https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx through the Agency for Healthcare Research and Quality. (2018). *Social Determinants of Health Database*. https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html.

k. Source: University of Wisconsin Population Health Institute. (2017). Map the Meal Gap through the 2020 *County Health Rankings & Roadmaps*. https://www.countyhealthrankings.org/

l. Area deprivation index measures socioeconomic disadvantage at the U.S. Census tract level using income, education, employment, and housing quality measures contained in the 2015 American Community Survey Five Year Estimates; a higher value indicates areas at a greater socioeconomic disadvantage. Sources: Kind, A.J.H., Buckingham, W. (2018). Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. *New England Journal of Medicine*, 2018. 378: 2456-2458. And University of Wisconsin School of Medicine Public Health. (2019). *2018 Area Deprivation Index v3.0.* Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/.

m. Percentage of occupied housing units that are owned by occupant. Source: American Community Survey (5-year estimates, 2014-2018) via the University of Wisconsin Population Health Institute. (2020). *County Health Rankings & Roadmaps.* https://www.countyhealthrankings.org/

n. Percentage of households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Source: Comprehensive Housing Affordability Strategy data, 2012-2016 through University of Wisconsin Population Health Institute. (2020). *County Health Rankings & Roadmaps.* https://www.countyhealthrankings.org/

Exhibit 1.4.   AR Goals and Stratification Approaches

Local InCK Model Name, State	Goals	Focus of Stratification Approach
All Hands Health Network (AHHN), Illinois	• Expand access to quality primary care, specialty care, and behavioral health services for Medicaid-covered youth with complex health needs from birth up to age 21. • Build capacity for integrated case management.	• AHHN InCK will use a hybrid approach for SIL stratification, based on Medicaid claims data, health needs, and risk assessment screenings. • Resource coordinators (AHHN term for InCK Model service integration coordinators) will serve as the single point of contact for beneficiaries and families.
Bronx Equity InCK New York (BE-InCK NY), New York	• Improve maternal and child health outcomes. • Provide support to children with complex behavioral needs and their families, prioritizing individuals under 21 with sickle cell disease. • Improve routine and preventive care by working with Partnership Council organizations to increase screening and care access, efficiency, and effectiveness of care.	• BE-InCK NY will use clinical and claims data to assess beneficiary needs and assign a preliminary stratification. • The service integration coordinators (SICs) will make initial SIL assignments using clinical and claims data and then use the BE-InCK NY Needs Screening Tool (Tool) to fill in gaps in CCS needs. Final SIL assignment will determine the type and level of services that each beneficiary receives.
Connecticut (CT) InCK Embrace New Haven, Connecticut	• Increase access to services and reduce disparities in health outcomes. • Improve community-based systems of care for children. • Integrate behavioral health, physical health, and social services.	• CT InCK Embrace New Haven will use Medicaid claims and data from the Department of Children and Families to develop an initial SIL assignment. Community health organizers (CHOs, the local term for SICs) will then use a screening tool to facilitate a needs conversation with beneficiaries and their caregivers. • CT InCK Embrace New Haven will use a data platform to share information with beneficiaries, caregivers, and providers. Community health organizers will coordinate with existing case managers and other members of the care team to ensure shared action plans are regularly updated.
North Carolina (NC) InCK, North Carolina	• Systematically identify the children and families with the greatest needs to better target interventions. • Strengthen integration and information sharing between medical and CCS providers. • Improve health and social outcomes and reduce out-of-home placement for high-risk children.	• NC InCK will use a hybrid approach, combining in-person screening for social needs, Medicaid claims, and data from education and juvenile justice, to stratify beneficiaries into SILs. • Integration consultants (the NC InCK term for SICs) will partner closely with existing care coordinators to provide families with a single point of contact and make sure they are receiving needed services.

Local InCK Model Name, State	Goals	Focus of Stratification Approach
New Jersey (NJ) InCK, New Jersey	• Promote holistic care through integration of social, behavioral, and medical models of care. • Implement an enhanced screening process and targeted case management. • Facilitate data sharing across healthcare systems. • Provide community-based care management that integrates with the pediatric health care system.	• Individuals will be stratified into SILs using a hybrid approach that produces a medical complexity score based on Medicaid claims data and a social complexity score based on a comprehensive health needs assessment. The scores will generate a preliminary SIL stratification that frontline NJ InCK staff will discuss with family members and primary care providers to determine a final SIL classification. • Care integration managers (CIMs) (the NJ InCK term for service integration coordinators) will triage SIL 2 and SIL 3 beneficiaries who elect to enroll in NJ InCK to advanced case management teams, consisting of a licensed social worker, community health workers, a family peer specialist, and a child life specialist. The advanced case management teams will perform integrated care management services.
Ohio (OH) InCK, Ohio	• Improve outcomes in both traditional healthcare quality measures and non-traditional measures for children in the InCK Model attributed region. • Reduce behavioral health-related inpatient hospitalizations and emergency department use, as well as out-of-home placements. • Eliminate duplicative services across agencies to conserve state resources and minimize confusion for children and their families.	• OH InCK will use historical healthcare utilization and data from the Ohio Department of Medicaid and Ohio Department of Job and Family Services to initially identify beneficiaries potentially eligible for SIL 2 and SIL 3. SICs will follow up with beneficiaries potentially eligible for SIL 2 or SIL 3 and screen them for additional needs to finalize SIL assignments. • OH InCK contracted with managed care plans and community-based mental health organizations to operate as single points of contact.
Village InCK, Illinois	• Increase utilization of preventive physical healthcare services and well-child visits. • Expand and improve mobile crisis response services. • Enhance substance use disorder (SUD) prevention, treatment, and recovery services.	• Village InCK will use a hybrid approach to stratify beneficiaries into SIL 1, 2, or 3. They will combine Medicaid claims and foster care data with screenings related to social drivers of health; adverse childhood experiences (ACEs); and housing, nutrition, and education needs. • SICs will serve as the single point of contact for beneficiaries in SIL 2 and SIL 3. EHD-employed family resource developers and existing wraparound coordinators will support the SICs.

Local InCK Model Name, State	Goals	Focus of Stratification Approach
Oregon (OR) InCK[a], Oregon	• Leverage existing work in the state and "knit together" child-serving programs and partners. • Contribute to the shift toward population-based health management and away from system-specific silos of care.	• OR InCK planned to use historical healthcare utilization (identified from Medicaid claims) to identify beneficiaries with physical and behavioral health needs. To assess social risk, OR InCK planned to use Medicaid claims to flag caregiver substance use disorders, mental health issues, and incarcerations. • System navigators (the OR InCK term for SICs) planned to monitor SIL assignments and support integrated case management across partner organizations.

Note:

a. In October 2021, Oregon Health Authority informed CMS of their intent to withdraw from the model.

1.4 Equity Embedded in the InCK Model Design

Stakeholders increasingly recognize that fragmented and multifaceted interactions between people and communities affect health outcomes, and that social, economic, and environmental conditions contribute to health inequities. One goal of the InCK Model is to break down traditional silos among the healthcare and CCS systems serving children. Through better integration of physical and behavioral health care with CCS, the model holds promise to contribute to improved health equity.

> CMS DEFINES **HEALTH EQUITY** AS THE ATTAINMENT OF THE HIGHEST LEVEL OF HEALTH FOR ALL PEOPLE, WHERE EVERYONE HAS A FAIR AND JUST OPPORTUNITY TO ATTAIN THEIR OPTIMAL HEALTH REGARDLESS OF RACE, ETHNICITY, DISABILITY, SEXUAL ORIENTATION, GENDER IDENTITY, SOCIOECONOMIC STATUS, GEOGRAPHY, PREFERRED LANGUAGE, OR OTHER FACTORS THAT AFFECT ACCESS TO CARE AND HEALTH OUTCOMES.

CMS embedded specific elements in the InCK Model NOFO to ensure that applicants infused equity[25] principles throughout their individualized approaches. Several elements target equity at a foundational programmatic level.

- As a population-level model, applicants must serve the entirety of Medicaid and CHIP-covered children in the selected InCK Model region. Applicants must not design an approach that limits its InCK Model region to a single hospital or healthcare system, or excludes or limits services based on gender, race, or any other identity.

- Applicants must describe their approach to impact health concerns and environmental/contextual factors influencing health for children, including out-of-home-placement, housing stability, and food security.

- Applicants must propose an approach to screen all InCK Model beneficiaries, regardless of language or level of engagement in services, so that providers identify needs early and then refer the beneficiary for necessary services.

- Applicants must meaningfully engage beneficiaries and their caregivers in planning and model design.

- Applicants must create and implement a sustainable APM to ensure provider accountability for costs and quality of care outcomes.

In response to the NOFO, each applicant designed an approach to meet the needs of their InCK Model regions identified through a root-cause analysis and self-assessment. By incorporating health equity throughout all tenets of the model, the InCK Model intends to identify and support children, young adults, and their caregivers in all social drivers related to health (commonly called social determinants of health). Therefore, the InCK Model focuses on populations experiencing the root causes of inequities. For example, health equity requires understanding that inadequate, poor, or substandard quality housing is a fundamental cause of individual poor health (i.e., association between mold and asthma), while living in poor housing is a result or symptom of fundamental structural inequities and racist and discriminatory policies such as redlining, predatory mortgage lending practices, and differential opportunities for affordable quality housing.

ARs aim to advance health equity by partnering with communities and, in some instances, with beneficiaries and their caregivers. The expectation is that equity will improve through increasing the level of involvement, impact, trust, and communication flow with communities, stakeholders, and other organizations.

1.5 INCK MODEL EVALUATION APPROACH AND PRE-IMPLEMENTATION PERIOD ACTIVITIES

CMS contracted with Abt Associates Inc. and its partners, Bailit Health and Insight Policy Research, to evaluate the implementation and impact of the InCK Model for each of the model's ARs and across all ARs. The InCK Model evaluation design incorporates variation among ARs' interventions, which include the context of implementation and historical service gaps; the alignment of the local model with that context; and the individual characteristics of the InCK Model populations.

Two studies framed the pre-implementation period's evaluation design.

- During the pre-implementation period, the evaluation's *Implementation Study* employed qualitative and descriptive quantitative analyses to capture information about ARs' local context and to characterize model implementation and providers', staff's, and patients' and their caregivers' experiences.

- During the pre-implementation period, the *Impact Study* assessed Medicaid and CCS data availability and quality, developed guidance on key data sources, and validated data provided by ARs. Additionally, the evaluation team determined an empirically constructed comparison group for each AR.

The Practical, Robust, Implementation, and Sustainability Model (PRISM)[26-27] provides the framework guiding the overall research design. The evaluation team is applying the PRISM framework for two main reasons.

1. The framework prioritizes the perspective of children, their caregivers, and local providers as central to understanding the implementation and impact of the model.

2. The framework emphasizes that successful implementation of the model depends on local context and alignment of the model to pre-existing initiatives, structures, and policies.

As such, PRISM offers a structure for understanding how local context and variation in implementation across ARs moderate impacts (**Exhibit 1.5**). To align with PRISM, the pre-implementation period's evaluation design emphasized variation among ARs' interventions, the context of implementation, and the size and characteristics of the InCK Model populations.

The evaluation goals in the pre-implementation period drove the research questions (RQs) and activities conducted by the evaluation team. **Exhibit 1.6** highlights the pre-implementation period's RQs and a brief summary of the findings of each RQ, with direction as to where find additional information in this report.

Exhibit 1.5. Our PRISM Framework Harnesses the Voices of ARs, Providers, and Patients and Their Caregivers
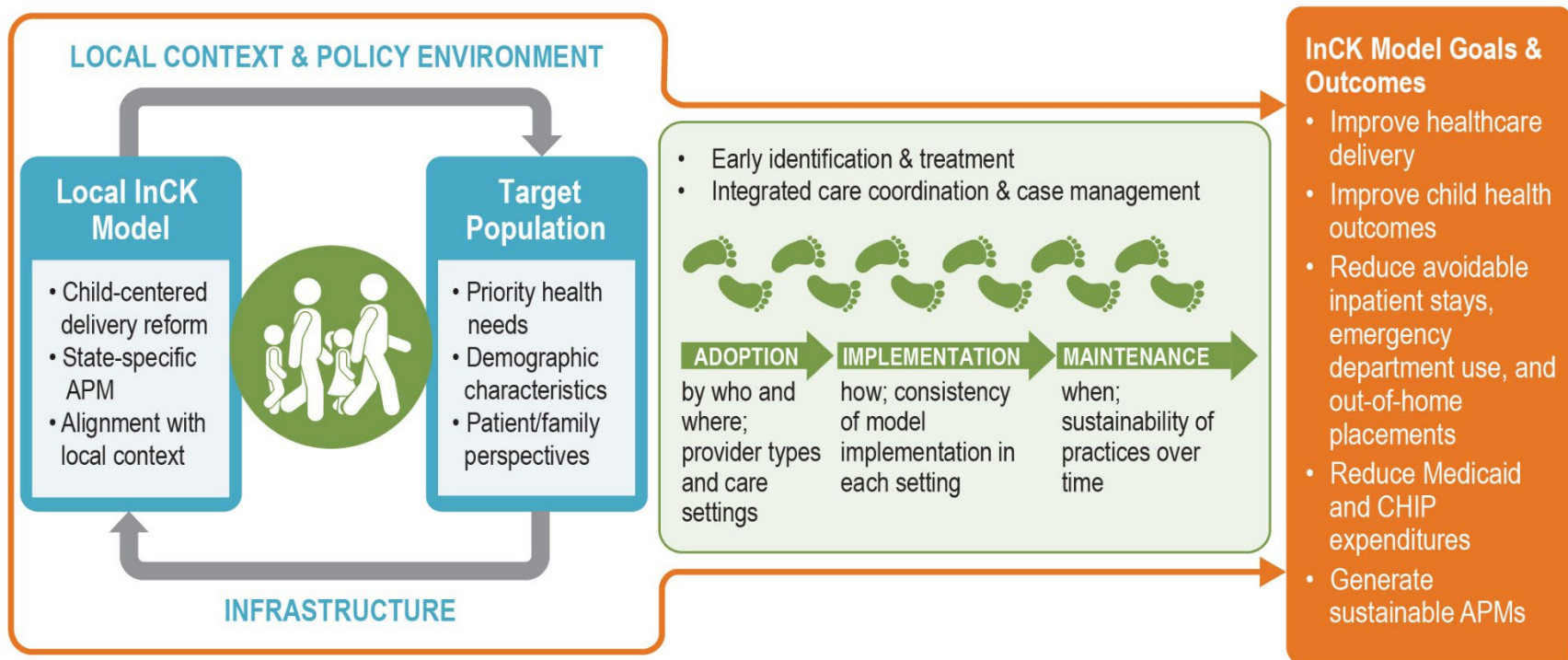
Exhibit 1.6.   Research Questions Studied in the Pre-Implementation Period and Results

Research Question	Brief Description of Findings	Location for More Information
1. What are the characteristics of the InCK Model population?	In response to the NOFO, ARs conducted root cause analyses and assessed community needs to determine their InCK Model regions. Each AR's region and corresponding population represents the unique characteristics of the community.	Chapter 1, Exhibits 1.2 and 1.3 Chapter 3, Cross-Cutting Findings 1 and 2 Chapter 7
2. What are the AR-specific and common challenges the InCK Model is designed to address?	Children with complex needs often have unmet needs. Screenings and comprehensive assessments help identify needs for services from a variety of health and CCS systems. The services are often provided in an uncoordinated manner, with limited information-sharing across providers and with beneficiaries and their families. In the context of a busy clinic serving a diverse patient population, increased reimbursement for the additional time required to screen for services and provide care that is comprehensive and coordinated is a valuable tool to improve the system of services for children with complex health needs. Providers need to be incentivized to screen for services and provide care in a comprehensive, coordinated, and holistic manner.	Chapter 2 Chapters 3-5
3. What are the barriers and facilitators to initiating the InCK Model?	Strong relationships with key partners and Partnership Council members facilitated activities during the pre-implementation period for all ARs. Often these relationships with partners pre-dated the InCK Model. Partnership Council members provided valuable insight into the planned service integration approach and helped initiate conversations about data sharing. Common barriers for ARs included difficulties establishing needed DUAs, designing and implementing universal screening, and determining how to coordinate an InCK Model service integration approach distinct from other concurrent care coordination programs. The COVID-19 public health emergency (PHE) also caused challenges for all ARs, such as hiring delays, limited staff bandwidth, and difficulty engaging key partners.	Chapter 2, Section 2.9 Chapters 3-5
4. How do these barriers and facilitators differ by AR and by local and state-specific context?	Local and state-specific contexts and relationships among partners that pre-dated the InCK Model influenced ARs' success in the pre-implementation period. Many ARs drew on existing data infrastructure to support InCK Model operations, including patient portals and data sharing agreements between providers. ARs with less pre-existing data sharing infrastructure had more work to do during the pre-implementation period to establish these systems. ARs with dedicated support from state leadership and partnership from the state Medicaid agency were better positioned to establish DUAs.	Chapter 2, Section 2.9 Chapters 3-5

Research Question	Brief Description of Findings	Location for More Information
5. How are ARs and partners working together to implement the InCK Model?	All ARs established required Partnership Councils during the pre-implementation period. Organizations on the Partnership Councils included local health departments, stakeholder representatives of families and community members, Medicaid payers including MCOs, and organizations representing all CCS (clinical care, behavioral health, local school districts, housing, food, early childhood, Title V agencies, child welfare, and mobile crisis response). ARs drew on relationships that pre-dated the InCK Model to establish the Partnership Councils and implement key components of the local model. The strength of these relationships varied across ARs. Strong relationships among the Partnership Councils facilitated engagement in planning activities. During the pre-implementation period, most ARs reported highly engaged Partnership Councils despite large and diverse groups, virtual meetings, competing priorities, and challenges related to the COVID-19 PHE.	Chapter 4, Cross-Cutting Finding 4
6. How do AR-designed APMs align with other local payment mechanisms?	ARs created tailored APM designs in the pre-implementation period. Except for CT InCK Embrace New Haven (which is in a fee-for-service state), all ARs will implement APMs in the context of managed care and negotiated with MCOs on APM design and roll-out during the pre-implementation period. Some ARs reported difficulties designing the APMs, which required more time than expected, and some ARs required external expertise.	Chapter 2, Section 2.8
7. What is the experience of the InCK Model beneficiaries and their caregivers accessing the services they need?	Children with complex needs and their caregivers receive services through an organizationally complex and siloed system. An inadequate supply of providers who deliver culturally-informed or child- and family-centered care are formidable barriers to obtain needed services efficiently and effectively. Transportation, childcare, work schedules, and other social needs create additional barriers to care. Lack of information-sharing between providers hinders provider and caregiver awareness of service needs for the child/youth and receipt of the services.	Chapter 2, Section 2.1 Chapter 3, Cross-Cutting Finding 2 Chapter 4, Cross-Cutting Finding 5
8. How are ARs planning to implement core services, e.g., mobile crisis services?	CMS requires ARs to implement a comprehensive array of core services through the InCK Model. Within the flexibility of the NOFO and the model's terms and conditions, each AR created tailored approaches unique to organizational characteristics; the needs of the AR's community; and the gaps encountered by local beneficiaries, caregivers, and providers. ARs refined their planned approaches throughout the pre-implementation period as they learned more about the model's requirements and collaborated with Partnership Councils.	Chapter 2 Chapter 3, Cross-Cutting Finding 1 Chapter 4, Cross-Cutting Finding 3 Chapter 5, Cross-Cutting Findings 6 and 7

Research Question	Brief Description of Findings	Location for More Information
9. What are the staffing structures that ARs are planning to implement?	Several types of organizations lead the local InCK Models: hospital/health care networks, mental health community providers, universities, local health departments, and state Medicaid agencies. While staffing structures and the expertise of staff vary widely, all local InCK Model programs have a primary project director or coordinator who is responsible for model operations. CMS requires ARs to identify a single point of contact for beneficiaries and their caregivers. Some of the ARs' service integration coordinators or local equivalents serve this role. Some ARs found themselves lacking internal expertise on key model elements, such as the APM design or how to establish data sharing agreements. It took time to hire consultants to support the InCK Model design, receive CMS funded technical assistance, or for staff to learn content and methodology skills during the pre-implementation period.	Chapter 1, Section 1.2 Chapter 2, Sections 2.3 and 2.7

The PRISM framework's domains, and how they align with the key InCK Model and research activities, are described in **Exhibit 1.7**.

Exhibit 1.7. The Abt Team's Application of the PRISM Domains to Our Evaluation Approach in the Pre-Implementation Period

Study	PRISM Domain	Research Question(s)	Description	Activities Used to Study the Domain
Implementation Study	Local InCK Model Design	RQs 1, 2, 5, 6, 7, 9	Overall model design, delivery reform elements, composition of Partnership Council, approach to implementation and APM design	Detailed analysis of all AR documentation; primary data collection with ARs, Partnership Councils, and local providers
	Target Population	RQs 1, 2, 7	Target population demographics, historical housing patterns, healthcare utilization rates, the landscape of providers, patient/family perspectives	Descriptive and trend analyses of historical Medicaid data, CCS data, and publicly available regional data; primary data collection with patients and families
	Local Context, Policy Environment, and Infrastructure	RQs 1, 2, 3, 4, 6	State Medicaid policy context and other historical and concurrent initiatives, pre-implementation infrastructure for information sharing and coordination among providers	Primary data collection with ARs, Partnership Councils, and key partners; ongoing environmental scans and AR document reviews
	Adoption	RQs 1, 2, 3, 4, 5	Workforce turnover and training, clinician engagement, Partnership Council engagement	Primary data collection with ARs, Partnership Councils, and local providers; ongoing environmental scans; baseline analysis of Medicaid data
	Implementation	RQs 3, 4, 8, 9	Success of pre-implementation period activities within each AR	Document review, primary data collection, and analyses of Medicaid data and service utilization
	Maintenance	RQs 5, 6, 8, 9	Infrastructure and staffing investments, alignment of eligibility and enrollment processes, data sharing between state/local systems	Primary data collection with ARs, document review
Impact Study	Impact	RQs 1, 2, 3, 4	Reduced use of inpatient stays and ED, lower total Medicaid/CHIP expenditures, improved healthcare quality and a reduction in OOHP	Baseline analysis of Medicaid data, other state administrative data, and AR-submitted data; creation of a comparison group

Triangulated data, analyses, and findings provided the foundation of the pre-implementation period's evaluation design, analysis, and resulting deliverables. The evaluation team conducted five primary activities in the pre-implementation period (**Appendix A** provides additional detail on these activities).

1. *AR document reviews:* As part of the terms and conditions of participating in the model, ARs submit progress reports, operational and implementation plans, and other information to CMS on an ongoing basis. Review of the program-related documents helped the evaluation team understand the specifics of each AR's model; identify the context within which the model operates; and prepare the Implementation Study's site visit teams for interviews with ARs, model partners, local providers, and caregivers. The document review also provided a starting point for identifying explanatory variables that could affect model implementation or outcomes and supported the development of the Comparison Group Feasibility Study (CGFS).

2. *Environmental scans:* The environmental scans fed into the Implementation and Impact Studies. For the Implementation Study, each AR's environmental scan provided insight into statewide initiatives and activities occurring in the AR's community and state that could affect care processes and influence implementation and impact of the model. For the Impact Study, each AR's environmental scan identified additional data and sources for inclusion in the CGFS.

3. *AR calls and site visits:* AR calls and site visits during the pre-implementation period provided AR-specific information on model design, local context, preparation to begin implementation, and the impact of the COVID-19 PHE on service provision and model design. Additionally, the individual AR interactions provided opportunities for the evaluation team to understand challenges faced by ARs and answer evaluation-related questions. We collected data from Lead Organizations, state Medicaid agencies, Partnership Council members, and other key partners. Additionally, we collected data from local providers and families in each InCK Model population. These activities provided critical insight into how each AR approached the pre-implementation period and details on caregivers' and providers' perspectives into gaps in service delivery and needs.

4. *Quantitative data acquisition and validation (Medicaid, CCS, attribution files, and other data):* The pre-implementation evaluation activities provided the foundation for developing comparison groups and conducting the implementation period's impacts analysis. During the pre-implementation period, we conducted exploratory baseline analyses of the Transformed Medicaid Statistical Information System (T-MSIS) data to determine quality, accuracy, and completeness. We also investigated the availability and quality of secondary data identified through the AR document review, environmental scan, and discussions with ARs and CMS project officers. Secondary data included health, CCS, and other publicly available data. Baseline analyses and investigation of secondary data furthered the evaluation team's understanding of the context for each AR's InCK Model and comparison populations and helped identify explanatory variables and contextual factors that could affect InCK Model implementation or outcomes. The validation and analytic process identified data quality concerns and the evaluation team

provided timely feedback to each AR to make corrections in data collection processes so that future data submissions and corresponding analyses meet quality thresholds.

5. *Comparison Group Feasibility Study:* The implementation period's impact analysis follows a quasi-experimental approach and difference-in-difference analysis to estimate the effects of each AR's model on health care utilization and OOHP relative to the experience of a comparison population both before and after the ARs have implemented the InCK Model. During the pre-implementation period, the evaluation team analyzed available data to select an appropriate comparison group as the standard against which each AR's performance will be measured.

Pre-implementation evaluation activities include the following key results.

1. *The InCK Model requires separate evaluation designs for each AR and integration of the evaluation team activities, staff, and results.* Each AR designed and planned to implement individual approaches responding to community needs, organizational strategies, partner capabilities, and available resources.

2. *A comprehensive evaluation hinges on collecting, analyzing, and integrating multiple data sources.* Data collected directly from ARs, providers, and beneficiaries and their caregivers complements health care claims data available through T-MSIS and allows the evaluation to directly assess equity, community involvement, and participant engagement. Combining SIL data with CCS data available through administrative datasets will enable the evaluation team to connect service need with service receipt.

3. *Ongoing engagement with ARs is part of designing and implementing a thorough evaluation.* ARs modify plans and approaches in real-time as they engage with the Partnership Council, assess community and beneficiary and their caregiver needs, learn more about data sharing and care coordination capabilities, and respond to the realities of implementation.

4. *Data collection directly from beneficiaries (as appropriate) and their caregivers requires a multi-pronged approach flexible and diverse methods.* It can be difficult to recruit and engage young adults and caregivers. Best practices for doing research with this population include keeping activities short and timely and to pursue innovative methods to engage participants.

5. *Selection of an appropriate comparison region requires flexibility.* Each AR selected specific ZIP Codes or counties to focus model activities. Through the CGFS, the evaluation team developed comparison groups for each AR based on

   – AR-proposed comparison region and requests,

   – Components of the ARs models and the local context in which the models are being implemented,

   – Empirical analyses of publicly available regional-level data pertinent to the InCK Model and the ARs' local contexts, and

   – Empirical analyses of baseline data (2017-2019) from T-MSIS.

6. *States submit Medicaid data to the federal government through a standard system; however, the quality of data submitted by states varies significantly.* The inconsistency

in data quality means that a standard set of reliable variables cannot be applied across all states at this time. These quality issues limit the ability to use T-MSIS data as originally envisioned and required the evaluation team to modify measure specifications to account for differences. States and the Center for Medicaid and CHIP Services continue to improve the data quality over time.

Thoughtful and tailored recruitment approaches with ARs, providers, and beneficiaries and their caregivers provided engagement during the pre-implementation period. The evaluation created AR-specific evaluation teams; each AR evaluation team assessed the AR's approach and data availability, developed a relationship with the AR, answered questions provided by the AR, and connected directly with the AR on an ongoing basis. The understanding of and engagement with each AR gained during the pre-implementation period will provide key context for the evaluation during the implementation period.

Chapter 2.
InCK Model
Approach Across
Award Recipients

2. InCK Model Approach Across Award Recipients

Chapter 2 documents the evaluation team's understanding of each award recipient's (AR's) rationale for participating in the model and each AR's approach to implement the core Integrated Care for Kids (InCK) Model requirements. The original notice of funding opportunity (NOFO) included specific model requirements. Throughout the pre-implementation period, ARs also had substantial flexibility to modify the individual approaches based on learnings, partnerships, experiences, and limitations.

Key Messages

1. All eight ARs cited the need to improve systems of care for children and families as their primary reason for applying to the InCK Model. Other reasons for applying to the model included leveraging existing work in the state or by the care delivery organizations; building or enhancing partnerships with Core Child Services (CCS) providers; and integrating primary, specialty, and behavioral health care.

2. All ARs developed a hybrid approach to screening and stratification. Most ARs defined this approach as using both historical utilization—identified from Medicaid claims and other administrative data—and follow-up screening to assess further needs. ARs will continue to adjust their approach to needs assessment and service integration level (SIL) stratification in Model Year 3 based on the availability of CCS data and their experiences with implementing and validating their methods.

3. All ARs developed processes so that the service integration coordinator (SIC) (or local equivalent) could fulfill various functions: determine final SIL eligibility, identify or serve as a front-line care coordinator/single point of contact, or provide resources to the family and/or providers. The number of SICs, their backgrounds, and anticipated caseloads varied substantially.

4. ARs created techniques to deliver care in a person- and family/caregiver-centered manner. ARs plan to establish two primary methods to allow beneficiary and caregiver access to care plans: 1. Providing beneficiaries and caregivers access to their InCK Model-specific care management platforms or 2. Embedding beneficiary care plans into their existing electronic health record (EHR).

5. Many ARs have existing two-generation care delivery practices that they plan to leverage as part of the InCK Model. All ARs except Oregon InCK planned to identify caregiver social needs through the screening process.

6. ARs invested considerable resources to establish data use agreements (DUAs) to support information and data sharing for the purposes of reporting on model performance measures, SIL stratification, and care coordination. Almost all ARs were still working to successfully execute all required information sharing agreements at the end of the pre-implementation period.

7. All ARs coordinated with existing mobile crisis response (MCR) services infrastructure in the attribution regions. ARs plan to use the InCK Model to improve information sharing between MCR providers and other provider types.

8. All ARs worked to finalize their state-specific alternative payment models (APMs) during the pre-implementation period. Some ARs reported unexpected complexity in developing the APM, and the process required more time than anticipated.

9. All ARs successfully established Partnership Councils and maintained their engagement in the design and implementation work during the pre-implementation period.

2.1   REASONS FOR APPLYING

The InCK Model is a Centers for Medicare & Medicaid Services (CMS) funded state payment and local service delivery model to support state and locally-driven innovations to improve the health of children and reduce out-of-home placements. The InCK Model tests whether combining local service delivery models with integrated child health and social services and state-specific APMs can reduce healthcare expenditures and improve the quality of care for pediatric Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

All eight ARs applied to the InCK Model for similar reasons. Specifically, they were all motivated to do the following:

1. Improve the care system for children up to age 21;

2. Leverage existing work in the state (including statewide or local initiatives) or by the care delivery organizations;

3. Build or enhance partnerships with CCS providers who provide services for social needs; and

4. Integrate primary, specialty, and behavioral health care.

All eight ARs cited the need to improve systems of care for the children, young adults, and their caregivers served by the InCK Model as their primary reason for applying to the InCK Model. All ARs described the current system of care as fragmented, uncoordinated, and siloed. ARs saw the InCK Model as an opportunity to improve care coordination and provide more integrated, holistic child- and family-centered care.

> *[InCK] is an exciting opportunity to have the clinical and social needs of kids integrated into one place. It's becoming part of our culture. We realize that it is important to meet people where they are and trying to move our focus upstream.*
>
> -   AHHN Leadership

All ARs applied to the InCK Model to leverage work in their state that pre-dated the model. For example, Bronx Equity InCK New York (BE-InCK NY) first identified the InCK Model as aligned with New York's broader strategy to improve maternal and child health outcomes. Similarly, North Carolina (NC) InCK saw the InCK Model as aligned with the goals of the state's concurrent managed care transition. Other ARs (All Hands Health Network (AHHN), Oregon (OR) InCK, and Village InCK) cited the opportunity to build on existing strong partnerships as part of the reason to apply.

All ARs described the medical and CCS systems that serve InCK Model-eligible children and young adults as complex and siloed. They indicated that caregivers are often uncertain who or where to ask for help. ARs applied to the InCK Model to better coordinate services across medical care and CCS and to better integrate medical care and social services for children and their families.

Across all eight ARs, CCS providers and caregivers for individuals with complex needs reported similar challenges accessing and engaging in medical care and CCS. These challenges included the following:

People are saying, 'I'm tired of telling my story over and over again – can't you just get this information? I don't want to re-tell my story.' This is our long-term goal. I say long-term because it's difficult to do.

- NJ InCK Leadership

5. Limited supply of specialists and behavioral health providers who accept Medicaid;

6. Inadequate supply of providers who deliver culturally-informed care or care that is child- and family-centered;

7. Lack of information sharing among medical providers and between medical and CCS providers means caregivers need to "tell their story again and again," and providers often rely on beneficiaries and their caregivers for information about other service needs and use; and

8. Transportation, childcare, work schedules, and other social needs or life circumstances make it difficult for beneficiaries and their caregivers to access care and stay engaged in services.

Some providers and caregivers also talked about a general sense of mistrust of medical providers and the CCS system as contributing to difficulty accessing and engaging in services. Some families with mixed immigration status expressed concern about attracting attention to their families if they engaged with CCS providers for help. Other families come from communities with a history of experiencing neglect or exploitation by the healthcare system and prefer to limit their engagement. Behavioral health providers in the Village InCK Model region reported significant stigma resulting from religious beliefs in the region which make it difficult to engage young people, particularly those identifying as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual/Ally, or Other Identities (LGBTQIA+).

Some ARs (BE-InCK NY, Connecticut (CT) InCK Embrace New Haven, NC InCK, and OR InCK) reported applying, at least in part, based on strong support from the state's Medicaid agency leadership or the Governor's office. For example, state leadership in Ohio identified the InCK Model as an opportunity to address rising out-of-home placements (OOHPs) in the area.

Exhibit 2.1 illustrates local initiatives, contextual factors, and service gaps that influenced ARs' InCK Model design and planning activities.

Exhibit 2.1. Community Influences in InCK Model Design and Planning Activities

Local InCK Model Name	Past or Concurrent Initiatives	Medicaid Policy and Community Context	Service Gaps
AHHN	• The state plans to implement Pathways to Success ("Pathways"), a program for Medicaid-enrolled children under the age of twenty-one in Illinois who have complex behavioral health needs and require intensive services and support. Overlap in benefits, service delivery, and ZIP Codes exists between Pathways and AHHN. • The Illinois Department of Healthcare and Family Services (Illinois Medicaid) will launch Integrated Health Homes, an initiative to integrate physical and behavioral healthcare coordination for adults and children with complex behavioral health needs, on a to-be-determined date.	• In 2018, Illinois expanded Medicaid to contract with managed care organizations (MCOs). • Illinois expanded Medicaid managed care to all counties in 2018. In 2020, all "youth in care" (i.e., children in foster care through the Illinois Department of Children and Family Services) were moved to the YouthCare Medicaid managed care program.	• Access to specialty providers who accept Medicaid is limited. • Though most residents in the AHHN service area have internet access, limited computer literacy makes telehealth difficult to implement universally. • Despite ample transit options, transportation to organizations that provide services remains difficult. • Distrust of the system (including health care, government programs, childcare, and early education) is a barrier to engaging in services for many families.
BE-InCK NY	• NY previously implemented innovative Medicaid reform efforts, including the Delivery System Reform Incentive Payment program, the First 1,000 days initiative, and the Medicaid Health Homes Serving Children program. Substantial overlap exists between the Medicaid Health Homes Serving Children program and the InCK Model.	• The three ZIP Codes that BE-InCK NY serves have the highest proportion of children and pregnant people with Medicaid coverage who receive care through the two major health systems partnering on the InCK Model: Montefiore and NYC Health + Hospitals (Jacobi and North-Central Bronx).	• There is an insufficient number of children's behavioral health providers, particularly child psychiatrists, in the Bronx. • Healthcare and social service systems are complex and overwhelming to navigate, leaving families feeling dismissed or left out of the system. • Bronx families experience many needs related to service access, most commonly transportation, language translation services, and immigration services.

Local InCK Model Name	Past or Concurrent Initiatives	Medicaid Policy and Community Context	Service Gaps
CT InCK Embrace New Haven	• The Connecticut Department of Social Services implemented state-wide person-centered medical homes for Medicaid beneficiaries in 2012, which support care coordination. CT InCK Embrace New Haven aligns with this and other care coordination initiatives implemented by the state.	• Medicaid in Connecticut is financed via fee-for-service. Administrative aspects of the Medicaid program and other human service programs are managed by two administrative service organizations: Beacon Health Options manages behavioral health care and Community Health Network manages physical health care.	• Physical and behavioral health providers in the InCK Model region are siloed, with limited information sharing–particularly with CCS organizations. • Families in the InCK Model region have significant CCS needs, and the system for addressing those needs is siloed, diffuse, and difficult for families to navigate. • Beyond CCS needs, many families in the InCK Model region experience trauma and secondary trauma, creating additional barriers to engaging in ongoing services.[a]
NC InCK	• As part of an overall strategy to address social drivers of health, North Carolina applied and received a 1115 waiver from CMS called the Healthy Opportunities Pilot, with an effective date of March 15, 2022.	• NC has not expanded Medicaid under the Affordable Care Act. As of fall 2021, Medicaid eligibility for caregivers of young children is limited to those who earn under 42% of the federal poverty level. • NC passed legislation to transition from fee-for-service to managed care in 2015. Resulting from various administrative issues and the COVID-19 public health emergency (PHE), the transition to managed care was delayed until July 1, 2021. Most individuals enrolled in Medicaid are enrolled in standard plans; individuals with complex physical and/or behavioral health needs are enrolled in tailored plans.	• Certain types of providers and services are not reliably available. Limited stock includes behavioral health and supportive service providers, those who speak Spanish, or provide care in a culturally-informed manner. • Children and families sometimes fail to maintain engagement in services for a variety of reasons. • The system is complex and often overwhelming to navigate.

Local InCK Model Name	Past or Concurrent Initiatives	Medicaid Policy and Community Context	Service Gaps
NJ InCK	• A statewide mobile crisis response (MCR) system and local community-based care management organizations support individuals with complex behavioral health conditions and their families, connecting them to behavioral health and social services. • New Jersey Medicaid MCO contracts cover care coordination, including a health screening intake form for adults and children.	• Local municipalities run school districts, public health departments, and other public programs under New Jersey's "home rule" structure. Individual counties oversee other health and human services, such as education and child welfare services.	• The number of behavioral health providers in the InCK Model region is not sufficient to meet service need. • Few providers fluent in other languages and sufficiently versed in culturally competent services practice in the area, and the population of individuals with limited English proficiency is growing. • Transportation is a barrier for many to access services. • The provision and completion of needs assessments and service delivery are fragmented. • Individuals in the NJ InCK Model region experience high rates of food insecurity and other social needs.
OH InCK	• OH is concurrently implementing OhioRISE (Resilience through Integrated Systems and Excellence), which provides specialized comprehensive managed care for youth with complex behavioral health needs. This statewide program will overlap with OH InCK. • OH InCK will build on Nationwide Children's Hospital pediatric accountable care organization, Partners for Kids, as the APM.	• Since 2005, Ohio mandated managed care enrollment for Medicaid beneficiaries. • Most children enrolled in Medicaid receive their services through a comprehensive managed care plan, which covers acute, primary, specialty, mental health, and substance use care services.	• There is limited supply of behavioral health providers in the InCK Model region. • Social risk factors are prevalent, and there are significant silos between health care and social services. • Caregivers and families are reluctant to seek out or stay engaged in services because of stigma among the close-knit communities in which individuals live.

Local InCK Model Name	Past or Concurrent Initiatives	Medicaid Policy and Community Context	Service Gaps
Village InCK	• Illinois Medicaid will launch Integrated Health Homes, an initiative to integrate physical and behavioral healthcare coordination for adults and children with complex behavioral health needs, on a to-be-determined date. EHD had planned to base Village InCK's APM on the IHH initiative's payment model.	• In 2018, Illinois expanded Medicaid to contract with managed care organizations (MCOs). • In 2020, all "youth in care" (i.e., children in foster care through the Illinois Department of Children and Family Services) were moved to the YouthCare Medicaid managed care program. • The Village InCK region is rural, most residents are white, and the majority of children in the area are enrolled in Medicaid. Many children receive physical and behavioral health through school-based health clinics located throughout the rural area.	• The rurality of southern Illinois, with limited access to public transportation and the internet, make accessing health care difficult. • There is a lack of specialists in the area, especially dentists and behavioral health providers who accept Medicaid. Patients needing certain specialty care are often referred to specialists in nearby states. • Stigma and caregiver substance use is associated with reduced engagement by children and families in behavioral health services.
OR InCK[b]	• OR has comprehensive Medicaid managed care operated through regional community care organizations. These organizations operate on a global budget and provide enhanced primary care to almost all Medicaid-enrolled individuals in the state.	• Approximately 90% of Medicaid-enrolled children in the InCK Model region are enrolled in a comprehensive care organization. • Oregon employs a "no-wrong-door" approach to public benefit enrollment. One application (online, in person, or by phone) allows an individual to enroll in Medicaid, Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and other social support programs.	• Not available.

Note:

a. The Center for Health Care Strategies provides information on trauma-informed care: https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/.

b. In October 2021, Oregon Health Authority informed CMS of the intent to withdrew from the model.

2.2 POPULATION-BASED SCREENING/NEEDS ASSESSMENT APPROACH TO EARLY IDENTIFICATION AND SERVICE DELIVERY

Model Requirements

CMS requires ARs to conduct an annual needs assessment on all Medicaid-enrolled children in the InCK Model region to assess individual and family medical needs, social needs, and functional impairments. CMS requires ARs to provide this assessment data on at least 80 percent of eligible beneficiaries in the InCK Model region. Needs identified with this assessment will inform the beneficiary's service integration level (SIL). CMS intentionally designed the SIL eligibility criteria flexibly so that each AR could tailor their approach to needs assessment and SIL stratification processes and protocols.

ARs' Approaches and Progress During the Pre-Implementation Period

All ARs developed hybrid approaches to screening and stratification. Most ARs defined this approach as using both historical utilization—identified from Medicaid claims[28] and other administrative data—and follow-up screening to assess further needs.

Exhibit 2.2 describes each AR's planned approach to needs assessment at the end of the pre-implementation period. ARs will continue to adjust their approach to needs assessment and SIL stratification in Model Year 3 based on the availability of CCS data and their experience with implementation.

Exhibit 2.2. Summary of Planned Approach to Needs Assessment and SIL Stratification

Local InCK Model Name	Administrative Data included in SIL Stratification	Additional Screening Data (if applicable)
AHHN	• Medicaid claims data run through the 3M Clinical Risk Grouping (3M CRG software)	• 20-item self-administered screening tool to confirm medical needs and identify social needs
BE-InCK NY	• Medicaid claims data including CPT Z-codes[a] that flag social drivers of health	• Screening tool conducted online or telephonically; screening items derived from the Accountable Health Communities • Health-Related Social Needs Screening tool, Children's Health Watch, 12-item short form survey, patient health questionnaire-2 and validated social drivers of health screening questions
CT InCK Embrace New Haven	• Medicaid claims data and child welfare data from the Connecticut Department of Children and Families	• Conversation to collect information about social needs via the Children's HealthWatch questions, the Survey of Well-being of Young Children (SWYC), and the Patient Health Questionnaire (PHQ)-2/PHQ-9, the CRAFFT tool, and the Ohio Mental Health Consumer Outcome Systems Functioning Scale

Local InCK Model Name	Administrative Data included in SIL Stratification	Additional Screening Data (if applicable)
NC InCK	• Medicaid claims using the Pediatric Medical Complexity Algorithm (PMCA) augmented by North Carolina Medicaid physical health complexity designations, juvenile justice, and education data	• Food and housing insecurity data collected via telephonic screens conducted by state managed care organizations
NJ InCK	• Medicaid claims data using the PMCA	• Web-based comprehensive social needs assessment (referred to as the NJ Health Story), combining questions from the SWYC, the Pediatric Adverse Childhood Events (ACEs) and Related Life-events Screener, the Pediatric Symptom Checklist, and the CRAFFT tool
OH InCK	• Medicaid claims data and data from the Ohio Department of Jobs and Family Services[b], which oversees WIC and TANF	• Telephonic screening tool to be conducted by the SICs; items derived from the Ohio Medicaid Health Risk Assessment, Pediatric Quality of Life Inventory, Short Form 12, and SWYC
Village InCK	• Medicaid claims data run through the 3M Clinical Risk Grouping (3M CRG software)	• SDOH and ACE screening via Village InCK's NowPow[c] portal and the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)
OR InCK[d]	• Medicaid claims data	• N/A

Notes:

a. Social drivers of health-related Z codes (Z55-Z65) are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation). https://www.cms.gov/files/document/zcodes-infographic.pdf

b. As of early 2022, OH InCK was also pursuing DUAs with the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Education to incorporate that data into SIL stratification.

c. NowPow, owned by Unite Us, is a community referral system to address basic needs like food, shelter and financial assistance to counseling, weight management and caregiver support.

d. In October 2021, Oregon Health Authority informed CMS of their intent to withdraw from the model.

2.3 APPROACH TO SERVICE INTEGRATION

Model Requirements

Service integration is a core requirement of the InCK Model. CMS expects ARs to improve coordination of medical care and CCS within their regions for the purposes of integrated care and case management. The NOFO required that ARs create a plan to integrate existing services to improve information sharing across systems and ensure that families have a single point of contact. Service integration coordinators (SICs) are required to support integrated, interdisciplinary care teams for beneficiaries and to develop and regularly update care plans for beneficiaries in SIL 3.

ARs' Approaches and Progress During the Pre-Implementation Period

During the pre-implementation period, ARs spent considerable time developing service integration approaches; determining the requirements; and staffing the SIC role, discussed further below. To conduct this work, ARs partnered with their Partnership Councils, local InCK leadership, and the CMS InCK Model Team.

Role of SICs

Most ARs developed standard operating procedures in which SICs will determine final SIL eligibility and identify a front-line care coordinator to serve as a family's single point of contact. In AHHN and New Jersey (NJ) InCK, SICs will serve as the front-line care coordinator for beneficiaries in SILs 2 or 3. Typically, the SIC (some ARs use a different term to refer to this required role) will base single point-of-contact assignments on the child's needs and where they already receive services.

For one AR (BE-InCK NY), SICs will serve as the single point of contact for beneficiaries who are not already aligned with other care management services. SICs will also monitor InCK Model beneficiaries to ensure care plans are regularly updated and that beneficiaries are receiving needed services. Across all ARs, SICs will provide resources to the front-line care coordinators; resources include asset maps or information about available resources for a given service need.

The number of SICs each AR planned to hire (and the status of that hiring during the pre-implementation period), the SICs' backgrounds, the SICs' anticipated caseloads, and the SICs' responsibilities for beneficiaries in those caseloads varied significantly across the ARs. **Exhibit 2.3** includes details about the role of SICs for each AR.

Exhibit 2.3. SIC Roles, Experience, and Caseload by AR

Local InCK Model Name	Local Title for SICs	Preferred Experience	Planned Number of SICs	Anticipated Caseload per SIC	Interaction with Front-line Care Coordinator/ Role Related to Other Care Coordinators
AHHN	Resource Coordinators	Community health worker or mental health/crisis responder; high school diploma required; preference for bilingual in Spanish	To-be-determined (5 hired as of fall 2021)	To-be-determined	Will serve as front-line care coordinator for families of beneficiaries in SIL 2 and SIL 3
BE-InCK NY	SICs	Associate degree and two years of experience or bachelor's degree and one year of experience; familiarity with Bronx community and lived experience	7	75	Will serve as the front-line care coordinator for beneficiaries and members who are pregnant and do not have a care coordinator; other beneficiaries will receive services from existing care coordinators and other Medicaid-funded programs
CT InCK Embrace New Haven	Community Health Organizers (CHOs)	Expertise in specific human services domains; familiarity with New Haven community, culture, geography, and history	8	To-be-determined	Will serve as a liaison for providers and existing care coordinators who will serve as the primary point of contact for children and families in SIL 2 and 3; will conduct screening with children and families without sufficient historical claims to inform data driven SIL assignment.
NC InCK	Integration consultants	Experience in nursing and/or case management; expertise in CCS preferred	16	700-800 SIL 2 and 3 beneficiaries	Will work closely with family navigators (existing care coordinators) who will serve as the frontline care coordinator; the CCS provider or the managed care plan can employ family navigators
NJ InCK	Care integration managers (CIMs)	None noted	5	750 SIL 2 and SIL 3 beneficiaries	Will serve as part of the advanced care management team comprised of community health workers, child life specialists, and family support specialists; the team will serve as single point of contact for families of beneficiaries in SILs 2 and 3

Local InCK Model Name	Local Title for SICs	Preferred Experience	Planned Number of SICs	Anticipated Caseload per SIC	Interaction with Front-line Care Coordinator/ Role Related to Other Care Coordinators
OH InCK	SICs	Bachelor's degree in social work or registered nurse	7	Each SIC will be the liaison for 2-3 single point of contact (SPCs) care coordination organizations and support beneficiaries assigned to those SPCs	Will support staff from SPCs, who will serve as the frontline care coordinator for families in SIL 2 and 3
Village InCK	SICs	Bachelor's degree; experience with computers; expertise with medical systems and CCS systems	11	100 SIL 2 and SIL 3 beneficiaries	Will work with EHD-employed care coordinators (known as family resource developers and wraparound coordinators); these care coordinators will be the frontline care coordinators for families of beneficiaries in SILs 2 and 3
OR InCK[a]	Systems navigators	None noted	2	40,000 beneficiaries	Will serve as frontline care coordinator for beneficiaries not receiving services from another source; other beneficiaries will receive services from existing care coordinators

Notes:

a. In October 2021, Oregon Health Authority informed CMS of their intent to withdraw from the model.

Coordination with Other Medicaid-funded Care Coordination Models

InCK Model-eligible beneficiaries will often qualify for care coordination through other sources such as their managed care plans or other Medicaid-funded programs. ARs designed service integration plans and processes to coordinate with other programs that serve beneficiaries in their InCK Model regions, making sure that families experienced a single point of contact.

> In Illinois, children under care by the Department of Children and Family Services are automatically enrolled in a specific MCO, which provides case management services. Additionally, there is a new program in the Chicago, IL area for children enrolled in Medicaid who have complex behavioral health needs and require intensive services. As of early 2022, this was targeted to launch in March 2022. AHHN continues to develop the process to avoid duplication of services across this program and the InCK Model.

For most ARs (all except AHHN and NJ InCK), the care coordinator associated with the other programs would continue as the single point of contact, whenever possible. For example, BE-InCK NY identified several Medicaid-funded care coordination and management programs that serve the InCK Model population, including Health Homes Serving Children (HHSC), Early Intervention, the Office of People with Developmental Disabilities programs, and care coordination through MCOs. Upon stratification into SIL 2 or SIL 3, SICs will refer families to these programs to determine eligibility. If they are determined to be eligible for HHSC, for example, the HHSC care coordinator would be the single point of contact. The SIC would continue to monitor the child and family for progress toward their goals and to make sure their care plan is being regularly updated. CT InCK Embrace New Haven, NC InCK, OR InCK, and Village InCK plan to follow a similar approach.

The two other ARs (AHHN and NJ InCK) were determining how to avoid duplicating care coordination services that exist with other programs, as the SICs will serve as the front-line coordinator for beneficiaries in SIL 2 and SIL 3.

2.4 Person and Family-centered Care Delivery

Model Requirements

One component of the InCK Model is that beneficiaries in SIL 2 and SIL 3 will receive integrated care coordination across medical care and CCS providers to facilitate care delivery that is individualized, family- and child-driven, and culturally and linguistically appropriate. For beneficiaries in SIL 3, this will be accomplished, in part, by the development of a beneficiary care plan (discussed in more detail below).

ARs' Approaches and Progress During the Pre-Implementation Period

ARs created beneficiary care plan processes and templates to document beneficiaries' service needs and goals in a single place. For example, NC InCK applied a detailed approach to care plan template development. The template aligned with best practices and prioritized families' goals for their child. NC InCK leadership characterized the final care plan as: "1. Simple and strengths-based; 2. Centered on the family voice; and 3. Accessible to families."

ARs' efforts to make sure that care is child- and family-centered included allowing beneficiaries and families to access their own care plans and other information. Some ARs (CT InCK Embrace New Haven, NC InCK, NJ InCK, and Village InCK) developed processes to provide beneficiaries and their caregivers access to their InCK Model-specific care management platforms. Others (AHHN, BE-InCK NY, OH InCK, and OR InCK) embedded care plans into their existing electronic health record (EHR).

> NJ INCK PLANS TO EMBED FAMILY SUPPORT SPECIALISTS IN THEIR ADVANCED CARE MANAGEMENT TEAM. FAMILY SUPPORT SPECIALISTS WILL BE HIRED AND TRAINED BY THE LOCAL PARENT ADVOCACY ORGANIZATIONS TO SERVE AS A FAMILY ADVOCATE ON ALL ASPECTS OF THE NJ INCK MODEL AND ASSIST OTHER PROFESSIONALS IN PROVIDING MORE FAMILY-CENTERED, CULTURALLY INFORMED, AND COORDINATED CARE.

2.5 TWO-GENERATION APPROACH

Model Requirements

As part of the NOFO, CMS highlighted the potential positive impacts of two-generation approaches to care delivery. Two-generation care combines interventions for beneficiaries and their caregivers or other family members. The underlying framework recognizes that the health and well-being of beneficiaries and their parents are inextricably linked. Two-generation approaches provide an opportunity to meet the needs of adults and children together.

ARs' Approaches and Progress During the Pre-Implementation Period

Many ARs have existing two-generation care delivery practices that they planned to build on as part of the InCK Model.

All ARs except OR InCK[29] planned to identify family/caregiver social needs through the screening process. Screening tools to identify social drivers of health (SDOH) and adverse childhood experiences (ACEs) will help identify families with social needs or other risk factors. BE-InCK NY, OH InCK, and OR InCK planned to use administrative data to identify or verify family social needs in addition to screening.

2.6   INFORMATION AND DATA SHARING

Model Requirements

Improving information sharing is a critical component of the success of the InCK Model. Throughout the NOFO, CMS defined requirements of the ARs related to data sharing to support SIL stratification, service integration and coordination, and InCK Model program monitoring, auditing, and evaluation activities.

ARs' Approaches and Progress During the Pre-Implementation Period

During the pre-implementation period, ARs invested considerable time and resources to establish data use agreements (DUAs) to support information sharing for the purposes of reporting on model performance measures, SIL stratification, and care coordination. Establishing these DUAs was challenging and almost all ARs were still working to execute all required information sharing agreements at the end of the pre-implementation period.

Data Sharing to Support SIL Stratification

As outlined above in **Exhibit 2.2**, some ARs (CT InCK Embrace New Haven, NC InCK, and OH InCK) plan to use administrative data from CCS in their SIL stratification algorithm. For example, OH InCK established a DUA with the Ohio Department of Jobs and Families. OH InCK also planned to include education data and data from the Department of Behavioral Health and Substance Use but were not able to establish DUAs with those two agencies by the end of the pre-implementation period. It is unclear when ARs will have access to all data needed to fully implement the SIL stratification approach.

Other ARs planned to use data collected from beneficiaries and their caregivers via needs assessments and screening rather than administrative data from CCS providers in their SIL stratification process. During the pre-implementation period, some ARs (BE-InCK NY, OH InCK, and OR InCK) worked on identifying proxies in the Medicaid claims data to identify social needs or social complexities of their InCK Model beneficiaries.

> BE-INCK NY PLANNED TO USE CPT Z CODES FROM MEDICAID CLAIMS AND OR INCK PLANNED TO USE DATA ON PARENTAL INCARCERATION IDENTIFIED VIA CLAIMS. CHALLENGES WITH THIS APPROACH EXIST: THESE DATA WERE OFTEN MISSING, AND IT IS DIFFICULT TO LINK FAMILY MEMBERS IN MEDICAID CLAIMS AND ACROSS DIFFERENT DATA SETS.

Data Sharing to Support Service Integration and Care Coordination

ARs use various data-sharing platforms to share information with providers and patients/families, communicate with one another, and make referrals. All but two ARs (NJ InCK and OH InCK) relied on third party vendors—such as NowPow[30], Unite Us, HealthEC, and VirtualHealth—to develop these data-sharing platforms. In addition to InCK Model-specific care management platforms, ARs will use existing data sharing infrastructure such as health information exchanges, community-based closed-loop referral platforms, and shared EHRs to foster information sharing among providers.

Engaging and managing third-party vendors in the development of InCK Model-specific care management platforms was challenging and time-consuming for ARs. Identifying an appropriate vendor took considerable effort for some ARs. After identifying a vendor, ensuring that the final product had sufficient functional capability to support information sharing was time intensive. Some vendors ultimately did not produce a product that aligned with the AR's needs.

Two ARs (NJ InCK and OH InCK) relied on internal resources or partner organizations to help develop needed care management platforms. For example, OH InCK contracted with The Ohio State University to create a new care management platform for OH InCK called Apricot 360. NJ InCK worked on developing its own InCK Model-specific data sharing platform from existing systems.

All ARs used the pre-implementation period to establish agreements with community-based providers and other organizations to provide access to care management platforms. ARs worked through the Partnership Councils to facilitate DUAs. Across ARs, members of the Partnership Council and providers expressed concerns that their InCK Model-specific care management platform would not necessarily integrate with other pre-existing data systems such as EHRs and local health information exchanges, which may limit the platforms' usability.

Information Sharing to Report on InCK Model Measures

As part of the application process, CMS required ARs to certify that they would provide data to both CMS and its contractors for program monitoring, auditing, and evaluation purposes. ARs would provide data for the following domains: clinical care (depression screening), non-clinical care (food and housing), and CCS (including child welfare, foster care, and cash assistance). CMS also required that ARs would provide data in these domains for both the InCK Model and comparison populations and SIL screening data for 80 percent of the InCK Model population.

Performance Measures

The NOFO linked performance-based funding in Model Years 5-7 to three CMS-selected measures.

1. NQF Measure #0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

2. NQF Measure #3148: Screening for Clinical Depression and Follow-Up Plan

3. NQF Measure #2843: Family Experiences with Coordination of Care (FECC) – Question 3: Care coordinator helped to obtain community services

ARs were also allowed to select two of the following CMS-approved measures to link to funding.

- Kindergarten School Readiness

- Food Insecurity

- Housing Stability Assessment

The NOFO stipulated determination of benchmarks for the measures linked to funding by the start of Model Year 3 by CMS (using the baseline data submitted by ARs during the model pre-implementation period).

During the pre-implementation period, ARs worked with CMS and its implementation and monitoring contractor to identify and assess source data, review measurement specifications, and review reporting requirements. At the same time, ARs and their partners were faced with the COVID-19 public health emergency (PHE). Schools were particularly impacted as they transitioned to remote or hybrid options and therefore had little capacity for initiating any new data collection. In response to these challenges, CMS eliminated the performance measure requirements for kindergarten readiness, while maintaining the requirements for food security and housing. CMS also delayed reporting of clinical measures beyond the NQF Measure #3148: Screening for Clinical Depression and Follow-Up Plan to later years in the implementation.

Core Child Services (CCS) Data
In the NOFO, CMS indicated that ARs would be required to submit source data to CMS in specific CCS domains: child welfare, foster care, food security, cash assistance, housing, education, and (optionally) juvenile justice. CMS provided guidance on three domains (child welfare, foster care, and juvenile justice) in spring 2021.[31] Guidance in the NOFO and an FAQ from December 16, 2021 specified that the earliest that ARs would be required to submit data in the remaining domains would be July 30, 2022.

ARs worked during the pre-implementation period to establish DUAs with the state agencies that oversee child welfare and foster care. Some ARs also needed to establish DUAs with their state Medicaid agencies to obtain data on clinical care and care coordination. Obtaining child welfare and foster care data was challenging and time consuming for all ARs, but some ARs (BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and OH InCK) successfully established DUAs to support reporting during the pre-implementation period. OR InCK was not able to establish DUAs with the child welfare agency in Oregon before they exited the model.

> IN SOME STATES, SHARING CHILD WELFARE AND FOSTER CARE DATA IS PROHIBITED BY STATE LAW. FOR EXAMPLE, IL (IN WHICH BOTH AHHN AND VILLAGE INCK WILL OPERATE) STATE LAWS ABOUT DATA SHARING ARE PARTICULARLY PROHIBITIVE. AHHN AND VILLAGE INCK WERE ABLE TO OBTAIN DE-IDENTIFIED CHILD WELFARE DATA AND CONTINUE TO WORK TOWARD THE POSSIBILITY OF OBTAINING IDENTIFIABLE DATA.

2.7 MOBILE CRISIS RESPONSE SERVICES

Model Requirements

It is a model requirement that ARs provide initiation of crisis and stabilization services. Mobile crisis response (MCR) services must be available 24/7/365 (24 hours a day/7 days a week/365 days a year) with appropriately trained staff to ensure coverage for the InCK Model population.

ARs' Approaches and Progress During the Pre-Implementation Period

To meet the MCR model requirement, all ARs developed approaches to coordinate with pre-existing MCR infrastructure in the InCK Model regions. Pre-existing MCR services typically included a mobile hotline, central intake, and a coordinated referral system. ARs in states or regions with well-established MCR systems (AHHN, NJ InCK, and OR InCK) indicated plans to rely on these existing systems. Other ARs (BE-InCK NY, NC InCK, OH InCK, and Village InCK) indicated plans to work with existing providers to expand services or ensure there is a single point of contact for all families in the InCK Model region. OH InCK worked closely with statewide efforts to establish the single 988 hotline[32] during the pre-implementation period.

ARs planned to create and begin developing processes for using InCK Model resources to improve information sharing between MCR providers and other providers. For example, some ARs (BE-InCK NY, NC InCK, NJ InCK, and OH InCK) reported using the pre-implementation period to establish better information sharing and communication protocols between medical providers and MCR services. Providers in the InCK Model regions for multiple ARs (NC InCK, NJ InCK, and Village InCK) shared that it was common to rely on patients or family members to self-report any MCR services they had used, as MCR information systems typically did not provide access to providers.

2.8 STATE-SPECIFIC ALTERNATIVE PAYMENT MODELS

Model Requirements

Based on CMS's requirements for participation, ARs must work with local providers to design and implement innovative APMs. Potential APM approaches include shared savings, episode-based, and population-based payment arrangements that incorporate meaningful quality measures and are designed in a manner that incentivizes providers to adopt high-value, patient-centered practices. The application process required state Medicaid agencies to commit to partnering with the Lead Organization to implement the InCK Model and to design and implement the pediatric APM. ARs also needed to use the pre-implementation period to secure any necessary state plan amendments or waivers. All ARs (except CT InCK Embrace New Haven, which is in a fee-for-service state) will implement APMs in the context of managed care.

ARs' Approaches and Progress During the Pre-Implementation Period

All ARs worked to finalize their state-specific APMs during the pre-implementation period. Some ARs reported unexpected complexity with developing the APM; hence, the process required more time than anticipated. In addition to collaborating with their Partnership Councils for APM development, two ARs—OR InCK and Village InCK—hired or consulted with an external party to assist with APM development to address the lack of internal expertise within the organizations. The level of engagement of local MCOs seemed to vary across ARs, which influenced the time commitment and complexity of the process of developing these local APMs.

Exhibit 2.4 includes details on each AR's planned APM(s). Most ARs are using Model Year 3 to pilot their proposed APM and will continue to fine-tune their APM approaches until then.

Exhibit 2.4.   Planned APM Design by AR

Local InCK Model Name	Planned APM Design	State Plan Amendment (SPA) or Program Waiver Needed
AHHN	• Pay-for-performance for provider pools funded via a shared savings program.	• AHHN submitted a 438.6(c)[a] preprint to modify the details of their managed care contract to allow them to implement an APM with a subset of the covered population.
BE-InCK NY	• Total cost of care model with shared savings and prospective funding in advance to support care delivery and population-based case management and care coordination.	• BE-InCK NY anticipated that they would be able to pursue their planned APM without any additional authorities.
CT InCK Embrace New Haven	• Per-member, per-month payment for case management/care coordination for beneficiaries in SIL 2 and SIL 3 with incentive payments which providers receive if they reach certain quality benchmarks.	• CT InCK Embrace New Haven submitted a draft Targeted Case Management state plan amendment in fall 2021.
NC InCK	• Fee-for-service accountable care organizations moving toward a shared savings model. • Primary care first model fee-for-service for advanced medical home. • Bundled payments for specific conditions.	• NC Medicaid anticipated that they would be able to pursue their planned APM without any additional authorities.
NJ InCK	• Per-member, per-month payment for case management needs for beneficiaries in SIL 2 and 3. • Fee-for-service coordination incentive payment to provider to interpret needs assessment with beneficiary (annual).	• NJ Medicaid anticipated that they would be able to pursue their planned APM without any additional authorities.
OH InCK	• Shared savings for pooled behavioral health and social service providers who are part of the Partners for Kids, a pediatric ACO. • Fee-for-service with pay-for-performance for providers not aligned with the ACO.	• OH Medicaid anticipated that they would be able to pursue their planned APM without any additional authorities.
Village InCK	• Pay-for-performance for provider pools funded via a shared savings program.	• Village InCK submitted a 438.6(c) preprint to modify the details of their managed care contract to allow them to implement an APM with a subset of the covered population.
OR InCK[b]	• Not applicable - OR InCK withdrew from the model.	• Not applicable - OR InCK withdrew from the model.

Notes:

a. According to the CMS guidance on Section 438.6(c) Preprint,

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or

PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D).

b. During the pre-implementation period, OR InCK partnered closely with the MCOs that provides services in the InCK Model region to start to design an APM for the InCK Model. They were not able to finalize design details before they submitted their intention to exit the model.

2.9 PARTNERSHIP COUNCILS

Model Requirements

The NOFO required each AR to establish a Partnership Council made up of representatives of the following agencies and organizations: local health department, families and community members, Medicaid payers including MCOs, and CCS (clinical care, behavioral health, local school districts, housing, food, early childhood, Title V agencies, child welfare, and MCR). Partnership Council members were required to sign a charter to indicate agreement to support model activities.

ARs' Approaches and Progress During the Pre-Implementation Period

All ARs successfully established Partnership Councils and maintained member engagement in the design and implementation work during the pre-implementation period. For example, BE-InCK NY established a particularly large Partnership Council, made up of over 50 organizations. ARs relied on sub-committees and working group structures to successfully engage members in key design discussions.

Most ARs included or planned to include families in their Partnership Council. Some ARs (BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK) successfully engaged families during the pre-implementation period. Village InCK was still working to engage families at the end of 2021. OR InCK left the model before engaging any families. It was not clear that AHHN and OH InCK had plans to engage families in their Partnership Councils in the immediate future.
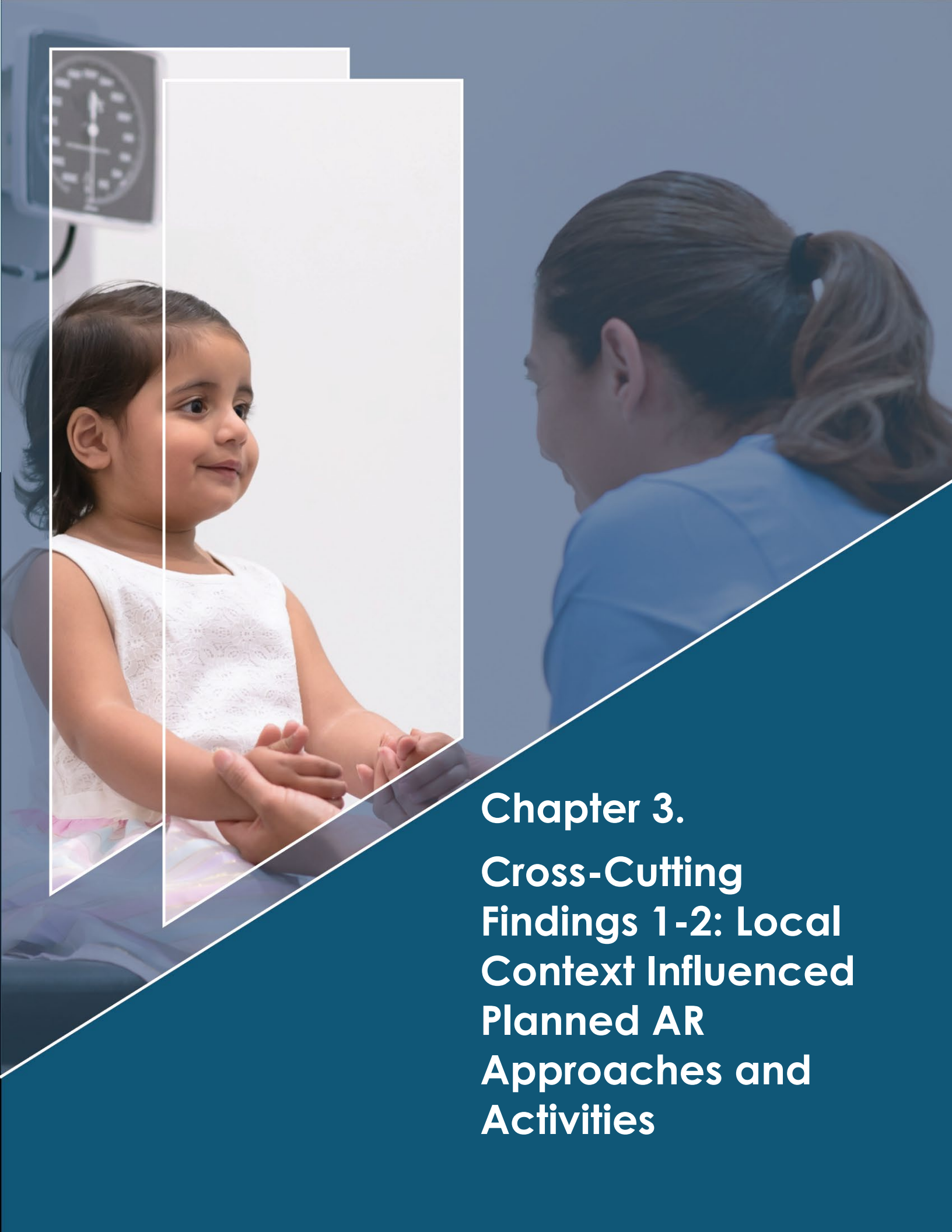
Chapter 3.

Cross-Cutting Findings 1-2: Local Context Influenced Planned AR Approaches and Activities

3. Cross-Cutting Findings 1-2: Local Context Influenced Planned AR Approaches and Activities

The Centers for Medicare & Medicaid Services (CMS) outlined general parameters for the InCK model in the notice of funding opportunity (NOFO) but allowed substantial leeway in program design. As discussed in **Chapter 2**, award recipients (ARs) proposed approaches based on individual community needs. All ARs, physical and behavioral health and Core Child Services (CCS) providers, and individuals and their caregivers identified similar community needs, service constraints, and other barriers. **Chapter 3** reviews two findings (Findings 1 and 2) related to how local context influenced planned AR approaches and activities.

Cross-Cutting Findings

1. While all ARs responded to the same NOFO, each AR designed individualized approaches based on their InCK Model region's and community's needs.

2. Across ARs, families faced common challenges accessing and engaging in needed services. Barriers include inadequate provider and care availability, unreliable transportation to providers and other services, and behavioral health stigma. ARs aim to overcome challenges through coordinating care, educating providers and communities, integrating data, and improving service delivery.

FINDING 1: WHILE ALL ARS RESPONDED TO THE SAME NOFO, EACH AR DESIGNED INDIVIDUALIZED APPROACHES BASED ON THEIR INCK MODEL REGION'S AND COMMUNITY'S NEEDS.

The Centers for Medicare & Medicaid Services (CMS) released the InCK NOFO in August 2018 with the goals of reducing costs to CMS while improving quality of care for children covered by Medicaid or the Children's Health Insurance Program (CHIP). CMS designed the InCK Model as a local service delivery and payment model to allow states and local communities to build on existing delivery system innovations. The NOFO provided a framework of required and optional design elements. The NOFO stipulated that ARs must address each required design element, though CMS would allow flexibility in terms of the specific approach to each element. The local policy context and existing delivery system influenced each AR's decision to apply, selection of their attribution and comparison regions, and their specific plans for addressing key elements.

Finding 1.1   State Policy Priorities and Other Pre-existing Initiatives Led All Eight ARs to Apply for the InCK Model.

All ARs described the InCK Model as aligned with the programmatic and policy priorities of the state Medicaid agency. For some ARs (Bronx Equity InCK New York (BE-InCK NY), Connecticut (CT) InCK Embrace New Haven, North Carolina (NC) InCK, Ohio (OH) InCK, and Oregon (OR) InCK), the InCK Model was aligned with broader priorities of their state Medicaid agency's leadership and governor's office. ARs affiliated with care delivery organizations (All Hands Health Network (AHHN), BE-InCK NY, CT InCK Embrace New Haven, OH InCK, and Village InCK) described the goals of the InCK Model as associated with their organizations' priorities and building on other programs they already had in place.

The InCK Model Aligned with Local Activities

✓ Connecticut Medicaid identified the InCK Model as aligned with other priorities of the State Medicaid Director. They reported that they saw the InCK Model as an opportunity to further their goal of "promoting community-based systems of services and the well-being of children." Once they decided to apply, Connecticut Medicaid put out a request for proposal to identify a Lead Organization in the state to work with on the application.

✓ Egyptian Health Department (EHD), a public health agency and a community based behavioral health provider, received a Systems of Care grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through this grant, they integrate behavioral health care providers with physical health providers for adult care. They were lacking this type of integration for their pediatric patients. They saw the InCK Model as an opportunity to build on the work done under the SAMHSA grant.

✓ OH InCK priorities overlap with those of a larger, statewide initiative, OhioRISE (Resilience through Integrated Systems and Excellence). Through OhioRISE, youth with complex behavioral health needs will receive specialized, comprehensive managed care. The two programs must coordinate to avoid duplication of services, and OH InCK leadership views this as an opportunity to "leverage the existing systems that people are being assigned to and then fill in the holes around those systems."

Finding 1.2   Local Factors Also Influenced How ARs Selected Their InCK Model Regions.

The Lead Organizations that are care delivery organizations (AHHN, BE-InCK NY, CT InCK Embrace New Haven, New Jersey (NJ) InCK, OH InCK, and Village InCK) selected the InCK Model region to align with their organizations' clinical catchment area, where they already served a sizable proportion of the Medicaid-enrolled children.

Some ARs (AHHN, BE-InCK NY, OH InCK, and OR InCK) used secondary data on local health statistics to select the specific ZIP Codes or counties within their clinical catchment area that could most benefit from the InCK Model.

Some Lead Organizations (NC InCK, OH InCK, and OR InCK) specifically included rural counties as part of their catchment areas to make sure they were designing an intervention that addressed the service system needs in different population contexts.

ARs Selected InCK Model Regions to Address Health Disparities

✓ AHHN and BE-InCK NY reviewed publicly available data on the ZIP Codes in their catchment areas. They selected the ZIP Codes with the poorest health outcomes as their INCK Model regions.

✓ In accordance with statewide goals focused on expanding access to marginalized groups, OR InCK leadership selected an InCK Model region that included several federally recognized tribes.

A few Lead Organizations (NC InCK and OR InCK) considered other ongoing initiatives with similar goals to avoid the potential for overlap. For example, Duke is the Lead Organization for NC InCK, and they are partnering with the University of North Carolina (UNC). Both Duke and UNC have large pediatric primary care practices. A crucial factor they cited for selecting the five InCK Model counties was that Duke and UNC have an "existing, large footprint" and provide primary care for most children enrolled in Medicaid in those counties. Concurrent with the InCK Model application period, North Carolina received approval from CMS to implement a Healthy Opportunities Pilot (HOP) program to test the effect of Medicaid-coverage for social supports, such as transportation and food, on health outcomes. NC InCK was careful to avoid overlap in counties selected for the HOP program and the NC InCK Model.

Finding 1.3   As They Designed Their Approaches to Service Integration, ARs Considered State and Local Policies and Pre-existing Care Coordination Activities that Might include Medicaid-enrolled Children in Their InCK Model Regions.

ARs considered state and local policies and the local delivery system when designing their approach to each of the InCK Model elements. For example, to fulfill the requirements to provide a single hotline number for children in crisis, all ARs will build on existing services in their states by expanding scope or reach of services to include new service types or populations served. Further, all ARs identified existing information-sharing platforms, like health information exchanges, that they could leverage to support service integration and information sharing among providers.

The model requires that ARs establish a single point of contact for families to avoid the confusion that can come from having multiple case managers (for the same as well as different programs). Accomplishing this consolidation is a complex task, and ARs were still solidifying how this would work as they transitioned to the implementation period.

Many ARs (BE-InCK NY, CT InCK Embrace New Haven, NC InCK, OH InCK, OR InCK, and Village InCK) determined the service integration coordinators' (SICs') role will be to assign a single point of contact based on both the child's primary needs (e.g., physical or behavioral health or engagement in the child welfare system), location, and alignment with other care coordination programs. SICs or local equivalents will review a child's file upon their assignment to service integration level (SIL) 2 or SIL 3 to determine receipt of services by other care coordination programs. For example, other programs include care management through a managed care company, a child welfare agency, or other Medicaid-funded care coordination programs. For children already engaged with a case manager or involved in other programs, that case manager will serve as the single point of contact. In this instance, the SIC's role will be to monitor each child's progress toward their goals and provide support to the established case manager (i.e., single point of contact). Some ARs determined that the SIC will serve as the single point of contact for all children in SILs 2 and 3 (AHHN and NJ InCK).

> FINDING 2: ACROSS ARS, FAMILIES FACED COMMON CHALLENGES ACCESSING AND ENGAGING IN NEEDED SERVICES. BARRIERS INCLUDE INADEQUATE PROVIDER AND CARE SUPPLY, UNRELIABLE TRANSPORTATION TO PROVIDERS AND OTHER SERVICES, AND BEHAVIORAL HEALTH STIGMA. ARS AIM TO OVERCOME CHALLENGES THROUGH COORDINATING CARE, EDUCATING PROVIDERS AND COMMUNITIES, INTEGRATING DATA, AND IMPROVING SERVICE DELIVERY.[33]

Finding 2.1 Across all ARs, Providers and Caregivers Agreed There Was Ample Supply of Pediatric Physical Health Providers (such as pediatricians), but the Supply of Behavioral Health Providers and Other Health Specialists (such as pediatric cardiologists, dentists, and therapists) Accepting Medicaid Was Too Low to Meet Demand.

Most caregivers and providers interviewed for the evaluation described long waits that could last weeks or even months for behavioral health providers that accept Medicaid. Families/caregivers sometimes chose to pay out-of-pocket for providers that do not accept Medicaid so their child could receive care in a timely manner. Families/caregivers noted this occurred more frequently with behavioral health providers that provide any kind of specialty behavioral health care, such as treatment for autism spectrum or eating disorders. Both physical health providers and caregivers in the OH InCK Model region

> *It's a minimum nine-month wait to see a pediatric behavioral health specialist, same thing if we need neuropsychological testing, nobody takes Medicaid and if they do, they are way backed up. There are very few resources for kids on Medicaid with complex behavioral health needs.*
>
> -   Provider in AHHN region

described that, while behavioral health inpatient services are available when warranted, the area lacks sufficient outpatient programs or intermediate care.

Across all ARs, providers and caregivers described a lack of specialty physical healthcare providers (e.g., cardiologists, adolescent medicine providers); physical, occupational, and speech therapists; and dentists. While physical, occupational, and speech therapy are sometimes available in schools, providers, and caregivers in three AR InCK Model regions (AHHN, CT InCK Embrace New Haven, and OH InCK) reported that obtaining those services through the public school system can be complicated and time consuming.

The lack of provider supply is particularly acute in rural areas. Four ARs (NC InCK, OH InCK, OR InCK, and Village InCK) included rural areas in their InCK Model regions. Across these ARs, caregivers and providers reported a lack of specialty care—specifically, behavioral health providers—and negative outcomes stemming from this lack of supply such as issues becoming more acute or having to engage law enforcement.
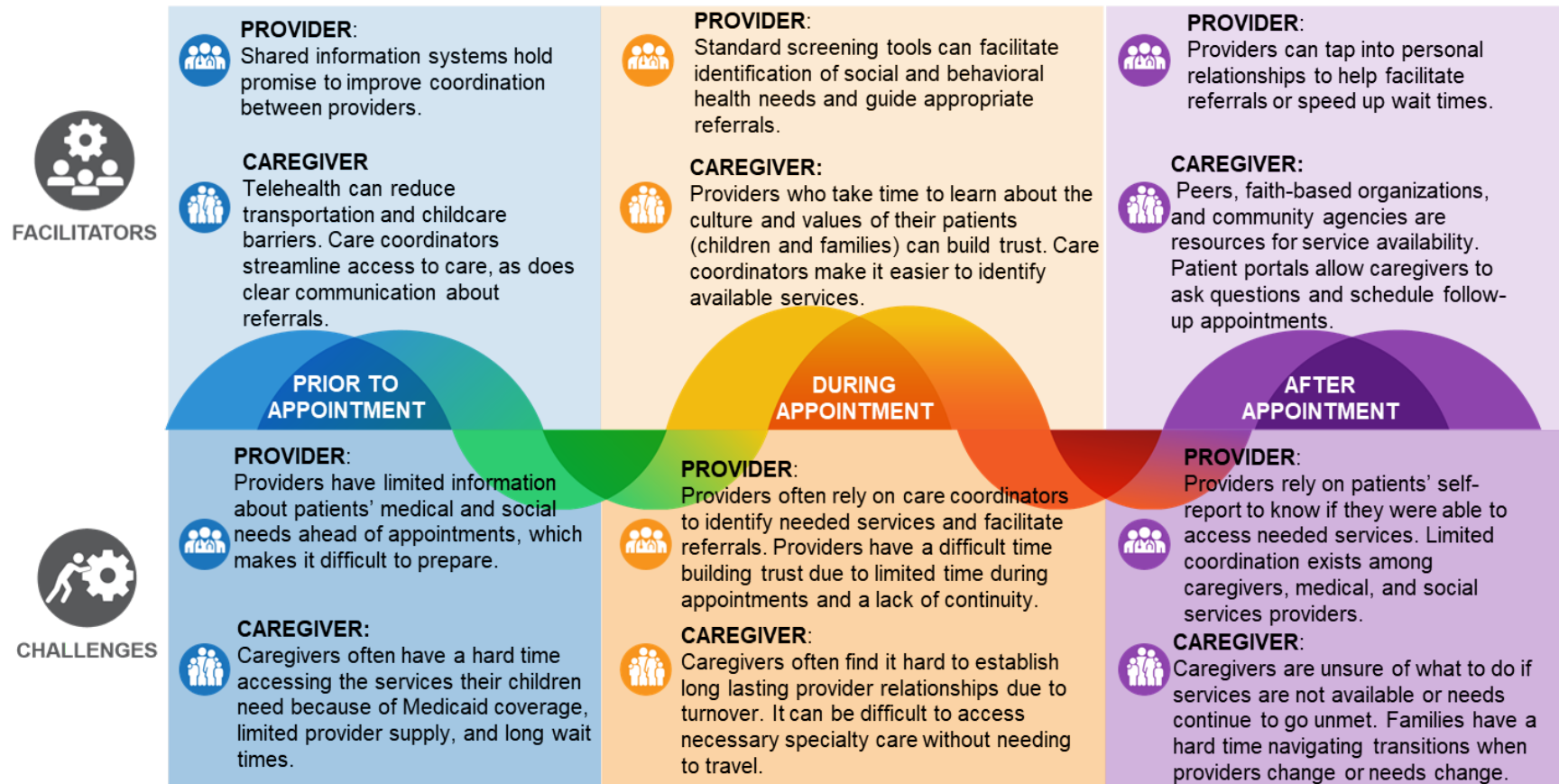
Barriers to Care Exist, including Provider Shortages

✓ Parents in the OH InCK and Village InCK regions reported needing to engage the police or court system to intervene when their child was in crisis because there was no alternative. For example, providers and caregivers in the OH InCK region reported that children often wind up in emergency rooms or juvenile detention centers while they wait for inpatient beds to become available, in response to a lack of inpatient beds or suitable and timely crisis intervention services.

✓ In the AHHN region, children in need of physical or occupational therapy services are often referred to Chicago Public Schools, because there are so few pediatric physical and occupational therapy providers that accept Medicaid.

✓ Providers in the Village InCK region reported that dental needs often go unmet. There is only one federally qualified health center in the area that provides dental care. The dentist sees patients on a first come, first serve basis, resulting in people leaving without receiving care.

Exhibit 3.1 includes detail on provider and patient perspectives on access and receipt of health care and CCS.

Exhibit 3.1. **Provider and Caregiver Perspectives on Facilitators and Barriers to Care Coordination**[a]

FACILITATORS

PRIOR TO APPOINTMENT

PROVIDER:
Shared information systems hold promise to improve coordination between providers.

CAREGIVER
Telehealth can reduce transportation and childcare barriers. Care coordinators streamline access to care, as does clear communication about referrals.

DURING APPOINTMENT

PROVIDER:
Standard screening tools can facilitate identification of social and behavioral health needs and guide appropriate referrals.

CAREGIVER:
Providers who take time to learn about the culture and values of their patients (children and families) can build trust. Care coordinators make it easier to identify available services.

AFTER APPOINTMENT

PROVIDER:
Providers can tap into personal relationships to help facilitate referrals or speed up wait times.

CAREGIVER:
Peers, faith-based organizations, and community agencies are resources for service availability. Patient portals allow caregivers to ask questions and schedule follow-up appointments.

CHALLENGES

PROVIDER:
Providers have limited information about patients' medical and social needs ahead of appointments, which makes it difficult to prepare.

CAREGIVER:
Caregivers often have a hard time accessing the services their children need because of Medicaid coverage, limited provider supply, and long wait times.

PROVIDER:
Providers often rely on care coordinators to identify needed services and facilitate referrals. Providers have a difficult time building trust due to limited time during appointments and a lack of continuity.

CAREGIVER:
Caregivers often find it hard to establish long lasting provider relationships due to turnover. It can be difficult to access necessary specialty care without needing to travel.

PROVIDER:
Providers rely on patients' self-report to know if they were able to access needed services. Limited coordination exists among caregivers, medical, and social services providers.

CAREGIVER:
Caregivers are unsure of what to do if services are not available or needs continue to go unmet. Families have a hard time navigating transitions when providers change or needs change.

Note:

a. Some providers and caregivers in AR regions contributed to a participant-led data collection activity known as Journey Mapping. More detail on the methods for this activity is included in Appendix C. This graphic includes a summary of results of this activity across ARs.

Finding 2.2   Beyond Provider Supply, Families Faced Significant Barriers Accessing and Maintaining Engagement in Services. Barriers included Hours of Operation, Waitlists, Eligibility Criteria, and Reliable Transportation.

To access CCS, families must navigate a complex and siloed system. Across all ARs, providers and caregivers reported the systems to address CCS are difficult for families to navigate. Navigating systems became more difficult after the start of the COVID-19 public health emergency (PHE). Across ARs, providers described that families face elevated levels of food insecurity, housing instability, and challenges with transportation and childcare. All of these heightened challenges for families and made sustained engagement in services even harder.

Across all ARs, physical, behavioral health, and CCS providers reported that families from historically marginalized communities often have an even harder time navigating the system because of a lack of resources, limited paid time off, and a history of negative interactions with the healthcare and CCS systems.

> *I teach families to use their voice and ask the right questions and empower them. Teach them what I learned on my own. Families say, "Why do I go if they don't listen anyway?" A lot of families have trust issues. Adults don't realize kids hear more than you think. Trust is the biggest barrier with them getting services.*
>
> - Caregiver in NC InCK region

> *Your typical family, we can connect them to the service. By we, I mean the school or a care coordinator, however getting there is a big obstacle. Many people don't have cars, they rely on buses. Buses cost money. When you are working with the Department of Children and Families, they give the family a monthly [bus] pass. But as soon as they exit the department's services, that pass stops. So, then the family needs to get a bus pass. They need to get three children on a bus in the snow to whatever behavioral health clinic that the kid goes to. Housing is another hard one. They don't know how to navigate that system. Same with signing up for food benefits. Language can be a big barrier.*
>
> - CT InCK Embrace New Haven SIC

Transportation is significant barrier to access services and attend appointments in both urban and rural areas. In urban areas, despite more ample transportation options, public transportation can be costly, time consuming, and difficult to navigate. For example, a BE-InCK NY care coordinator shared a photo to illustrate how transportation in the city is difficult for individuals with mobility challenges, people who are pregnant or post-partum, and families traveling with young children (**Exhibit 3.2**). Many subway stations have no working elevators, only stairs. Medicaid-funded transportation options are often limited and difficult to access, and both families and providers noted that services were especially poor for picking people up to return home.

Exhibit 3.2.   A Woman Navigating the Subway Station Stairs with a Stroller[a]

Note:

a. As part of the virtual site visits conducted with ARs, the evaluation team engaged SICs in PhotoVoice to capture their perspectives on the challenges the families they work with face. Appendix C includes more detail on PhotoVoice methods.

In rural areas, families often need to travel long distances—even across state lines—to access needed services, which can make sustained engagement more difficult. **Exhibit 3.3** includes results of a PhotoVoice activity describing the difficulty of transportation in some rural areas in the OH InCK region. Roads are often gravel or dirt and may be more difficult to navigate in inclement weather.

Exhibit 3.3.   Inclement Weather Limits Access to Services in the OH InCK Region[a]

Note:

a. As part of the virtual site visits conducted with ARs, the evaluation team engaged SICs in PhotoVoice to capture their perspectives on the challenges the families they work with face. Appendix C includes more detail on PhotoVoice methods.

For many families, challenges of daily life compound transportation barriers. Time, distance, and competing demands can make it difficult for families to engage and remain engaged in services. **Exhibit 3.4** details the experience of a family in the CT InCK Embrace New Haven region accessing the services their family needs on a "typical" day. It shows the seven destinations in one afternoon to provide care for one child, which required personal transportation since the services were not on a public transportation route.

Transportation sometimes, even a family wants to get mental health treatment and they recognize the value of mental health treatment for their kid, they just can't do it because they are juggling so many other things, they're working... I think parents often struggle – with stigma and blaming themselves for their kids presentation.

- Behavioral health provider in AHHN region

Exhibit 3.4. "Mom's Busy Day": An Example of a Family's Experience Navigating Multiple Systems for Their Children[a]
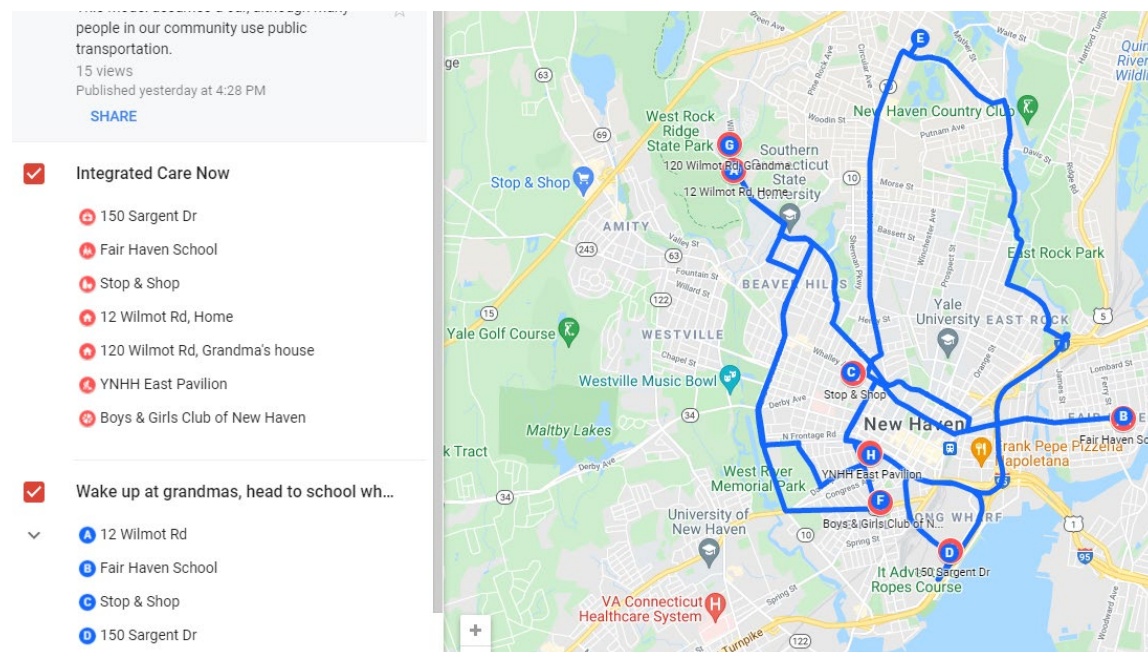
Note:

a. As part of the virtual site visits conducted with ARs, the evaluation team engaged SICs in PhotoVoice to capture their perspectives on the challenges the families they work with face. Appendix C includes more detail on PhotoVoice methods.

Finding 2.3 Across all ARs, Caregivers and Providers Reported That It Was Difficult to Find Linguistically and Culturally Informed Care.

Many caregivers and providers described that, while some providers spoke Spanish, it was more difficult to find providers that spoke other languages. Physical and behavioral health providers, as well as CCS providers, had similar experiences.

Caregivers of non-White children reported that it was difficult to find providers who they could relate to, reflect their culture, or asked about their child's needs in a family centered manner. Across all ARs, caregivers noted that having providers who looked like them and their child supported positive engagement. Similarly, when asked about what worked well, caregivers reported that providers who took the time to get to know their family and talk to them about their families' goals helped support better outcomes for their children.

The truth is that a hospital with bilingual staff is needed. Sometimes when you go to the hospital and ask something in Spanish, they ignore you. I don't have insurance and while I'm grateful that they finally give me care, I would also like for them to understand me. They treat you worse than a dog. I am there and really in pain and they don't take me seriously.

- Caregiver in NJ InCK region

The system works when [the provider] sits eye level with us. When they make the space and the time so that we could talk about concerns and repeating back concerns. The provider actively listens and genuinely cares.

- Caregiver in NC InCK region

Individuals Found It Difficult to Identify and Access Culturally and Linguistically Appropriate Care

✓ Parents in the NJ InCK region shared that, while they could access primary care providers that speak Spanish, finding Spanish-speaking specialists in hospitals was much more difficult.

✓ BE-InCK NY's region includes individuals with a variety of cultures and languages. Providers rarely provide services in languages other English or Spanish. Providers reported that, while they do have access to on-demand translation services, direct communication between providers and families who can speak the same language is far preferable. They also shared that most information about CCS is only available in English or Spanish.

✓ A parent in the NC InCK region described difficulty finding a specialty provider who spoke Spanish. While this parent was comfortable speaking in English, other family members have limited English proficiency; moreover, providers frequently did not offer translation services but would ask the child to translate for their parent(s) or caregiver(s).

Finding 2.4   Across ARs, Some Physical Heath, Behavioral Health, and CCS Providers Reported that Some Caregivers Were Unable (because of barriers) or Unwilling (because of cultural beliefs or concerns about child welfare or immigration referral) to Engage in Services.

Providers identified multiple reasons caregivers may be less likely to engage in services, including stigma around needing services, a caregiver's own health problems or substance use, and fear of the potential attention the family may receive from child protective or immigration services. Other providers reported that caregivers were just sometimes not interested in engaging in behavioral health or CCS, which some attributed to the stigma of seeking help.

Stigma and Familial Substance Use Influence Engagement in Care

✓ Providers in both the OH InCK and Village InCK regions reported that parents' own substance use was often a barrier to obtaining or engaging in services for their children.

- For example, one provider in the OH InCK region noted that, while an adolescent may be committed to working on their own substance use issues, if they are in a house with a parent who is using substances, it can be difficult for the child to achieve their individual goals.

✓ Providers in both the OH InCK and Village InCK Model regions reported there is significant stigma related to behavioral health services. A lack of anonymity exists in rural areas, where most people tend to know one another, compounds culturally-embedded stigma, and creates a formidable barrier for families to engage in and sustain behavioral health treatment.

✓ Providers in the AHHN, BE-InCK NY, CT InCK Embrace New Haven, and NC InCK Model regions reported mistrust of the "system" was another barrier to engage in services. Mistrust was particularly acute among families with mixed immigration status and among those who have prior experiences of mistreatment or neglect in healthcare systems.
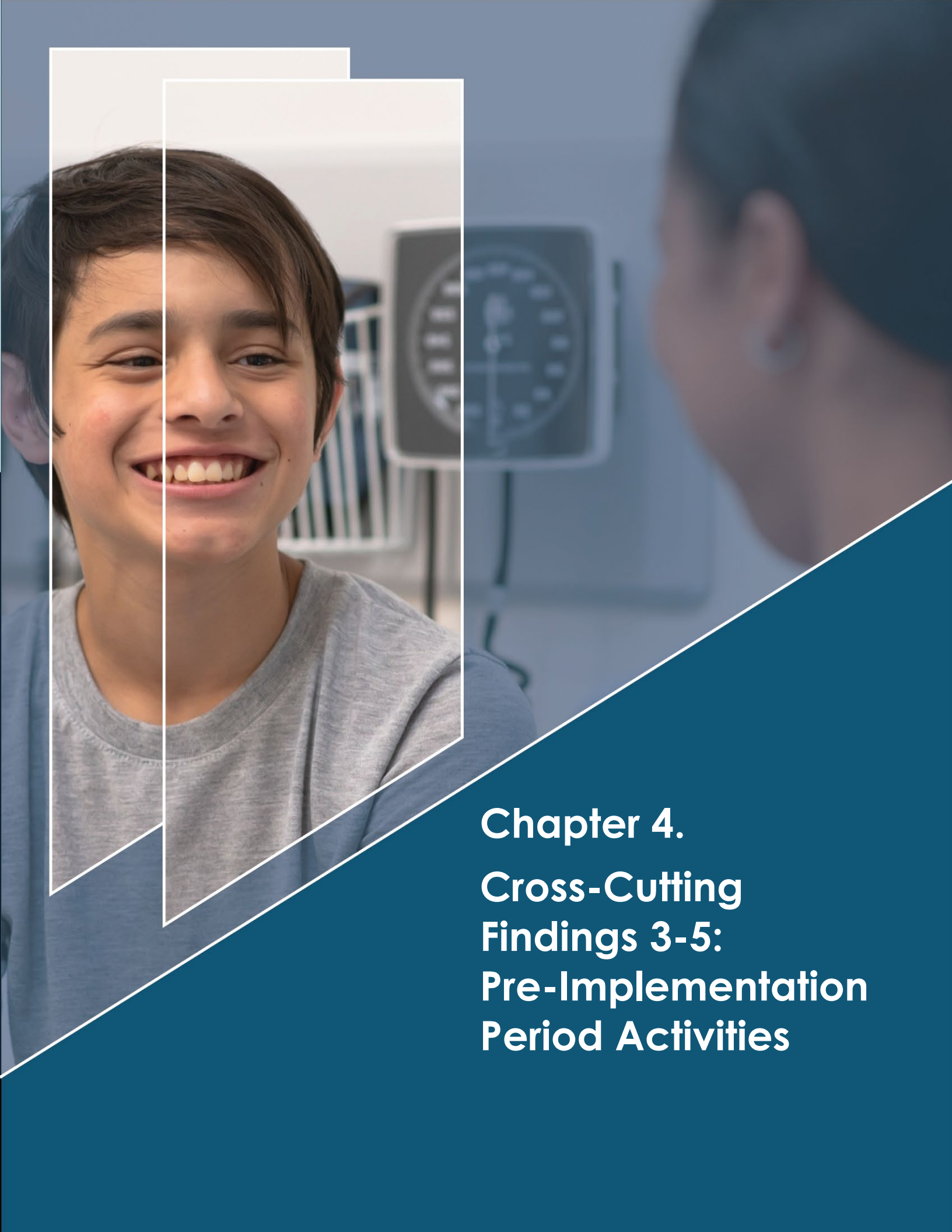
Chapter 4.

Cross-Cutting Findings 3-5: Pre-Implementation Period Activities

4. Cross-Cutting Findings 3-5: Pre-Implementation Period Activities

In the design of the InCK Model, the Centers for Medicare & Medicaid Services (CMS) provided award recipients (ARs) with a two-year planning period—known as the pre-implementation period. Through this period, CMS and the ARs modified approaches in real-time as learning and knowledge expanded. As one of the first CMS funded models that incorporated a planning period, the experiences of CMS, ARs and their stakeholders, and CMS's contractors provide valuable lessons to inform future models. **Chapter 4** reviews three findings (Findings 3, 4, and 5) related to ARs' activities during the pre-implementation period.

Cross-Cutting Findings

3. Over the course of the pre-implementation period, ARs refined plans for model activities. Changes usually happened in response to clarification provided by CMS, increased understanding of model requirements, and greater awareness of the complexity involved in system transformation.

4. ARs successfully established and engaged Partnership Councils in model design, planning, and pre-implementation period activities.

5. The COVID PHE exacerbated the demands on health care and CCS systems, which limited the attention available to contribute to the InCK Model planning activities.

FINDING 3: OVER THE COURSE OF THE PRE-IMPLEMENTATION PERIOD, ARs REFINED
PLANS FOR MODEL ACTIVITIES. CHANGES USUALLY HAPPENED IN RESPONSE TO
CLARIFICATION PROVIDED BY CMS, INCREASED UNDERSTANDING OF MODEL
REQUIREMENTS, AND GREATER AWARENESS OF THE COMPLEXITY INVOLVED IN SYSTEM
TRANSFORMATION.

During the pre-implementation period, all ARs made changes to their initial proposed approaches to screening, needs assessment, and service integration to comply with model requirements. The notice of funding opportunity (NOFO) stated that ARs would annually screen all individuals in the InCK Model population for physical health, behavioral health, and social needs. Additionally, the NOFO stipulated that ARs must report on the results of the screenings and on data related to performance measures for a minimum of 80 percent of the InCK Model attributed population.

In their original applications, ARs proposed a wide variety of strategies to achieve this goal.

- Connecticut (CT) InCK Embrace New Haven, New Jersey (NJ) InCK, and Ohio (OH) InCK planned to use a combination of data from Medicaid claims or other administrative data and data collected from families through in-person or telephonic screens.

- All Hands Health Network (AHHN), Bronx Equity InCK New York (BE-InCK NY), NC InCK, and Village InCK originally planned to rely entirely on screening to collect information about family needs and stratify children into service integration levels (SILs).

- Three ARs (BE-InCK NY, NC InCK, and OR InCK) considered the information about social needs they could obtain from the Medicaid claims or other administrative data. A concern about relying on administrative data, however, is that significant numbers of Medicaid-enrolled children do not go to well-child or well-care visits regularly or do not have a regular source of care and may be mistakenly assigned to a specific SIL.

Though many providers already screen children for physical and behavioral health and social needs, providers use varied assessment tools. During the pre-implementation period, ARs that planned to use screening tools raised concerns about their ability to annually screen all children in their InCK Model region. ARs reported that it would be difficult to implement new screening tools into existing clinical workflows given that they lack mechanisms to require providers not affiliated with their organization to adopt standardized screening. ARs also noted that requiring the same tool across all organizations and systems would be disruptive and potentially impossible.

[Screening would not be feasible] due to the sheer number of kids and frankly we don't have control over the majority of clinical teams who take care of them, nor do we have the resources to incentivize them to do the thing we would need them to do. Screening would require repetition to keep things up to date in a way that would be hard.

- North Carolina (NC) InCK Lead Organization

By the end of the pre-implementation period, all ARs decided to rely primarily on historical healthcare utilization identified via Medicaid claims to identify physical and behavioral health needs and inform initial SIL assignment. All ARs, except OR InCK, elected to also incorporate data obtained from in-person, virtual or telephonic screening to confirm

healthcare needs and identify social needs. ARs chose this approach primarily because of the complexity, feasibility, and burden associated with primary data collection for individual screening. ARs moved to a primarily data-driven approach based on an increase in awareness and understanding of model requirements. During the implementation period, ARs will validate and finalize their approaches.

**Some ARs Created Approaches to Use Administrative Data
for Identifying Social Needs**

✓ NC plans to capitalize on new contracts with managed care organizations to capture food and housing insecurity screens that align with the InCK Model requirements.

✓ BE-InCK NY plans to use Current Procedural Terminology (CPT)-z codes from Medicaid claims to identify children and families with concerns related to social drivers of health. BE-InCK NY will conduct validation testing of their method and hope to better understand the capacities of administrative data.

Despite partnership between the AR and CCS providers through the Partnership Councils, ARs did not have plans to conduct screenings in community-based settings. These challenges contributed to two ARs (BE-InCK NY and OR InCK) decreasing the size of their InCK Model regions.

**Two ARs Reduced the InCK Model Regions Based on Increased Knowledge of
Model Requirements and Changes to Proposed Approaches**

✓ BE-InCK NY originally planned to include eight ZIP Codes, encompassing 143,460 Medicaid-enrolled children and pregnant people. During the pre-implementation period, BE-InCK NY reduced their region from 8 to 3 ZIP Codes, resulting in a new coverage total estimated at 31,576 children and pregnant people (as of January 2022) to make screening 80 percent of the InCK Model population more feasible. They selected the final three ZIP Codes because they had the largest proportion of Medicaid-covered children and pregnant people already receiving care at their care delivery partners. BE-InCK NY anticipated that this would make it easier for them to fulfill the requirements for screening and needs assessment.

✓ OR InCK requested a change in scope to decrease the size of their attribution population to only those individuals who participate in the state's managed care system, as tribal populations have a separate health system. CMS denied this request as it would have systematically excluded tribal children and did not align with model requirements to include all eligible beneficiaries in the designated geographic region.

Two other ARs (NJ InCK and Village InCK) identified large increases in the number of children they would be obligated to serve in response to expansions of the eligible Medicaid population during the COVID-19 PHE (discussed further in [Finding 5](#)).

Some ARs Faced Expanded InCK Model Populations Resulting from the PHE

- ✓ Village InCK originally included approximately 7,900 Medicaid-enrolled children and young adults aged 0 to 21 in five southern adjacent Illinois counties: Gallatin, Hamilton, Saline, Wayne, and White in their InCK Model region. As of fall 2021, EHD requested a change in scope to increase the number of InCK Model children to 10,919 youth, including 1,403 Children's Health Insurance Program beneficiaries, to account for the increase in Medicaid beneficiaries during the PHE.

- ✓ NJ InCK's population also increased since 2020 as a result of the PHE. The number of children enrolled in Medicaid increased because of economic challenges and federal regulations, which allowed for continuous enrollment during the PHE.

Concurrent initiatives that three ARs (AHHN, NC InCK, and Village InCK) were planning to build on or partner with either changed scope or were delayed, which required adaptations to the ARs' models. As discussed above in Finding 1, Illinois and North Carolina planned significant Medicaid reforms slated for implementation concurrent with InCK. Illinois and Ohio also had significant concurrent initiatives in their Medicaid programs that have not yet influenced their InCK implementation. For example, in Illinois, the state Medicaid program was planning a delayed transition to Integrated Health Homes that would have overlapped with InCK Model aims for AHHN and Village InCK. In Ohio, the state designed a new specialty managed care program for children at risk of entering the foster care system called OhioRISE. OH InCK is still determining the best way to align their InCK Model design with the OhioRISE initiative.

Concurrent Initiatives Led Some ARs to Change Their InCK Model Approaches

- ✓ IL Medicaid originally planned to launch an initiative called Integrated Health Homes (IHH) to integrate physical and behavioral healthcare for children and adults with complex needs. The program was set to launch in 2021, and both AHHN and Village InCK planned to design their InCK Model Alternative Payment Models (APMs) to align with the IHH incentives. The IHH launch was delayed following legislative and administrative challenges, and the COVID-19 public health emergency (PHE), which delayed AHHN's and Village InCK's APM designs.

- ✓ North Carolina originally planned to transition their Medicaid program from fee-for-service to managed care early in 2020. But the PHE and other issues delayed implementation until July 2021. For NC InCK, these delays created additional uncertainty about how the InCK Model would align with elements of the newly formed managed care entities. In the end, however, the delay in the managed care transition allowed for synergy between the two programs and facilitated implementation. For example, NC InCK was able to work with the managed care companies in North Carolina to integrate screening for housing and food insecurity into the requirements for enrolled providers. NC InCK will use results from that screening in their initial SIL assignments.

FINDING 4: ARs SUCCESSFULLY ESTABLISHED AND ENGAGED PARTNERSHIP COUNCILS IN MODEL DESIGN, PLANNING, AND PRE-IMPLEMENTATION PERIOD ACTIVITIES.

The NOFO outlined the Partnership Council's primary responsibility as supporting the Lead Organization in developing and implementing strategies to achieve integrated care coordination and case management across CCS for the InCK Model population.

[AHHN] has been very intentional in allowing those that are working in the community with expertise to lead and direct and guide the different aspects of [InCK Model design].

- AHHN Partnership Council Member

Finding 4.1 During the Pre-implementation Period, All ARs Established Partnership Councils.

To meet CMS's requirements for the types of organizations that must participate in Partnership Councils, ARs recruited members who represented a broad array of organizations and agencies, including hospitals, community-based health care providers, social service providers, managed care organizations, departments of education, city and state agencies, child welfare organizations, health information exchanges, and family representatives. Partnership Councils included large numbers of organizations (in one AR—BE-InCK NY—over 100 organizations contributed to the Partnership Council).

All ARs reported establishing relationships with Partnership Council members. Partnership Council members remained engaged despite challenges related to the PHE, including a pivot to virtual meetings and competing priorities. For NC InCK and OH InCK, meeting virtually actually made it easier to convene all the different members of the Partnership Council. CT InCK Embrace New Haven expressed that virtual trainings were less impactful than in-person but still felt they were making progress.

ARs developed processes and procedures to encourage active involvement in Council activities. All ARs created workgroups and committees within their Partnership Councils to

> *I think the level of engagement, especially considering all the COVID challenges and resources, the demands on resources, limitation of resources, everybody having to wear multiple hats to cover different responsibilities…I have been so excited, happy, impressed with what we've been able to do on the Partnership Council side of things. I think that's definitely one of our biggest successes.*
>
> - BE-InCK NY Lead Organization

engage individual members in their specific areas of expertise. Members of three Partnership Councils (AHHN, BE-InCK, and NC InCK) reported this structure was an effective way to leverage expertise and focus more deeply on various aspects of the InCK Model to inform model design.

ARs Used Partnership Council Workgroups to Facilitate Involvement

✓ BE-InCK NY's Partnership Council membership is segmented into four workgroups (Primary Care and Complex Health Care Integration, Behavioral Health and Developmental Disabilities, Out-of-Home Placement, and Data Sharing and Information Technology). Within the workgroups, small interest groups focus on specific issues, such as sickle cell disease and maternal health. The workgroups typically meet two to three times per quarter to discuss key issues or elements of the BE-InCK NY Model.

✓ OH InCK developed Partnership Council subcommittees focused on data governance structure to inform data sharing, ensure compliance with privacy laws, and prepare draft data sharing agreements. Other subcommittees (clinical care, education, and family youth advisory committees) started the creation of model practice workflows.

✓ CT InCK Embrace New Haven's Partnership Council included three design groups focused on 1) the needs conversation, 2) service integration, and 3) the APM. CT InCK Embrace New Haven Leadership reported that design groups have provided critical feedback on key model elements.

Finding 4.2   Partnership Council Activities Were Primarily Administrative During the Pre-implementation Period.

ARs focused on design and planning during the pre-implementation period. Therefore, ARs engaged Partnership Council members for the administrative support related to design, planning, and training activities. Most planned to rely more heavily on Partnership Council member organizations for screening, care coordination, and data sharing during the implementation period. Partnership Council members in three ARs (AHHN, BE InCK-NY, and OH InCK) anticipated they would have a larger role in implementing the model when ARs started to provide services. AHHN respondents noted the Partnership Council work primarily involved the management staff from their organization and expected that beneficiary-facing engagement would increase during implementation.

ARs Engaged Partnership Councils to Facilitate Understanding and Processes

✓ Providers participating in the BE-InCK NY Partnership Council noted that they were intimately involved in pre-implementation planning. Partnership Council agencies reported educating providers at their organizations about the InCK Model and related programs and services in the Bronx through "lunch and learn" sessions, webinars, grand rounds, and dissemination of resources and tools received through involvement in the Council.

✓ NJ InCK Partnership Council members were actively involved in shaping business associate agreements and data use agreements (DUAs) both during and outside of regular Partnership Council meetings.

Finding 4.3   Many Partnership Council Members Had Longstanding Relationships with One Another or Had Collaborated on Prior Projects.

Pre-existing relationships positioned ARs well in terms of creating Partnership Councils that represented the providers, CCS, health systems, and other community stakeholders interacting with the InCK Model population. Strong existing collaboration on prior innovation and care transformation efforts and a shared commitment to improving care for children and families in the ARs' InCK Model regions contributed to productive partnerships, which may enhance the impact of the local models.

Finding 4.4   Even with Many Previous or Existing Relationships, Partnership Council Members of Some ARs Learned Further Details about Local Healthcare and CCS Systems through Their Membership.

Members of the BE-InCK NY and OH InCK Partnership Councils shared anecdotes about making personal connections at other organizations with which they were already familiar, establishing or refining communication channels between organizations and agencies, and learning about local services they did not know about despite extensive experience working in the local community.

4.5 Some ARs Successfully included Beneficiaries and Their Families in Partnership Councils, While Others Worked toward Doing So.

ARs and Partnership Council members recognized they still had work to do to meaningfully engage beneficiaries and families. They acknowledged the importance of involving and engaging the local community in implementation efforts, so the ARs' interventions best meet the needs of the communities they serve.

Four AR Partnership Councils (BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK) began engaging beneficiaries and families during the pre-implementation period

I really learned a lot and thought it was a great experience with the Partnership Council and all the different counties that came together, not just the physical and behavioral health providers and care coordinators... [but also] school-based providers and others. They wanted to understand how the elaborate system of care works and where the point of accountability for each child was. It was really great to see that start to get teased out.

- OH InCK Partnership Council Member

through ad hoc meetings, community outreach sessions, and focus groups. For example, BE-InCK NY and NC InCK beneficiaries and families provided feedback on educational and promotional materials and key activities, helped identify the most prevalent needs within the community, and reviewed tools and templates.

Despite efforts to engage patients, families, and community members, other ARs (AHHN, OH InCK, and Village InCK) had extremely limited engagement with these groups during the pre-implementation period. These ARs were still working to determine the best methods to engage families. OR InCK did not engage beneficiaries or families before withdrawing from the model.

ARs Created Opportunities for Child, Youth, and Parent Participation in Partnership Councils

✓ CT InCK Embrace New Haven sought family input on the needs assessment screening tool.

✓ NC InCK developed an action plan template centered around beneficiary/family goals. Partnership Council members and the Family Advisory group reviewed drafts to ensure that the template is simple, accessible, and elevates the family voice.

FINDING 5: THE COVID PHE EXACERBATED THE DEMANDS ON HEALTH CARE AND CCS SYSTEMS AND WORKFORCE, WHICH LIMITED THE ATTENTION AVAILABLE TO CONTRIBUTE TO THE INCK MODEL PLANNING ACTIVITIES.

The COVID-19 PHE impacted all ARs during the pre-implementation period. Communities and individuals experienced increases in health care and CCS needs and utilization, and telehealth service use increased dramatically, becoming available for the first time in many practices. Hiring freezes, labor shortages, and restrictions on in-person gatherings also necessitated modifications to planned activities and processes during the pre-implementation period.

Parents were afraid to bring babies out [during the COVID-19 PHE] so, right now I'm spending a lot of time catching kids up.

- Provider in AHHN region

Finding 5.1   The PHE Overburdened the Already Strained Workforce and Intensified Staffing Shortages. The PHE Exacerbated Needs for Physical Health, Behavioral Health, and Social Services.

During the first wave of the PHE, many families delayed preventive care, either because of reduced provider capacity to see patients or fear of exposing themselves, their children, or others in their household to the COVID-19 virus. Missed well-child visits and vaccinations created a backlog that subsequently strained pediatricians later in 2021 (**Exhibits 4.1 and 4.2**).

Exhibit 4.1.   Trends in Well-care Visits (age 3 to 21) in the AHHN, CT InCK Embrace New Haven, NC InCK, and Village InCK Regions (2017-2021)
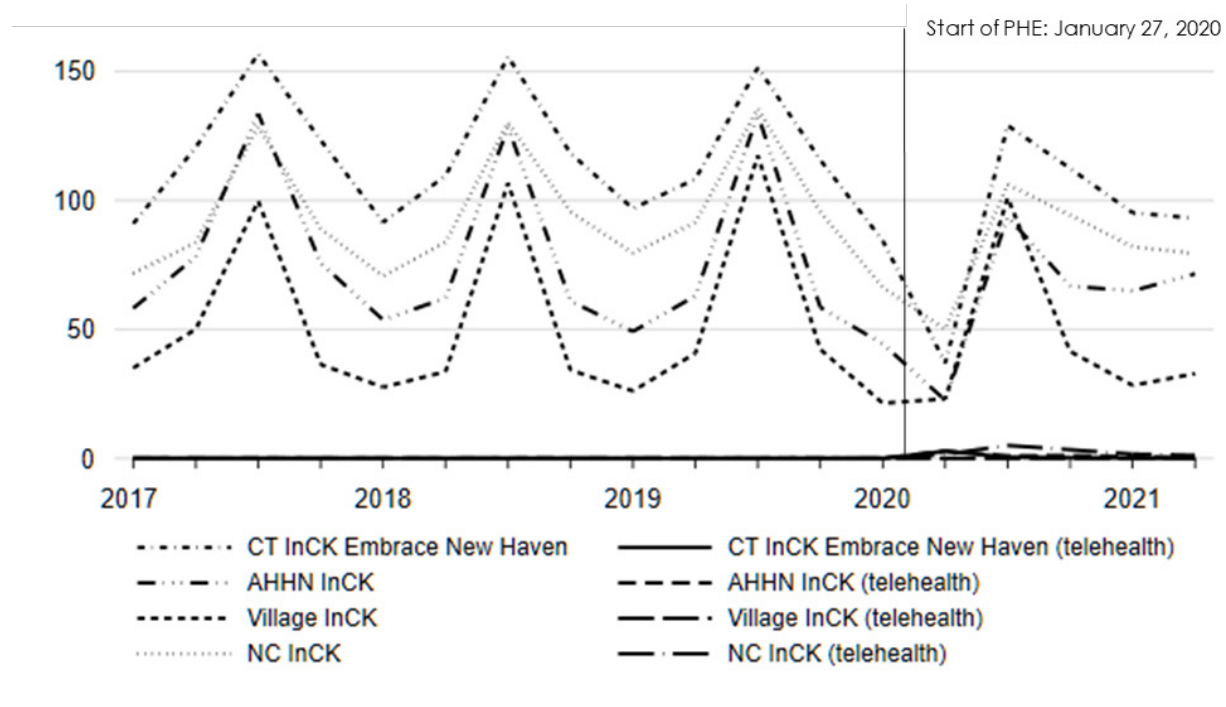
Exhibit 4.2.   Trends in Well-care Visits (age 3 to 21) in the BE-InCK NY, NJ InCK, OH InCK, and OR InCK Regions (2017-2021)
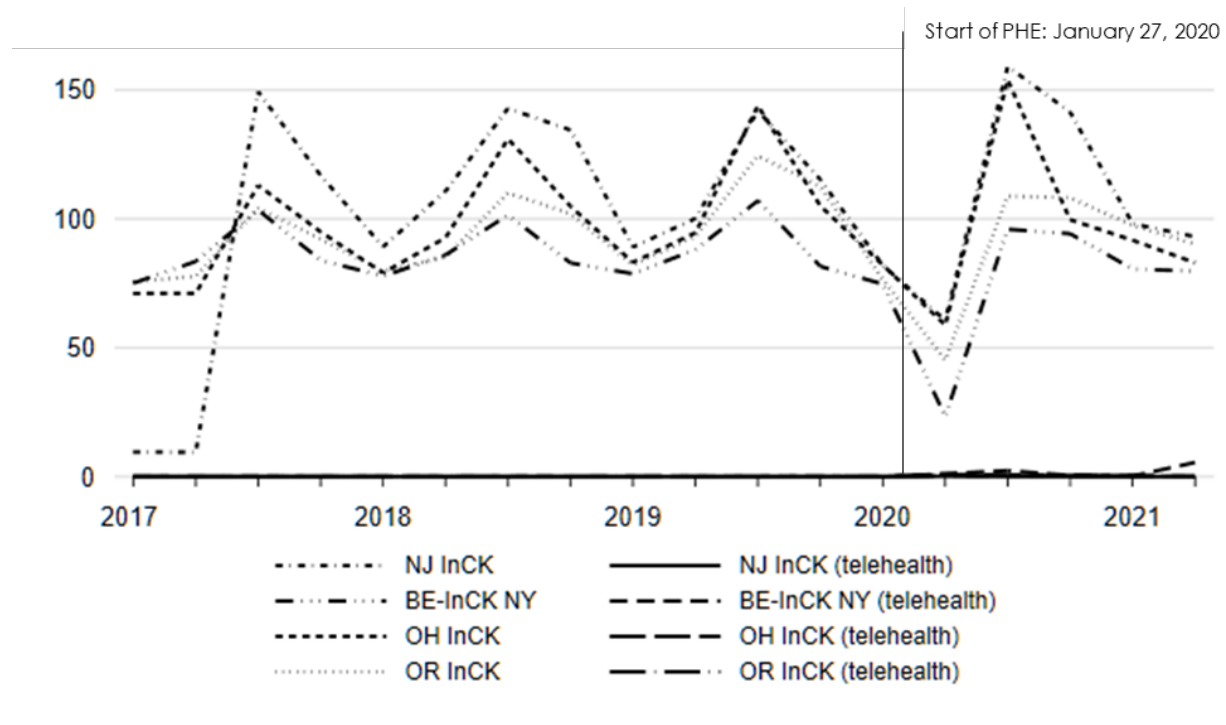
The PHE particularly increased need for behavioral health services across all InCK programs. Caregivers and providers across ARs reported a limited supply of behavioral health providers, particularly those that accept Medicaid. Access to behavioral health services was a challenge before the PHE, and the increased demand exacerbated shortages. Increased demand led to some pediatricians providing services beyond their typical areas of practice, families going to the emergency department to circumvent waitlists, or needs simply being unmet. While most ARs (AHHN, BE-InCK NY, NJ InCK, OH InCK, and Village InCK) described increased prevalence of anxiety, depression, and substance use in their InCK Model population, other ARs noted increased trauma related to PHE-related deaths (deaths directly caused by COVID or increased substance use related deaths).

I think that COVID highlighted some of the issues we weren't adequately addressing, like food insecurity. [There was] probably a lot before and we just weren't asking the question. I think we were more aware of some of our shortcomings during COVID.

- Pediatrician in BE-InCK NY region

In addition to impacting health care and behavioral health, the PHE increased CCS needs across ARs. Providers in the AR regions struggled to address increased poverty, food insecurity, and housing instability related to the PHE. School closures meant that children did not receive services through schools, such as meals. With fewer eyes on children, CCS providers across ARs suspected that abuse, neglect, and domestic violence went undetected, which national reports confirmed.[34]

Many families could no longer access early intervention services, which meant that children missed critical supportive services, such as physical, occupational, and speech therapy. Across ARs, CCS providers were concerned that they have yet to see the full effect of the PHE on the children they serve. Some ARs reallocated resources to address these emergent needs, such as to COVID-19 support services, transportation activities, and other social services.

Communities Encountered Increased Behavioral Health Needs During the PHE

✓ AHHN reported demand for behavioral health services "skyrocketed" since March 2020, with long waitlists. Providers reported 1,500 children were on the waitlist for behavioral health services in April 2021, and little had changed by December 2021.

✓ A behavioral health provider in NC noted that demand for services in summer 2020 was nearly three times as high as it had been the previous year. Increased demand for behavioral health services remained high throughout 2020 and 2021.

✓ In NY, wait times for outpatient mental health services were over a month in some community-based settings in fall 2021.

As part of the epicenter of the emerging PHE in spring 2020, the BE-InCK NY region was hit particularly hard, because so little was yet known about preventing and treating COVID-19. Hundreds of Bronx children lost a parent or caretaker to COVID-19, placing them at risk of entry into foster care or kinship care. BE-InCK NY leadership also noted significant increases in domestic violence, intimate partner violence, child abuse, and gun violence and crime. They reported that the Bronx emerged as the area with the highest crime rate in New York City in 2021. BE-InCK NY established a modest transportation fund to support families seeking care during the PHE. They also used InCK Model funding to launch the Healthy Moms pilot, provide support for implementation of the HealthySteps model at Jacobi and North Central Bronx sites, and enhance the NowPow referral platform[35] to include a BE-InCK NY preferred provider network and a list of COVID-19 support services.

> *I definitely know that because of the program I work in, the mental health of some of our youth is heightened and has been heightened…I think as the pandemic has gone on, it's definitely impacted kids. The good part is that mobile crisis has been out there since day 1. We did not stop going to see people. The call volume definitely changed. People weren't calling as often. Part of it was because they didn't want us in their homes. They didn't want any strangers coming out, even though the youth was in crisis. I think families utilized call services less because of the pandemic.*
>
> - Behavioral health provider in CT InCK Embrace New Haven region

Finding 5.2   Telehealth Facilitated Access to Needed Services and Mitigated Some Barriers to Attending Appointments, Such as Transportation and Childcare.

All ARs saw an increase in telehealth and virtual services (e.g., behavioral health, school) in response to the PHE (**Exhibits 4.3 and 4.4**), and telehealth services provided by physicians increased substantially after March 2020. Telehealth services related to behavioral health comprised the majority of visits.

Exhibit 4.3.   Trends in Use of Telehealth in the AHHN, CT InCK Embrace New Haven, NC InCK, and Village InCK Regions (2017-2021)
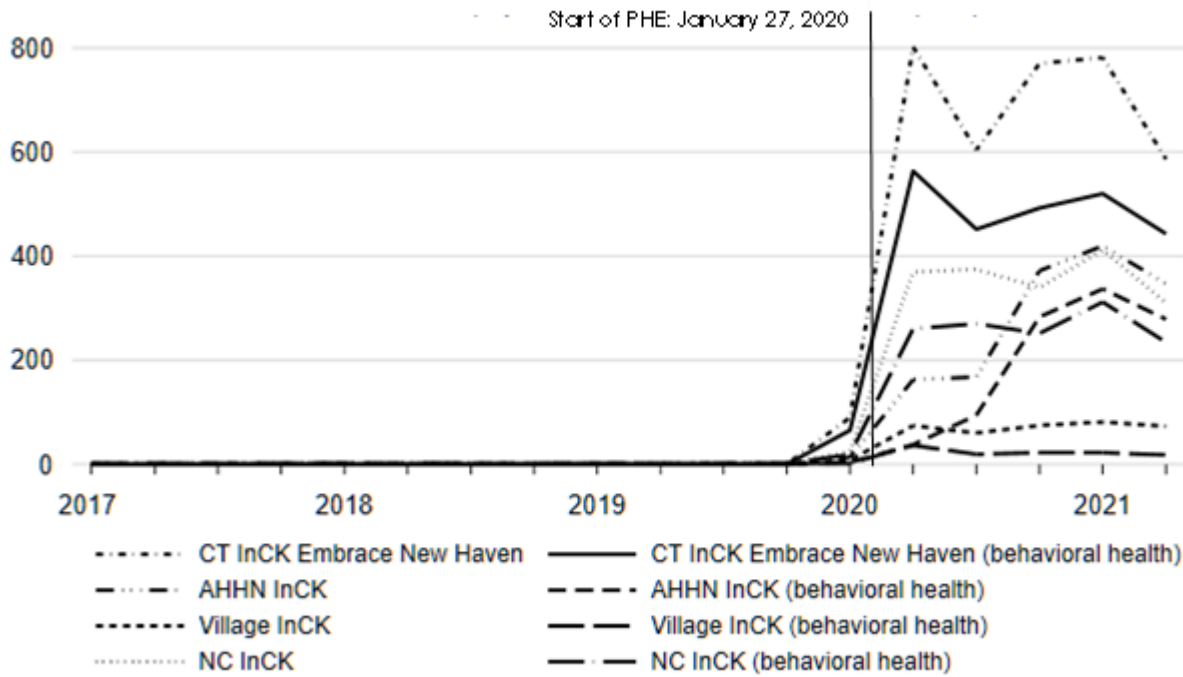
Exhibit 4.4.   Trends in Use of Telehealth in the BE-InCK NY, NJ InCK, OH InCK, and OR InCK Regions (2017-2021)
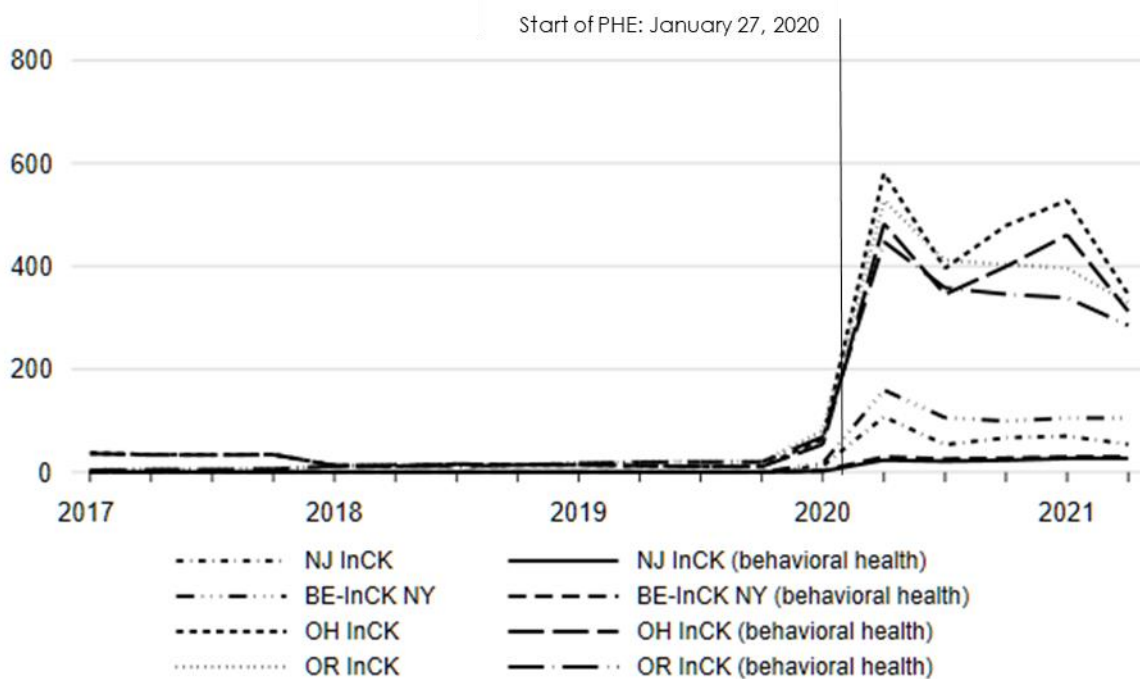
The transition to virtual services was challenging for both providers and families. Many ARs reported mixed success with equitably engaging all children and families, which was also differentially successful by service type (e.g., behavioral health) and for specific populations. Providers noted that telehealth worked well for some visit types (e.g., medication management, behavioral health) and was better than not seeing a patient at all. Some types of visits were not feasible to conduct through telehealth, such as vaccinations, physical exams, or behavioral health services with very young children. Behavioral health and CCS providers across ARs (BE-InCK NY, NC InCK, NJ InCK, OH InCK, and Village InCK) described how virtual visits could be difficult when there were several children in the home, the child or caregiver did not have a private space for the visit, or families were uncomfortable showing the inside of their home.

> *In some respects [the transition to virtual care] has been helpful because we haven't had to take the kids of out of school or have to deal with taking them to an appointment. But some services can't be replicated like therapy and it can be difficult [to do therapy via telehealth] when they've already been on a screen all day.*
>
> - Caregiver in NC InCK region

Some families reported that virtual visits made it easier to keep appointments, as they no longer needed to drive long distances or take their child out of school. However, caregivers of young children or children with more complex needs found the virtual care transition especially challenging. For example, one caregiver from the Village InCK region shared that their eight-year-old child with attention-deficit/hyperactivity disorder often struggled to sit in front of a computer for the length of an appointment. One caregiver in North Carolina reported that her school-aged child with autism was placed in the same virtual schooling program as other children, with no provisions for his educational needs.

Unreliable or nonexistent internet access; a lack of, or limited, web-enabled devices in the home; and challenges with computer literacy prevented many families from accessing virtual care. Village InCK attempted to address lack of internet access by providing phones to families who needed telehealth services but did not have internet access at home. The phone/internet card typically lasted 90 days, after which patients could be reevaluated and given an additional 90-day phone/internet card. However, not all families participated in the reevaluation and would discard the phones, because they could not afford to purchase phone minutes on their own.

> *The internet access issue is also a structural issue, right? It's not just because I, as an individual home renter, can't afford high-speed internet. It's that Verizon doesn't put that availability in certain neighborhoods. And so, it totally is structural racism.*
>
> - BE-InCK NY Partnership Council Member

The PHE overburdened the medical care, CCS, and AR workforce and created staffing shortages. All ARs experienced reduced provider capacity as staff left the field (because of layoffs or burnout) or were redeployed to care for patients with COVID-19 and support vaccine rollout. Across ARs, providers — particularly, CCS providers— reported they were overburdened by high demand and staff shortages resulting from the PHE. Staff turnover and staffing shortages disrupted continuity of care and impeded the ability for children and families to build long-term relationships and trust with providers.

Since the lockdown ended, there were a lot of providers who decided they didn't want to do this work anymore. So, there was a big dip in the number of providers left in the field – and that has been challenging.

- Behavioral health provider in NJ InCK region

Early in the PHE and across ARs, families delayed regular care or services. As the PHE continued, delayed care created a significant backlog of well-child visits, immunizations, and other preventive care, along with the sick-child visits for the flu, sore throats, hurt limbs, and other common services.

Finding 5.3   Some Lead Organizations Struggled with the Demands of the PHE, Which Impacted Their Bandwidth to Work on InCK Model implementation During the Pre-Implementation Period.

Several ARs (CT InCK Embrace New Haven, NC InCK, OH InCK, OR InCK, and Village InCK) described the challenge of maintaining focus on the InCK Model as the pre-implementation period coincided with the PHE.

Lead Organizations Faced Challenges and Changes Resulting from the PHE

- ✓ As the local public health department, EHD juggled multiple responsibilities during the PHE as they maintained care for patients and facilitated vaccine rollout.

- ✓ In OH, the PHE brought about statewide hiring freezes and limited staff resources that eventually necessitated transfer of the award from the OH Department of Medicaid to Nationwide Children's Hospital (NCH). The transition to NCH created a delay of almost one year in planning and implementation design. NCH accelerated the planning processes to recover lost time.
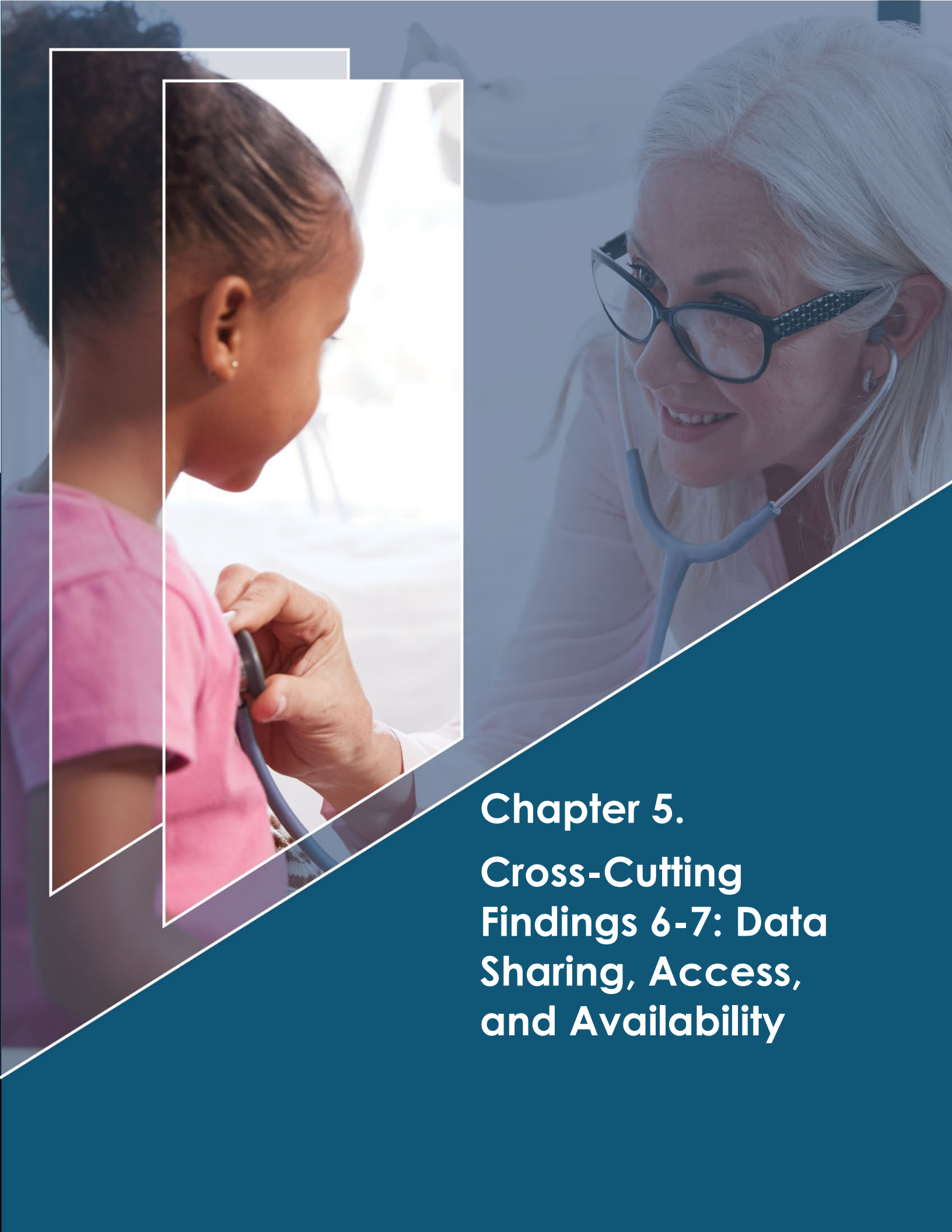
Chapter 5.

Cross-Cutting Findings 6-7: Data Sharing, Access, and Availability

5. Cross-Cutting Findings 6-7: Data Sharing, Access, and Availability

The Integrated Care for Kids (InCK) Model notice of funding opportunity (NOFO) defined expectations and requirements related to Medicaid, Core Child Services (CCS), and other data. Accessing and sharing the data has been more complex and time-consuming than either ARs or CMS anticipated. CMS and the ARs invested significant resources to understand data availability, facilitate and obtain access, and share data across organizations, as described in two cross-cutting findings (Cross-Cutting Findings 6-7) discussed in **Chapter 5**.

Cross-Cutting Findings

6. ARs navigated complex legal and regulatory environments as they worked to establish data sharing processes and agreements with CCS organizations.

7. Most ARs developed new data platforms to share information to support service integration.

FINDING 6: ARs NAVIGATED COMPLEX LEGAL AND REGULATORY ENVIRONMENTS AS THEY WORKED TO ESTABLISH DATA SHARING PROCESSES AND AGREEMENTS WITH CCS ORGANIZATIONS.

Finding 6.1   Legal Restrictions, Siloed Business Processes, Time Constraints, and Incompatible Data Platforms among State Agencies Were All Data Sharing Barriers.

ARs struggled to establish DUAs with the state agencies that manage CCS data. The challenges most often cited were legal barriers to share data and staff bandwidth issues related to the COVID-19 public health emergency (PHE). Lead Organization staff at AHHN, BE-InCK NY, and Village InCK reported that program staff at the state CCS agencies supported data sharing for InCK Model purposes and were even excited about the model; however, lawyers at those agencies reported that statutory regulations made sharing individual-level, identifiable data difficult and sometimes impossible.

> *The sharing of identifiable data has been the biggest pain point. It seemed like [other state agencies] were okay with the data sharing to inform stratification but not to share beyond the agency that was responsible for producing the stratification.*
>
> -   NC InCK Lead Organization

For many ARs (Bronx Equity InCK New York (BE-InCK NY), North Carolina (NC) InCK, Ohio (OH) InCK, Oregon (OR) InCK, and Village InCK), state CCS agencies could share data with the state Medicaid agency for the purposes of implementing the model. However, many agencies cited concerns about sharing individually identifiable data that would be submitted to CMS. Two ARs (NC InCK and OH InCK) had the most success negotiating with partners by the end of the pre-implementation period.

Two ARs (All Hands Health Network (AHHN) and Village InCK)—both care delivery organizations—faced their own internal challenges finalizing DUAs with state Medicaid agencies to obtain regular access to claims, enrollment, and demographic files.

Several ARs (BE-InCK NY, NJ InCK, OH InCK, and Village InCK) reported CCS organizations and other state CCS agencies raised the most concerns about data for behavioral health, substance use, and child welfare. A few ARs (OH InCK and Village InCK) raised concerns about what type of behavioral health and substance use data could be shared with whom without violating any laws or privacy regulations (such as 42 CFR Part 2). Similarly, BE-InCK NY and NJ InCK reported that establishing data sharing agreements with child welfare agencies was particularly challenging, and their respective agencies might not be able to share identifiable data at all.

> *So, there's the ability to share it with us and then also the questions of [whether we can] share it with CMS. This is not data – data about child abuse, physical abuse, that they share with anyone. It's not data that they share period.*
>
> -   BE-InCK NY Lead Organization

ARs Faced Difficulties Establishing DUAs

✓ AHHN reported that it took them over a year to finalize the DUA with Illinois Medicaid. The primary challenge was aligning the regulations applicable to AHHN with the regulations applicable to Illinois Medicaid. AHHN described that as a children's hospital, data use is governed by HIPPA regulations, but Illinois Medicaid has different regulations as a steward of federal data.

✓ Village InCK reported that, as neither a state entity nor a payor for healthcare services, they were not sure how to start conversations about data sharing with key partners and state agencies.

✓ Under New Jersey's "home rule" structure, municipalities run school districts and public health departments, while counties operate child welfare services. Decentralized services create additional data sharing challenges for NJ InCK leaders, who must establish DUAs with multiple local agencies rather than a single state government department.

Finding 6.2 *While Many Health Providers Regularly Conduct Health-related Social Needs Screening, Information is Disjointed and Not Systematically Shared with All the Providers.*

ARs reported that many organizations regularly screen Medicaid beneficiaries for a broad range of needs and health-related issues using evidence-based screening tools to assess medical needs, including behavioral health and social needs. Typically, these screenings occur during in-person office visits. BE-InCK NY described trying to transition to conducting screenings electronically ahead of visits, a process met with mixed success. While many organizations provide services to these families, few mechanisms exist to share information. Thus, providers continue to rely on families to self-report needs and receipt of services, meaning families must repeat the same information in multiple settings. If caregivers are not engaged, not communicative, or reluctant to ask for help, providers may be unaware of the family's needs.

> *I have very little information about the patient before they enter the room. Sometimes the social worker here at the school will have some information, but generally very little. And the parents, usually, like I said, are not fully engaged, so I am running on very little at times.*
>
> — Behavioral health provider in the OH InCK region

Across ARs, behavioral health providers reported they typically have little information about a patient's other health or social needs. Likewise, physical health providers do not know about services their patients may be receiving from other providers or organizations. For example, one adolescent health provider in the NC InCK region reported the only way he knows if a patient is receiving behavioral health services through school is if the patient tells him.

Finding 6.3   The COVID-19 PHE Impacted the Bandwidth of Staff at Most State Agencies with CCS Data.

As a result of resource limitations and staff focused on PHE, DUA review times often took longer than anticipated. Some agencies reported general limits on internal bandwidth as a barrier to engaging in this effort. State education agencies particularly lacked sufficient resources to develop DUAs and share data during the ongoing PHE. Connecticut (CT) InCK Embrace New Haven and NC InCK reported engaging education departments was not possible during the 2020-2021 school year when schools had to pivot to remote learning. Similarly, AHHN described that it took even longer than anticipated to established DUAs with key partners in the Illinois Medicaid office during the COVID-19 PHE. They described that Illinois Medicaid was "completely overwhelmed due to COVID."

> *I mean COVID all around and I'll list multiple reasons. I think one, it has been more challenging for us to do this work…because we've had to build these relationships virtually, which is harder. I think, maybe equally as big, is every Core Child Service sector that we are working with has been so overburdened and at this point is, frankly, burnt out. And so, we are working hard to not be just another thing that they are being asked to do…I mean we are in a workforce crisis, in every Core Child Service area.*
>
> -   NC InCK Lead Organization

Finding 6.4   Representatives of Appropriate State Agencies Were on Partnership Councils, but Their Involvement Did Not Facilitate Establishing DUAs in the Way CMS Had Anticipated.

In the NOFO, CMS provided guidance on the types of CCS providers that should be included on the Partnership Council. The intent was that this type of engagement in local model planning and implementation would facilitate establishing data-sharing agreements and information sharing more broadly. Some ARs established subcommittees focused on data sharing within the Partnership Council. Subcommittees may have helped start the conversation and obtain buy-in about participating in the InCK Model from other state agencies, but it did not necessarily facilitate the signing of DUAs or other commitments to data sharing. Most barriers to data sharing were statutory rather than a lack of interest in collaboration.

Finding 6.5   ARs Sought Substantial Guidance from CMS and Its Contractors on How to Access Medicaid and CCS Data.

ARs requested that CMS facilitate receipt of data from federal agencies responsible for CCS data, for example, the U.S. Administration for Children and Families. However, limitations related to measures, identifiers, and timelines did not allow for this facilitation. Some ARs (NC InCK and OR InCK) reported that the state agencies may have been able to submit data needed to fulfill CMS reporting requirements directly to CMS more easily (compared to first submitting data to the AR and then having the AR submit the data to CMS).

ARs Sought Guidance on Data Access from CMS

✓ The Department of Public Safety (NC's Justice Department) made a request to enter into a DUA directly with CMS instead of with NC InCK.

✓ OH InCK ran into difficulties when state agencies raised concerns about sharing data about behavioral health and substance use treatment. It was not clear to either OH InCK or the state agencies whether restrictions for data covering behavioral health and substance use treatment would apply to the InCK Model. This meant that they were unclear whether it was appropriate to share the data. OH InCK asked the InCK Model Implementation and Monitoring (I&M) contractor for technical assistance about the privacy standards for behavioral health and substance use data. They asked for this assistance so that the I&M contractor could help them discuss the issue with internal lawyers and with other entities.

In response to ARs' concerns and feedback regarding delays and challenges during the course of the pre-implementation period, CMS and its support contractors provided additional mechanisms for technical support, further clarified or relaxed the requirements, and delayed timelines for meeting milestones. ARs reported that the accommodations created additional challenges, including complicating negotiations with state agencies.

> *The moving target in terms of what was going to be acceptable, and what's not, what is going to be part of the requirements, made it so that we can't really feel solid in terms of what we are messaging to the Partnership Council.*
>
> - BE-InCK Lead Organization

Finding 6.6   ARs Primarily Focused Data Sharing Activities to Support Reporting Requirements; Only a Few Also Planned to Use CCS Data to Inform SIL Stratification.

Throughout the pre-implementation period, negotiations about DUAs to share CCS data primarily focused on the need to meet the InCK Model reporting requirements, as described in the NOFO. Either because it was their original plan or because DUAs were too difficult to obtain, only three ARs (CT InCK Embrace New Haven, NC InCK, and OH InCK) plan to use CCS data in SIL stratification (**Chapter 2, Exhibit 2.2**). As of the end of the pre-implementation period, NC InCK successfully established data sharing agreements with the state Departments of Education and Justice to facilitate SIL stratification. Similarly, OH InCK successfully established data sharing with the Ohio Department of Jobs and Families for the purposes of SIL stratification. They plan to include data from the Department of Mental Health and Addiction Services and the Department of Education, but the process for establishing data sharing agreements with those two agencies is taking longer.

FINDING 7: MOST ARS DEVELOPED NEW DATA PLATFORMS TO SHARE DATA TO SUPPORT SERVICE INTEGRATION.

ARs planned to use existing or newly created data systems for service integration coordinators (SICs) to track their work; store care plans; and facilitate information sharing between CCS providers, SICs, physical and behavioral health providers, and patients and families/caregivers. Across ARs, both providers and caregivers described lack of information sharing across providers as a challenge. Providers often rely on patients to self-report the clinical or social services they access. Caregivers described frustration in having to tell their stories "over and over." Despite having data sharing systems in place and pre-existing closed loop referrals systems, physical and behavioral health, and social service providers across ARs described having little awareness of services that patients may receive in other settings. Information that providers did obtain often came through informal channels, such as relationships with other providers (see Finding 2).

> *The nature of the system is that it is intended to support robust case management type services…it's not a medical record…the concept we have built it around is to be a mesh point. It's the mesh point between imported data from state agency sources, and the data documented by end users. …to enable partners to be able to access and see a shared beneficiary at the record level.*
>
> - OH InCK Lead Organization

Improved information sharing across providers, SICs, and families is a core element of the planned approach to service integration for most ARs. ARs plan to use a combination of existing data-sharing infrastructure and newly developed or expanded virtual platforms to share information, such as SIL stratification assignments and care plans. Many ARs (AHHN, BE-InCK NY, NC InCK, OH InCK, and OR INCK) had data sharing infrastructure that predated the InCK Model. Despite the existing data sharing capacity, health and CCS providers in these states still identified substantial challenges to sharing and accessing beneficiaries' information across systems.

Many of the ARs (BE-InCK NY, NC InCK, OH InCK, and OR InCK) also already had closed loop systems to track referrals and follow-up on those referrals in place. Some ARs (AHHN, BE-InCK NY, CT InCK Embrace New Haven, OR InCK, and Village InCK) are using a common vendor, NowPow (Unite Us). Only NJ InCK planned to build their own system without relying on a vendor. ARs that have systems in place reported that use of these systems at the end of the pre-implementation period was low or mixed.

Data-sharing Infrastructure Pre-dated the InCK Model

✓ Providers at Duke and UNC, the two largest pediatric providers in the NC InCK region, can access information about physical and behavioral health care their patients have received through either organization.

✓ In AHHN, Lurie (a specialty care children's hospital) allows community-based providers and local federally qualified health centers access to their electronic medical records to facilitate information sharing.

✓ The Bronx, where BE-InCK NY is located, has a robust regional health information exchange (Bronx Regional Health Information Organization). Some providers in the area regularly use the Bronx Regional Health Information Organization to share clinical information with one another, but gaps in information sharing persist.

Developing the new virtual platforms and integrating them into existing workflows and information sharing processes took significant effort in the pre-implementation period. For some ARs (AHHN, BE-InCK NY, CT InCK Embrace New Haven, and Village InCK), delays in procuring a vendor to develop these platforms, managing that vendor, and then making sure the vendor can produce a tool with the functionality originally promised was a significant challenge.

For some ARs, procurement took longer than anticipated and design work was slow, as their planned approach evolved over the course of the pre-implementation period. Toward the end of 2021, two of the common vendors—Unite Us and NowPow—merged. ARs reported that staff turnover and other changes resulting from the merger led to further delays. CT InCK Embrace New Haven initially planned to use Unite Us but decided to move forward with a different vendor for some activities after difficulties executing their planned approach.

Finally, late in 2021, some ARs raised concerns that these virtual platforms would not have the robust functionality that vendors originally promised. At the end of the pre-implementation period, most of the ARs were still working to finalize these systems and integrate them into existing workflows. It remains unclear whether system functionality allows ARs to implement as planned.

ARs Identified Opportunities to Enhance Data Infrastructure

✓ OH InCK contracted with a 3rd party vendor to build a platform called Apricot 360, which will allow for a family's single point of contact to invite members of the patient's care team to share information with one another.

✓ Village InCK did not have an information exchange platform in place prior to award. Community partners believed that implementing an electronic information exchange would be a significant positive outcome of the InCK Model. One partner said that if Village InCK could implement such a system successfully, the system could be a model for community-based care coordination in other rural communities.

Chapter 6.

Evaluation Considerations for the Implementation Period

6. Evaluation Considerations for the Implementation Period

Work conducted by the evaluation team in the pre-implementation period provided critical insight into each award recipient's (AR's) approach, data availability and quality, and determined the comparison group for each AR. To provide a comprehensive and cohesive understanding of the Integrated Care for Kids (InCK) Model's implementation and impact, the evaluation team will collect and analyze data to answer five overarching research questions (RQs) during the implementation period. RQs and data collection activities build on experiences and lessons learned during the pre-implementation period, including questions raised during the pre-implementation period's case studies (discussed in **Chapter 7**).

Key Messages

1. Triangulated data, analyses, and findings from the pre-implementation period serve as the foundation of the implementation period's evaluation design, RQs (see below), and proposed analysis.
2. During the implementation period, the evaluation will use primary and secondary data to answer five primary RQs that examine the implementation and impact of the InCK Model. Data will serve multiple purposes.
3. ARs, partners, and beneficiaries and their caregivers will play a significant role in the evaluation's activities.

6.1   IMPLEMENTATION PERIOD'S RESEARCH QUESTIONS

We will answer these questions for each AR and collectively across ARs. Across the RQs, we will examine the influence of social, historical, geographical, and other contextual factors unique to the intended populations and local delivery systems and the extent the model was responsive to the needs, concerns, or priorities of communities facing inequities.

1. **How was the InCK Model implemented by each AR?**

The evaluation will determine how ARs implemented the model within their local contexts, design and sustainability of the Alternative Payment Models (APMs), alignment with other state Medicaid initiatives and other local programs, and how ARs adapted to the changing needs of the target population.

2. **How has the InCK Model, as implemented by each AR, affected children and families in four areas: navigation and coordination, utilization and expenditures, quality of care, and beneficiary and caregiver experience of care?**

The evaluation will examine the influence of the model on how children and their caregivers access care, which factors contribute to integrated case management, navigation and coordination of care; the impact of the model on use of healthcare services, Core Child Services (CCS), and on out-of-home placement; and the role of the state APM on costs.

3. **To what extent did service changes or disruptions (e.g., transitioning between service integration levels (SILs), lapses in coverage or eligibility, delays in services, discontinuation of care) occur in the InCK Model and what impact did it have on care delivery by each AR?**

The evaluation will assess how ARs transition beneficiaries in and out of model enrollment (i.e., in and out of Medicaid or reaching age 21) to and between SILs. The evaluation will also consider the COVID-19 public health emergency's (PHE) effects on trends in healthcare delivery and the utilization of CCS.

4. **What is the return on investment of the InCK Model by each AR, including the influence of the alternative payment model?**

The evaluation will analyze investments ARs, partners, and providers made to support implementation on provider behavior and quality of care; cost-effectiveness of the model for a similar comparison group; and if the achievement of cost-savings is greater than CMS's InCK Model investment.

5. **To what extent do the effects of the InCK Model vary?**

The evaluation will assess differences in impact by state, AR, beneficiary subgroups (e.g., age, diagnoses, SIL assignment), and equity subgroups (e.g., racial-ethnic groups, religious minorities, sexual orientation and gender identity (SOGI) minorities, people with disabilities, rural residents).

The evaluation team and CMS will continue to refine the evaluation's approach as the ARs' models and programmatic activities shift and respond to policy changes, partner activities, and beneficiaries' needs. Through answering the InCK Model evaluation's RQs, we aim to achieve the following:

- The unmet health and social service needs of children, youth, and pregnant people in InCK Model AR attributed regions;

- Delivery and finance system innovations that can better meet youths' and families' needs; and

- The impact of state- and sub-state factors, such as existing health care delivery systems and infrastructure, and policy and financing.

6.2   REPORTING INCK MODEL RESEARCH QUESTIONS

Throughout InCK Model implementation, the evaluation team will produce communication materials that include case study briefs; special study analyses; memoranda, other reports for CMS; and public-facing materials, such as reports, manuscripts, and presentations. **Exhibit 6.1** presents our initial assessment of when we will answer the RQs and which evaluation study (Implementation and Impact) will provide data to answer each RQ. Timing of evaluation results depends on the availability of clean, complete, and accurate data.

6.3   ROLE OF ARS IN EVALUATION ACTIVITIES

ARs (that may include state Medicaid agencies), their partners, and beneficiaries and their caregivers will all contribute to the evaluation. ARs provide critical input to the accuracy, comprehensiveness, and appropriateness of the evaluation design, data, results, and findings. ARs provide service data, including enrollment, SIL, and CCS data. ARs also submit programmatic data, including reports and operational plans, to CMS and its contractors. ARs, partners, and beneficiaries and their caregivers contribute to and participate in interviews, focus groups, and site visits. State Medicaid agencies submit Transformed Medicaid Statistical Information System (T-MSIS) data.

Exhibit 6.1.   Reporting InCK Model Findings through the Evaluation Studies (2022-2028)

Research Question	2022	2023	2024	2025	2026	2027	2028
1. How was the InCK Model implemented by each award recipient?	◔	◔	◑	◑	◑	●	●
2. How has the InCK Model affected children and families?							
Navigation/ coordination	◔	◔	◑	◑	◑ ◑	● ●	● ●
Utilization/expenditure		◔	◑	◑	●	●	●
Quality of care	◔ ◔	◔ ◑	◑ ◑	◑ ◑	● ●	● ●	● ●
Beneficiary and caregiver experience of care	◔	◔	◑	◑	◑	●	●
3. What was the role of service disruption in the InCK Model?	◔ ◑	◔ ◑	◑ ◑	◑ ◑	◑ ●	● ●	● ●
4. What is the return on investment of the InCK Model?	◔ ◔	◔ ◔	◔ ◔	◔ ◔	◑ ◑	◑ ◑	● ●
5. To what extent do the effects of the InCK Model vary?	◔ ◔	◔ ◔	◑ ◑	◑ ◑	◑ ◑	● ●	● ●

Notes:

Implementation Study: ◔ = Descriptive data; ◑ = Preliminary trends; ● = Summative results

Impact Study: ◔ = Descriptive data; ◑ = Preliminary trends; ● = Impact estimates

Chapter 7.

Award Recipient Snapshots

7. Award Recipient Snapshots

Each Integrated Care for Kids (InCK) Model award recipient (AR) designed individual approaches to implement the requirements of the InCK Model based on analysis of their community context, existing resources and care, state Medicaid environment, and potential beneficiary and caregiver needs. Leadership and staff from all ARs all reported believing in the model's goals, components, and domains, but how each AR operationalized and will conduct services differs substantially.

Individual snapshots present key information for each AR, as gathered though the evaluation team's pre-implementation period activities.

- Overview of the local InCK Model

- Community context, including local context, common service gaps, available resources, and Medicaid policy context and related initiatives

- Planned approach to implement the model and progress toward implementation during the pre-implementation period

- Outstanding questions identified by the evaluation team during the evaluation's pre-implementation period's activities

Award Recipients

1. All Hands Health Network (AHHN), Illinois
2. Bronx Equity InCK New York (BE-InCK NY), New York
3. Connecticut (CT) InCK Embrace New Haven, Connecticut
4. North Carolina (NC) InCK, North Carolina
5. New Jersey (NJ) InCK, New Jersey
6. Ohio (OH) InCK, Ohio
7. Village InCK. Illinois
8. Oregon (OR) InCK, Oregon

7.1   ALL HANDS HEALTH NETWORK (AHHN)

Overview

Characteristic	Description
Lead Organization	• Ann & Robert H. Lurie Children's Hospital
Location	• Chicago, Illinois (IL)
Goals and Targets	• Expand access to quality primary care, specialty care, and behavioral health services for Medicaid-covered youth with complex health needs from birth up to age 21 • Build capacity for integrated case management
Region	• Two ZIP Codes in Chicago, IL's Cook County: 60639 and 60651, which are the neighborhoods of Belmont-Cragin and Austin (Exhibit 7.1)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 42,653
Include Pregnant Beneficiaries Aged 21+	• No
Include Children's Health Insurance Program	• No
Selected Comparison Region	• Six ZIP Codes in Chicago, IL's Cook County 60617, 60623, 60629, 60632, 60165, and 60426 in select neighborhoods (Exhibit 7.1)
Focus of AR Stratification Approach	• AHHN InCK will use a hybrid approach for service integration level (SIL) stratification based on Medicaid claims data, health needs, and risk assessment screenings. • Resource coordinators (AHHN term for the InCK Model service integration coordinators (SICs)) will serve as the single point of contact for beneficiaries and families.

Exhibit 7.1. Map of AHHN InCK and Comparison Regions
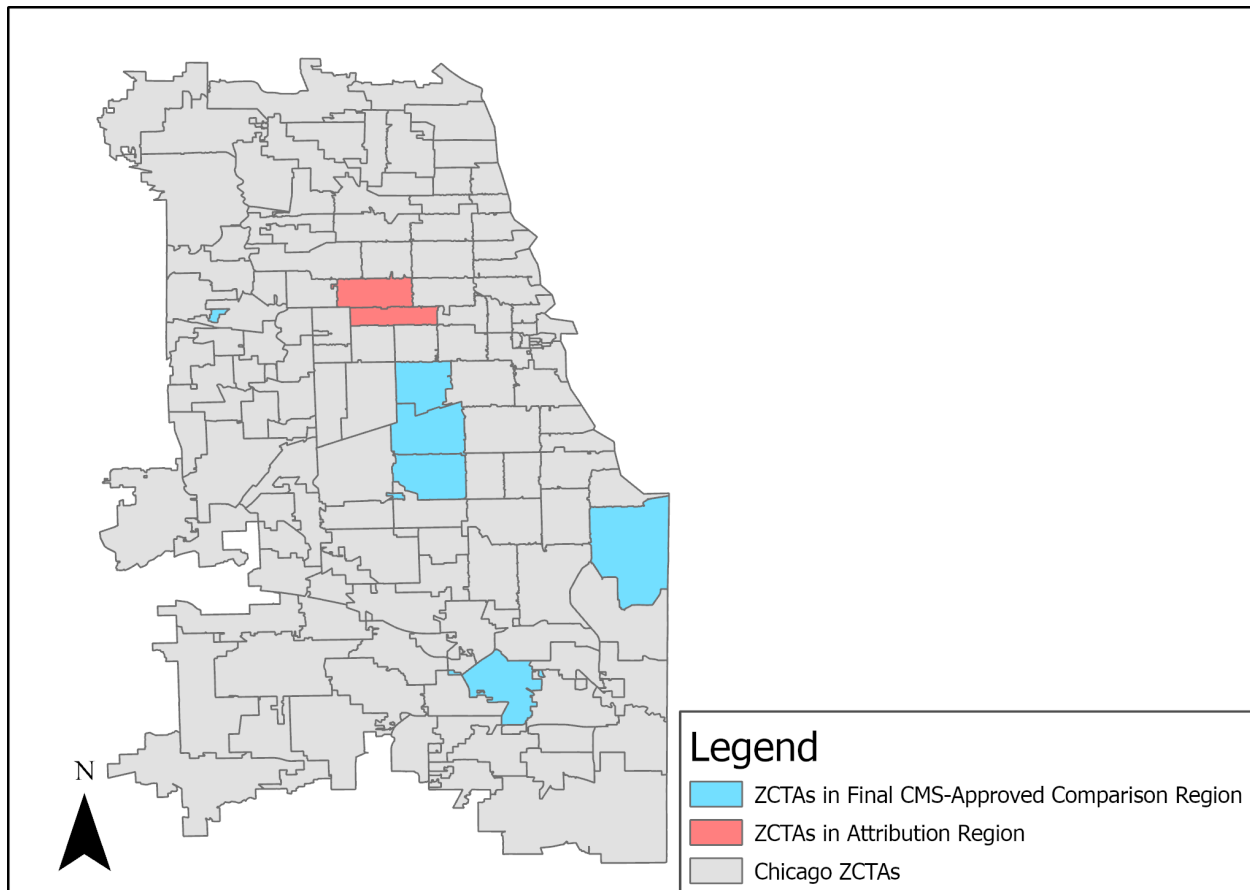
Note: ZIP Code Tabulation Areas (ZCTAs) are generalized areal representations of United States Postal Service (USPS) ZIP Code service areas.

Community Context

Local Context

Exhibit 7.2 provides demographic characteristics of the InCK Model region.

Exhibit 7.2. Demographic Characteristics of the AHHN InCK Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees[a]	
Enrollees who are Black	27.7%
Enrollees who are Hispanic	43.5%
Enrollees who are Asian American/Pacific Islander	0.7%
Enrollees who are 18-20 years old	8.6%
Characteristics for All Residents[b]	
Median household income[c]	$41,655
Residents living in a rural ZIP Code[d]	0%
Residents speaking limited English[c]	14.4%
Residents who are food insecure[e]	12.0%
Residents with some college or more[c]	37.9%
Area deprivation index[c,f]	4.45
Homeownership[g]	56.9%
Severe housing problems[h]	18.9%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

AHHN InCK staff and providers identified shared challenges to access services throughout the InCK Model region in Chicago.

1. **Access to specialty providers who accept Medicaid is limited**. Few local behavioral health providers accept Medicaid, so beneficiaries seeking treatment encounter significant delays. Occupational, speech, physical, and developmental therapies are also difficult to access. Pediatricians and other providers often refer families to Chicago Public Schools to access therapy services, which can have long wait times.

2. **Though most residents in the AHHN service area have internet access, computer literacy may be limited.** Having limited computer literacy creates barriers for setting up appointments, accessing health information, or attending virtual visits.

You need to meet people where they are at. . . We need to bring the hospital to the people, then they are using the hospital as they should. People are not using the emergency room as they should because they just don't know.

- Caregiver in AHHN region

3. **Despite ample transit options, transportation to services remains difficult.** Medicaid transportation is complicated to arrange and confined to certain geographic areas. Public transportation is available but time-consuming and inconvenient for families, particularly in bad weather.

4. Distrust of the system (including health care, government programs, childcare, and early education) is a barrier to accessing services for many families. Distrust is particularly high among families who have members without documentation of U.S. citizenship.

Resource coordinators indicated that the PHE affected local businesses and community resources. As part of the PhotoVoice activity[36], one participant shared a photo of a boarded-up building (**Exhibit 7.3**) and explained that many places that previously supported members of the local community have closed during the COVID-19 public health emergency (PHE), which could add additional challenges for local residents trying to access the services and supports they need.

Available Resources

Providers and AHHN InCK staff reported a shortage of behavioral

Exhibit 7.3. **Local Businesses Closed During the COVID-19 Public Health Emergency**

health and specialty providers who accept Medicaid. Beneficiaries and families sometimes travel to the Chicago suburbs to access services unavailable in the AHHN region. **Exhibit 7.4** includes details on the Medicaid-certified providers in the InCK Model region.[37]

Exhibit 7.4. **Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]**

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Clinic or group practice – Ambulatory health care facility	<1
Emergency medicine physicians[b]	<1
Family practice[b]	4.22
Pediatrician	<1
Physical therapy[b]	<1

Notes:

  a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files.*

  b. Providers treat adults and children.

Medicaid Policy Context and Related Initiatives

The AHHN region is two ZIP Codes in Chicago, encompassing the Austin and Belmont-Cragin neighborhoods in Chicago's Cook County, including 42,653 Medicaid beneficiaries up to age 21. Residents in these ZIP Codes are predominately Black and Hispanic.

In 2018, the Illinois Department of Health and Family Services expanded their Medicaid managed care program to contract with managed care organizations (MCOs) to provide healthcare services to most Medicaid beneficiaries in all counties in the state.

The state of Illinois also plans to implement Pathways to Success (Pathways), a program for Medicaid-enrolled children under age twenty-one in the Chicago area who have complex behavioral health needs and require intensive services and support. The program will provide access to an evidence-based model of intensive care coordination and additional home and community-based services. Targeted to launch on March 1, 2022, Pathways will operationalize the children's mental health benefit under the pending 1915(i) Medicaid State Plan Amendment. The program will provide benefits to children in the same ZIP Codes as AHHN, though participation will not be limited to the AHHN ZIP Codes.

Planned Approach and Progress to Implementation

Exhibit 7.5 highlights key components of AHHN's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.5.   Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress during the Pre-implementation Period
Alternative Payment Model (APM) Design	• AHHN will secure buy-in on the APM from local MCOs and file a 438.6 preprint with CMS. • MCOs will earn per-member, per-month payments under the proposed APM. AHHN and the MCOs have agreed to focus on well-child visits and immunizations.	• MCOs and AHHN negotiated on APM design. • AHHN submitted a 438.6 preprint[a] to CMS seeking approval to launch an APM in a subset of the managed care area.
Integrated Case Management	• Resource coordinators will serve as the single point of contact for beneficiaries, families, and providers. • Resource coordinators will use information in NowPow[b] and the electronic health record (EHR) to inform case management activities.	• AHHN contracted with three vendors to staff the resource coordinator positions; two vendors already provide mental health or crisis response services in the community. • AHHN hired and began training resource coordinators. Trainings focused on patient engagement. Future trainings will focus on the NowPow referral system and the EHR.

Domain	Planned Approach	Progress during the Pre-implementation Period
Key Partnerships and Partnership Council	• AHHN will build on a strong existing relationship with the Illinois Department of Health & Family Services; the two have collaborated on similar pediatric service delivery interventions before. • The Partnership Council will meet regularly for pre-implementation planning, with representation from an array of local Core Child Services (CCS) organizations.	• AHHN formed the Partnership Council and engaged members through meetings every other week. • The Partnership Council has sub-committees and workgroups that engage members on specific topics, such as Clinical Quality, Information Technology/Data, Finance, Outreach and Engagement, Behavioral Health, and Evaluation.
Mobile Crisis Response (MCR)	• IL will leverage the existing state-wide MCR system (named SASS) functioning in the InCK Model region. Two of the outside vendors hired by AHHN to provide staffing for the resource coordinators also provide MCR services.	• MCR services will be offered through the existing state-wide MCR system (SASS) to staff resource coordinator positions and ensure that SASS complies with InCK Model requirements.
Person- and Family-Centered Care	• Families will be connected to an AHHN program helpline after their initial health needs and risk assessment screening. • Local clinics will feature multiple, co-located services that serve caregivers and beneficiaries in the same space.	• AHHN leadership discussed promotional materials to use in raising community member awareness. • Key staff interviewed did not identify any patient engagement conducted during the pre-implementation period.
Screening and SIL Stratification	• AHHN will use a hybrid approach for SIL stratification based on Medicaid claims data and health needs and risk assessment screenings. • Resource coordinators will re-assess SIL stratification for beneficiaries monthly, relying on real-time clinical data in the EHR to signal major health changes, which may prompt a change in SIL.	• AHHN established a data use agreement to acquire de-identified foster care data from the Department of Children and Family Services. • IL Medicaid claims shared updated data to enable access to real-time data on healthcare utilization.

Notes:

a. According to the CMS guidance on Section 438.6(c) Preprint,

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D).

b. NowPow is a community referral system to address basic needs like food, shelter and financial assistance to counseling, weight management and caregiver support. During the pre-implementation period, NowPow was acquired by Unite Us. They will be a single organization in the implementation period.

Outstanding Questions[38]

1. *What are AHHN's plans to market the InCK Model to beneficiaries and families given local mistrust in the healthcare system? Are there specific types of beneficiaries and families who may be less likely to join the InCK Model? How will AHHN outreach to these families?*

2. *What are AHHN's plans to market the InCK Model to providers? What are the reasons a provider might choose to join the model (with signed agreements to participate in the APM) or choose not to join?*

3. *How will the electronic social needs screener and the comprehensive assessment provide a thorough understanding of needs for all beneficiaries?*

4. *How will AHHN deal with the potential of multiple case managers working with the same beneficiary? For example, YouthCare, a specialized healthcare program for the Illinois DCFS, assigns a case manager to children in their system. Once the Pathways program begins implementation, that program may also assign case workers to these same beneficiaries. How will AHHN eliminate redundancy across similar programs?*

7.2   BRONX EQUITY INCK NEW YORK (BE-INCK NY)

Overview

Characteristic	Description
Lead Organization	• Montefiore Medical Center
Location	• Bronx, New York (NY)
Goals and Targets	• Improve maternal and child health outcomes • Provide support to beneficiaries with complex behavioral needs and their families, prioritizing individuals under 21 with sickle cell disease • Improve routine and preventive care by working with Partnership Council organizations to increase screening and care access, efficiency, and effectiveness of care
Region	• Three ZIP Codes in North-Central Bronx: 10461, 10467, and 10469 (Exhibit 7.6)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 31,576
Include Pregnant Beneficiaries Aged 21+	• Yes
Include Children's Health Insurance Program	• No
Selected Comparison Region	• Eight ZIP Codes in Brooklyn: 11207, 11208, 11212, 11221, 11223, 11230, 11232, and 11234 (Exhibit 7.6)
Focus of AR Stratification Approach	• BE-InCK NY will use clinical and claims data to assess beneficiary needs and assign a preliminary stratification. • Service integration coordinators (SICs) will make initial service integration level (SIL) assignments using clinical and claims data and then use the BE-InCK NY Needs Screening Tool (Tool) to fill in gaps in CCS needs. Final SIL assignment will determine the type and level of services that each beneficiary receives.

Exhibit 7.6.   Map of BE-InCK NY and Comparison Regions
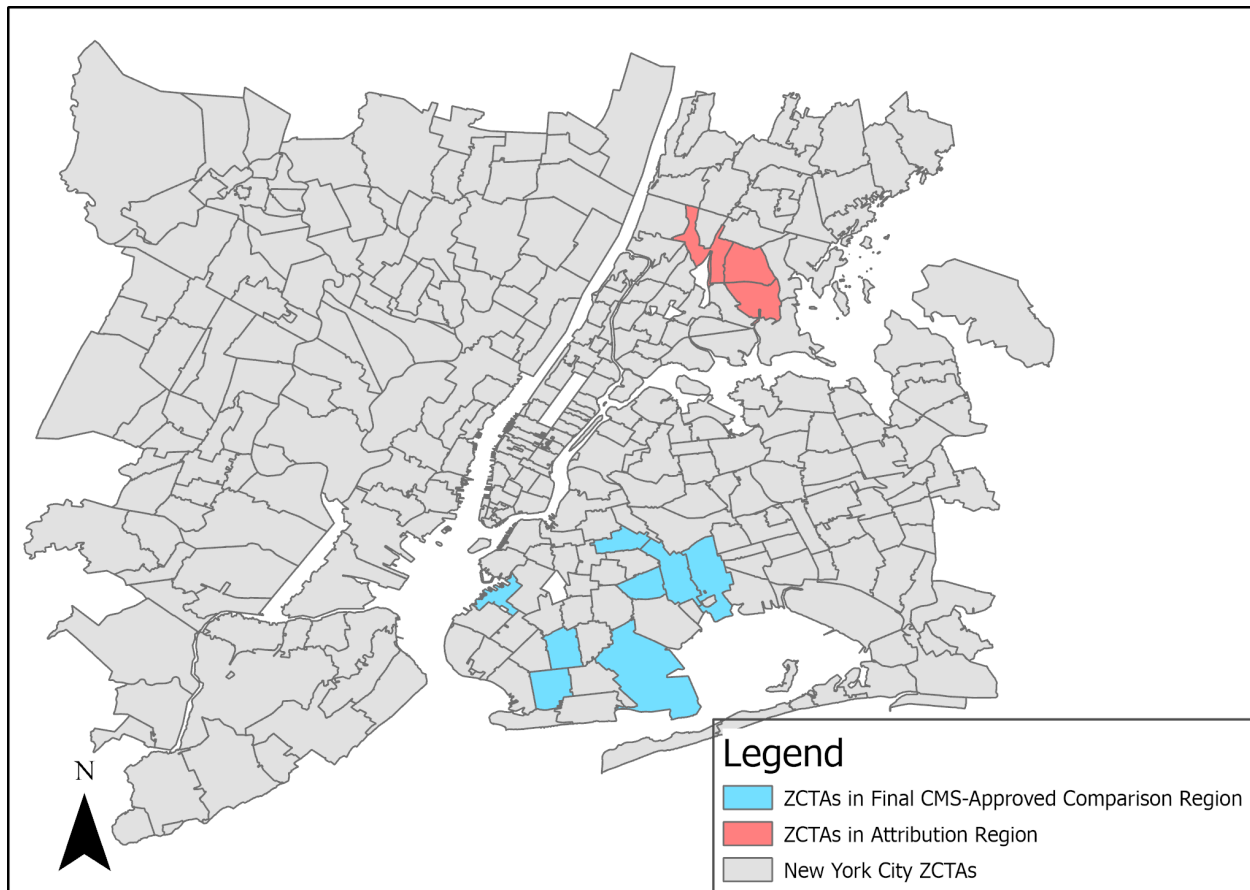
Note: ZIP Code Tabulation Areas (ZCTAs) are generalized areal representations of United States Postal Service (USPS) ZIP Code service areas.

Community Context

Local Context

Exhibit 7.7 provides sample demographic characteristics of the InCK Model region.

Exhibit 7.7.   Demographic Characteristics of the BE-InCK NY Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees[a]	
Enrollees who are Black	39.1%
Enrollees who are Hispanic	33.9%
Enrollees who are Asian American/Pacific Islander	14.6%
Enrollees who are 18-20 years old	8.6%
Characteristics for All Residents[b]	
Median household income[c]	$49,975
Residents living in a rural ZIP Code[d]	0%
Residents speaking limited English[c]	13.0%
Residents who are food insecure[e]	16.0%
Residents with some college or more[c]	48.1%
Area deprivation index[f]	5.67
Homeownership[g]	19.6%
Severe housing problems[h]	31.7%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

BE-InCK NY leadership indicated that the Bronx has the worst health indicators in the state, particularly among children. BE-InCK NY leadership, members of the Partnership Council, providers, and caregivers all described similar challenges and barriers families experience while accessing essential medical care and social services.

1. **The number of children's behavioral health providers in the Bronx, particularly child psychiatrists, is insufficient.** Behavioral health needs rose among the InCK Model population during the COVID-19 PHE and the number of providers available cannot meet the demand. Telehealth has helped expand access to behavioral health services, but long wait times and inconsistent access to technology and internet persist.

2. **Complex healthcare and social service systems are overwhelming to navigate, leaving families feeling dismissed or left out of the system.** Prior to BE-InCK NY, CCS—such as childcare, housing, child welfare, and access to healthy and nutritious food—had not been consistently linked to medical services. Families and providers are often not aware of the breadth of services that exist or for what a family may be eligible. Families often struggle to understand application processes.

3. **Bronx families face many barriers to access services; most commonly transportation, limited English proficiency, and immigration status.** Public transportation can be expensive, time consuming, and difficult to access (e.g., subway stairs can be inaccessible for individuals with mobility challenges, people who are pregnant or postpartum, or families traveling with children, especially those in strollers). Care coordinators attempt to help connect families with providers who share a common language or culture, but such matching is not always possible given provider availability. Many CCS programs (for example, food banks) require identification, which creates access challenges for undocumented immigrants, families with mixed immigration status, and individuals who are homeless.

> *It was trial and error to learn the system. A certain evaluation is needed to be seen within a certain amount of time. They need all of these documents in order to get services. There is a challenge of going to various places to get the paperwork together to submit. . . I've learned to travel with all the things I need with me. . . You feel like a fish out of water. It feels like everyone knows what is going on but you.*
>
> - Caregiver in BE-InCK NY region

A care coordinator shared a photo[39] of signage at a grocery store about Supplemental Nutrition Assistance Program (SNAP) benefits but emphasized they are only in Spanish, while patrons of the store speak many other languages (**Exhibit 7.8**). She also noted that while SNAP is an important program, there is a lack of awareness about SNAP initiatives and other available resources to help address social service needs.

Exhibit 7.8.   A SNAP Benefits Display Sign in Spanish in the Baby Food Aisle of a Bronx Grocery Store

Available Resources

BE-InCK NY leadership, members of the Partnership Council, providers, and caregivers all described a lack of providers who accept Medicaid, long wait times, and siloed systems of care between medical and CCS providers. **Exhibit 7.9** provides detail on the Medicaid-certified providers in the BE-InCK NY region.

Exhibit 7.9.   Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Clinical psychologist – Pediatric	4.75
Community mental health center and federally qualified health center	1.26
Dentist – Pediatric	1.26
Internal medicine – Adolescent	<1
Certified nurse midwife	10.4
OB/GYN	89.1
Pediatrician – Multiple specialties	155.9
Nurse practitioner – Pediatric subspecialties	130.0
Neuropsychology – Pediatrics	12.9
Occupational therapy – Pediatric	<1
Physical therapy – Pediatric	<1

Notes:

a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files.

Medicaid Policy Context and Related Initiatives

The BE-InCK NY region is three ZIP Codes in North-Central Bronx; the region includes over 32,000 Medicaid beneficiaries who are either between birth and 21 years or over 21 years and pregnant. These three ZIP Codes have the highest proportion of children and pregnant Medicaid beneficiaries who receive care through the two major health systems in the county: Montefiore and NYC Health + Hospitals (Jacobi and North-Central Bronx).

The BE-InCK NY Model builds upon the progress and lessons learned through NY's other Medicaid reform efforts, including the Delivery System Reform Incentive Payment (DSRIP) program, the First 1,000 days Initiative, and the Medicaid Health Homes Serving Children (HHSC) program. Through DSRIP, the state of New York aimed to reduce hospital admissions by 25 percent via community-level collaborations. Montefiore Medical Center (the BE-InCK NY Lead Organization) was one of the DSRIP Performing Provider Systems and had extensive experience with value-based payment arrangements. The HHSC program began in 2016 to better serve and coordinate care for children with complex healthcare needs. There are 16 sites statewide and three in the BE-InCK NY model service area, and representatives from the three in the BE-InCK NY service area are on the BE-InCK NY Partnership Council. To avoid duplication of services, children eligible for HHSC will not be eligible for BE-InCK NY navigation services. If a child is determined to be HHSC-eligible, they will be referred to HHSC agencies for outreach and health home enrollment.

Planned Approach and Progress to Implementation

Exhibit 7.10 highlights key components of BE-InCK NY's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.10. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress in the Pre-implementation Period
Alternative Payment Model (APM) Design	• The APM will use a shared savings on total-cost-of-care approach and incorporate multiple provider types, including both medical and non-medical providers. The APM arrangement will include a subset of the approximately 32,000 InCK Model beneficiaries. • BE-InCK NY will pilot the APM with Healthfirst, the largest managed care organization in New York City, which serves a significant percentage of the BE-InCK NY population.	• BE-InCK NY refined the APM design and plan to complete the design in 2022.
Integrated Case Management	• If a SIL 2 or SIL 3 member is determined to be eligible for other Medicaid-funded programs that provide case management similar to what BE-InCK NY plans to offer, such as the HHSC, they will be referred to those programs. These members will not receive case management services from InCK Model staff; BE-InCK NY will continue to monitor and report on their progress. • SICs and Medicaid-funded program care coordinators and case managers will be responsible for helping members access preventive and primary healthcare and supportive services. • BE-InCK NY uses two health information exchanges, Bronx Regional Health Information Organization and Healthix, and will encourage other Medicaid-funded programs providing care coordination and care management to the InCK population to join these exchanges to facilitate data sharing.	• BE-InCK NY onboarded two of seven SICs. SICs have at a minimum either an associate degree with two years' experience or a bachelor's degree with one year of experience. BE-InCK NY Leadership anticipates having all seven SICs in place early in the implementation period (which starts January 1, 2022).

Domain	Planned Approach	Progress in the Pre-implementation Period
Key Partnerships and Partnership Council	• The Partnership Council includes hospitals, federally qualified health centers, child welfare agencies, community-based health care providers, social service providers, managed care organizations, city and state agencies, two health information exchanges, and family representatives.	• BE-InCK NY established the Partnership Council with more than 190 individual members from over 50 organizations. The Partnership Council is led by a Steering Committee comprised of the Partnership Council co-chairs, workgroup co-chairs, NYS DOH and Montefiore Project Leads, a managed care organization, and a family representative. • BE-InCK NY continues to work on connecting with the education systems. • The Partnership Council was engaged in robust conversations through the end of 2021 and BE-InCK NY used the feedback to improve the proposed BE-InCK NY referral process and develop draft promotional materials.
Mobile Crisis Response (MCR)	• The MCR program will build on the New York City Well mobile crisis program, an existing and known service in the Bronx.	• The Visiting Nurse Service of New York (VNSNY) contracted with BE-InCK NY to provide additional support to crisis hotline services through the award period. The VNSNY team will identify and onboard an InCK Model-funded staff member who will serve as the BE-InCK NY liaison and assist in efforts to expand access to MCR services.
Person- and Family-Centered Care	• To reduce beneficiary burden, BE-InCK NY will use a data driven approach to screening. • BE-InCK NY will continue to refine community engagement strategies and ensure the Bronx community is involved and engaged in implementation efforts.	• BE-InCK NY created a Partnership Council subgroup focused on equity and is exploring ways to amplify community voices as the model is implemented. • They also collected feedback on how to best educate and engage Medicaid members in BE-InCK NY and conducted outreach to providers and families about the BE-InCK NY Model. • Family representatives identified the most prevalent needs within the Bronx community and provided feedback on educational and promotional material and key BE-InCK NY activities.

Domain	Planned Approach	Progress in the Pre-implementation Period
Screening and SIL Stratification	• BE-InCK NY will use a hybrid approach to identify needs, using clinical and claims data to assess beneficiary needs and assign a preliminary stratification. • The SICs will make initial SIL assignments using clinical and claims data and then use the BE-InCK NY Needs Screening Tool (Tool) to fill in gaps in CCS needs. Final SIL assignment will determine the type and level of services that each member receives. For beneficiaries who do not have a primary care visit, BE-InCK NY plan to conduct further screening.	• BE-InCK NY outlined the details of their data driven approach to SIL stratification and developed the Screening Tool. • NYS DOH signed a DUA with BE-InCK NY that outlines the data elements that they will share with Montefiore Health System and how they can use the data. • BE-InCK NY secured business associate agreements with 19 of the 20 Partnership Council agencies serving the BE-InCK NY population.

Outstanding Questions[40]

1. *BE-InCK NY SICs will coordinate with existing Medicaid-funded care coordination programs to provide care management services.* What percentage of individuals in the InCK Model population are anticipated to be managed by other Medicaid-funded programs versus by BE-InCK NY SICs? What are the challenges with tracking individuals who are receiving care coordination services through other Medicaid-funded programs?

2. *The BE-InCK NY region is very culturally and linguistically diverse.* How will the BE-InCK NY team ensure families that speak languages other than English or Spanish have both access to services and are engaged in the model?

3. *BE-InCK NY shared anticipated benefits and challenges of using a data driven approach to SIL stratification.* How will this approach work in practice? What modifications will BE-InCK NY need to make during the implementation period? Are there populations for whom the approach works well? Are there populations for whom it does not work as well?

4. *BE-InCK NY engaged the Partnership Council meaningfully during the pre-implementation period.* How will BE-InCK NY continue to engage Partnership Council members in the implementation period?

5. *The Bronx Regional Health Information Organization and NowPow (Unite Us) aim to help medical and social service providers more seamlessly coordinate care for InCK Model families.* How will providers and care coordinators use NowPow (Unite Us)? Will these platforms facilitate information sharing between providers?

7.3 CT InCK Embrace New Haven

Overview

Characteristic	Description
Lead Organization	• Clifford W. Beers Guidance Clinic
Location	• New Haven, Connecticut (CT)
Goals and Targets	• Increase access to services and reduce disparities in health outcomes • Improve community-based systems of care for children • Integrate behavioral health, physical health, and social services
InCK Model Region	• Six ZIP Codes in New Haven, CT: 06510, 06511, 06512, 06513, 06515, and 06519 (Exhibit 7.11)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 34,695
Include Pregnant Beneficiaries Aged 21+	• Yes
Include CHIP	• Yes
Selected Comparison Region	• Five ZIP Codes in Bridgeport, CT: 06604, 06605, 06606, 06608, and 06610 (Exhibit 7.11)
Focus of AR Stratification Approach	• CT InCK Embrace New Haven will use Medicaid claims and data from the Department of Children and Families to develop an initial SIL assignment. Community health organizers (CHOs, the local term for service integration coordinators) will then use a screening tool to facilitate a "needs conversation" with beneficiaries and their caregivers. • CT InCK Embrace New Haven will use a data platform to share information with beneficiaries, their caregivers, and providers. CHOs will coordinate with existing case managers and other members of the care team to ensure shared action plans are regularly updated.

Exhibit 7.11. Map of CT InCK Embrace New Haven's InCK Model and Comparison Regions
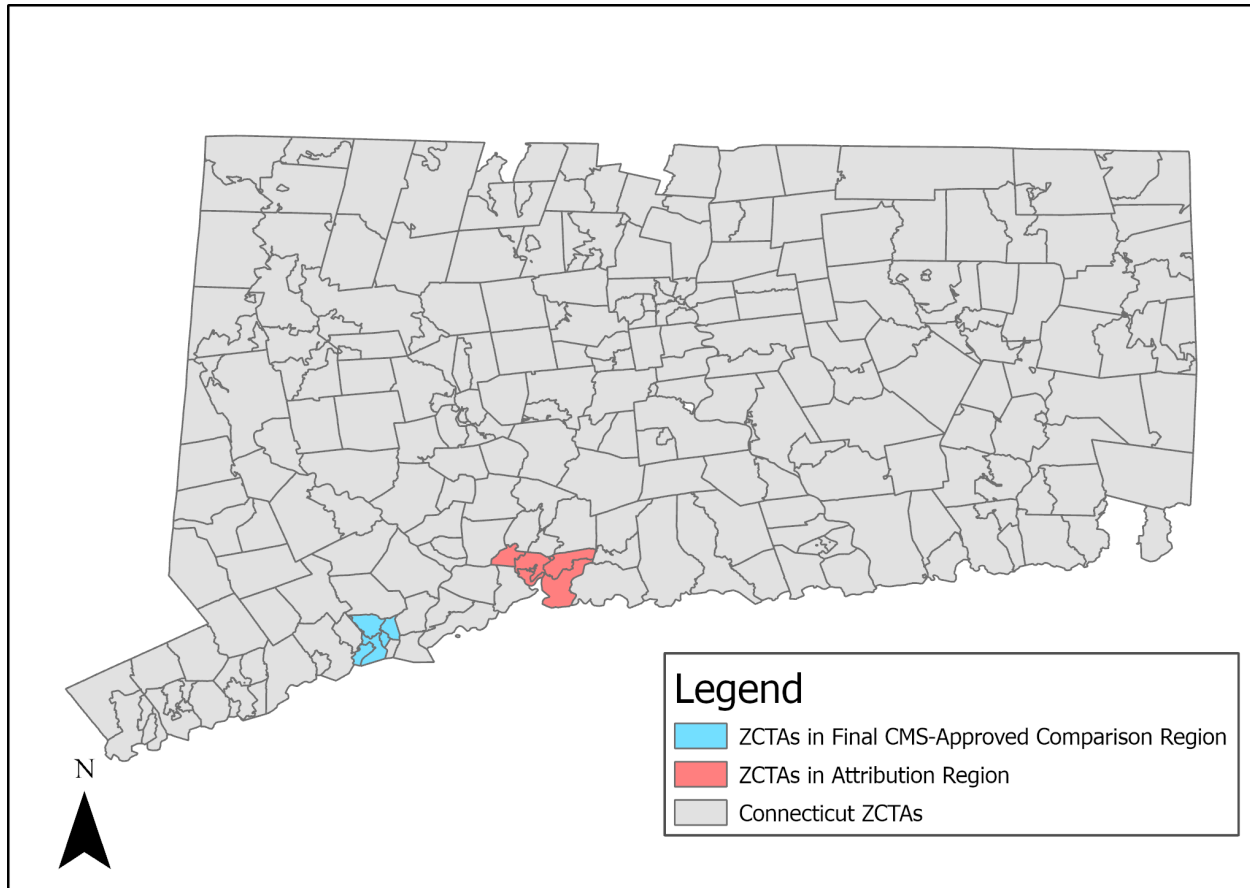
Note: ZIP Code Tabulation Areas (ZCTAs) are generalized areal representations of United States Postal Service (USPS) ZIP Code service areas.

Community Context

Local Context

Exhibit 7.12 provides demographic characteristics of the InCK Model region.

Exhibit 7.12. Demographic Characteristics of the CT InCK Embrace New Haven InCK Model Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees in the InCK Model Region	
Enrollees who are Black[a]	58.7%
Enrollees who are Asian American/Pacific Islander[a]	4.1%
Enrollees who are 18-20 years old[a]	8.4%
Characteristics for All Residents[b]	
Residents who are Hispanic[c]	27.7%
Median household income[c]	$45,570
Residents living in a rural ZIP Code[d]	0%
Residents speaking limited English[c]	7.9%
Residents who are food insecure[e]	12.1%
Residents with some college or more[c]	53.1%
Area deprivation index[f]	6.36
Homeownership[g]	61.9%
Severe housing problems[h]	18.1%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

CT InCK Embrace New Haven leadership, CHOs, and local behavioral health providers described similar challenges for children and their families accessing the service(s) they need.

1. **Families in the InCK Model region have significant CCS needs, and the systems for addressing those needs are siloed**. The fragmentation makes it difficult for families to navigate.

2. **Beyond CCS needs, many families in the InCK Model region experience trauma and secondary trauma.** This trauma can create additional need for CCS services and serve as an additional barrier to families engaging in ongoing services.

> *You would think as a parent, like "I'm just gonna go take my child to get glasses." Those are fundamental rights that these children are entitled to, and they're limited because they have to go to the providers that aren't accepting patients that take Medicaid. Providers that have openings for Medicaid patients are exceedingly rare. The waiting lists are extensive for a variety of services, and at some point, we haven't even gotten care, and we've been living here in New Haven since 2015.*
>
> - Caregiver in CT InCK Embrace New Haven region

3. **Medical providers in the InCK Model region are siloed**, with limited information sharing—particularly with CCS organizations. Providers are often not aware that children and families may be accessing services, such as supportive therapies in school, unless they hear directly from the family.

One CHO shared this image of a local park (**Exhibit 7.13**)[41]. The city recently sold the property to a real estate developer. The park had been a hub of activity in the neighborhood— particularly during the COVID-19 PHE — and it is one of the only green spaces in the neighborhood. Since its sale, residents have come together to try to preserve the park. The CHOs agreed that the situation with this park highlights the systemic oppression, disparities, and inequities in certain communities. As one CHO described, "When you talk about development in Black and Brown communities, the first thing to go is the parks…but you can only imagine what green space does for your health." CHOs at CT InCK Embrace

Exhibit 7.13. Local Park Sold to Developers

New Haven highlighted that in New Haven there is a history of local organizations prioritizing the needs of real estate developers or other external agents over those of local residents in a manner that has at times been exploitative.
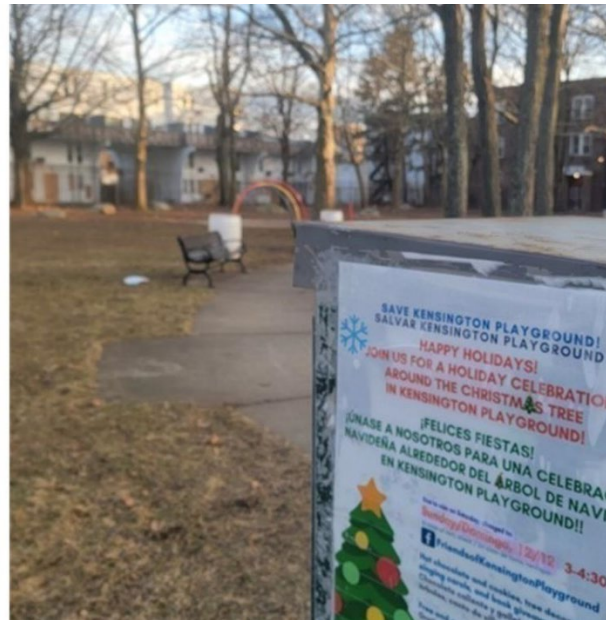
Available Resources

Providers in the CT InCK Embrace New Haven InCK Model region reported there are sufficient medical resources in the area. However, the need for CCS is greater than the available resources, and the systems are disconnected and difficult to navigate. Behavioral health providers reported limited information sharing between themselves and physical health providers. **Exhibit 7.14** includes details on the supply of Medicaid-certified providers in the area, by specialty.

Exhibit 7.14. Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Pediatricians – All specialties	11.5
Nurse practitioners – Pediatric specialties	20.2
Family practice – Pediatric specialties	3.46
Clinical psychologist	1.15
Neuropsychology – Pediatric	0.86
Certified nurse midwife	9.80
OB/GYN	14.4
Physical therapy[b]	1.73
Dentist – Pediatric	2.02

Notes:

    a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files*.

    b. Providers treat adults and children.

Medicaid Policy Context and Related Initiatives

The CT InCK Embrace New Haven region encompasses six ZIP Codes which includes 34,695 Medicaid beneficiaries eligible for the InCK Model. The CT InCK Embrace New Haven attribution population includes both beneficiaries from birth up to age 21 and pregnant beneficiaries. Medicaid in Connecticut is financed via fee-for-service rather than managed care. Administrative aspects of the Medicaid program and other human service programs are managed by two administrative service organizations (ASOs). Department of Social Services (DSS) has contracted with them to support reporting requirements of the model and APM implementation.

The CT InCK Embrace New Haven InCK Model aligns with strategic priorities of the DSS, which oversees Medicaid and Children's Health Insurance Program (CHIP) in the state. These priorities include improving services for pregnant and postpartum beneficiaries and eligible children and bolstering community-based behavioral health services. For example, DSS implemented state-wide person-centered medical homes for Medicaid and CHIP beneficiaries in 2012, which support care coordination. CT InCK Embrace New Haven will build on these existing activities.

Planned Approach and Progress to Implementation

Exhibit 7.15 highlights key components of CT InCK Embrace New Haven's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.15. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress in the Pre-implementation Period
Alternative Payment Model (APM) Design	• CT InCK Embrace New Haven will incorporate a per member per month payment for case management/care coordination for beneficiaries in SIL 2 and SIL 3 with upside-only quality incentive payments (incentive payments which providers receive if they reach certain quality benchmarks).	• CT InCK Embrace New Haven and Connecticut DSS partnered closely to design the InCK APM.
Integrated Case Management	• Service integration for beneficiaries in SIL 2 and SIL 3 will be delivered either through care coordinators associated with community-based organizations, behavioral health providers, attributed primary care providers, person-centered medical homes, or a CHO for beneficiaries not affiliated with a provider.	• CT InCK Embrace New Haven hired, onboarded, and trained seven CHOs with expertise in the local provider landscape, community resources, and CCS systems of care. • They also contracted with a third-party vendor to develop a care management platform to support service integration.
Key Partnerships and Partnership Council	• CT InCK Embrace New Haven's Partnership Council will include representatives of CCS organizations, state agencies, Connecticut Medicaid, and the ASOs.	• Partnership Council engagement steadily increased over the course of the pre-implementation period. During the initial award period Partnership Council members were focused on response to the PHE and efforts to advance racial equity in response to racial justice protests in summer 2020. • CT InCK Embrace New Haven also connected with community stakeholders who are not part of the Partnership Council but are invested in the effort.
Mobile Crisis Response (MCR)	• Clifford Beers is the current pediatric MCR provider in the CT InCK Embrace New Haven region. They will leverage and expand the existing MCR services to make sure they are available 24/7/365.	• CT InCK Embrace New Haven coordinated with the adult MCR provider in the InCK Model region on design and implementation.
Person- and Family-Centered Care	• Intensive care coordinators (ICCs) will develop a shared care plan for beneficiaries in SIL 3. Shared care plans will align with Clifford Beers' existing wraparound services approach, which centers on the child and their caregivers.	• CT InCK Embrace New Haven finalized the details of data elements to include in the care plan and how to operationalize it. • ICCs will receive training on active listening, motivational interviewing, and other techniques to help them facilitate care planning conversations with families and caregivers.

Domain	Planned Approach	Progress in the Pre-implementation Period
Screening and SIL Stratification	• CT InCK Embrace New Haven will use a hybrid approach including data from Medicaid claims, child welfare, and the results of a screener conducted via telephone or in person. • CT InCK Embrace New Haven will use the Pediatric Medical Complexity Algorithm[a] and CareAnalyzer[b] for children 0-21 and pregnant and postpartum individuals to identify historical healthcare needs.	• State ASOs and state agencies will partner with CT InCK Embrace New Haven and share data to support SIL stratification. • CT InCK Embrace New Haven will finalize content to be included in the screener (called "needs conversation") template.

Notes:
   a. Pediatric Medical Complexity Algorithm is publicly available algorithm that identifies children with complex disease using Medicaid claims data. Simon, Lawrence Cawthon, Stanford, et al. (2014). Pediatric Medical Complexity Algorithm: A New Method to Stratify Children by Medical Complexity. *Pediatrics, 133*(6): e1647-1654.
   b. CareAnalyzer is an analytic tool used by Connecticut for population health management.

Outstanding Questions[42]

1. CT InCK Embrace New Haven has hired and onboarded seven CHOs to serve as the service integration coordinators for the InCK Model population. The CHOs have an extensive understanding of the local community and CCS. *How will the CHO role be operationalized? How will they coordinate with local community-based providers to identify families and align them with needed services? Is there enough capacity on the CHO team to address the needs of the attributed population? How will CHOs engage families of children that do not have Medicaid claims? How will CHOs engage families of children who do not have an existing relationship with an InCK Model provider?*

2. CT InCK Embrace New Haven will have designated InCK Model providers with integrated care coordinators (ICCs) across the attributed region to provide care coordination services to individuals in SIL 2 and SIL 3. *What will be the caseload for each InCK Model provider organization and ICC? How will ICCs and CHOs interact and coordinate? Will there be enough enrolled InCK Model providers to serve the attributed population? How will CHOs engage potential InCK Model providers? Will the APM rates be prohibitive for provider participation, and how will Embrace New Haven address this?*

3. Clifford Beers, the CT InCK Embrace New Haven Lead Organization, is a community-based behavioral health provider. *How will they coordinate with physical health providers in the region to support the integration of physical and behavioral health care? How will they engage Yale New Haven Hospital in implementation efforts?*

4. CT InCK Embrace New Haven had challenges engaging New Haven Public Schools during the ongoing COVID-19 PHE. *Will CT InCK Embrace New Haven successfully engage New Haven Public Schools and other CCS providers during implementation through data sharing and delivery of services? How will this enhance model impact?*

5. The Connecticut DSS considers the InCK Model as an opportunity to test the model with the goal of potentially scaling it statewide. *What impact will these efforts have on the evaluation? Will the DSS be able to scale beyond New Haven?*

7.4   NORTH CAROLINA (NC) InCK

Overview

Characteristic	Description
Lead Organization	• Duke University, in partnership with University of North Carolina (UNC)
Location	• Select counties in North Carolina (NC)
Goals and Targets	• Systematically identify the children with the greatest needs to better target interventions • Strengthen integration and information sharing between medical and Core Child Services (CCS) providers • Improve health and social outcomes and reduce out-of-home placements for high-risk children
InCK Model Region	• Five counties in NC: three urban (Alamance, Orange, and Durham) and two rural (Granville and Vance) (Exhibit 7.16)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 104,176
Include Pregnant Beneficiaries Aged 21+	• No
Include Children's Health Insurance Program	• Yes
Selected Comparison Region	• Eleven counties in NC: Camden, Catawba, Cumberland, Currituck, Forsyth, Lenoir, Richmond, Scotland, Wake, Washington, and Wilson (Exhibit 7.16)
Focus of AR Stratification Approach	• NC InCK will use a hybrid approach, combining in-person screening for social needs, Medicaid claims, and data from education and juvenile justice to stratify beneficiaries into SILs. • Integration consultants (the NC InCK term for SICs) will partner closely with existing care coordinators to provide families with a single point of contact and make sure they are getting needed services.

Exhibit 7.16. Map of NC InCK Attribution and Comparison Regions
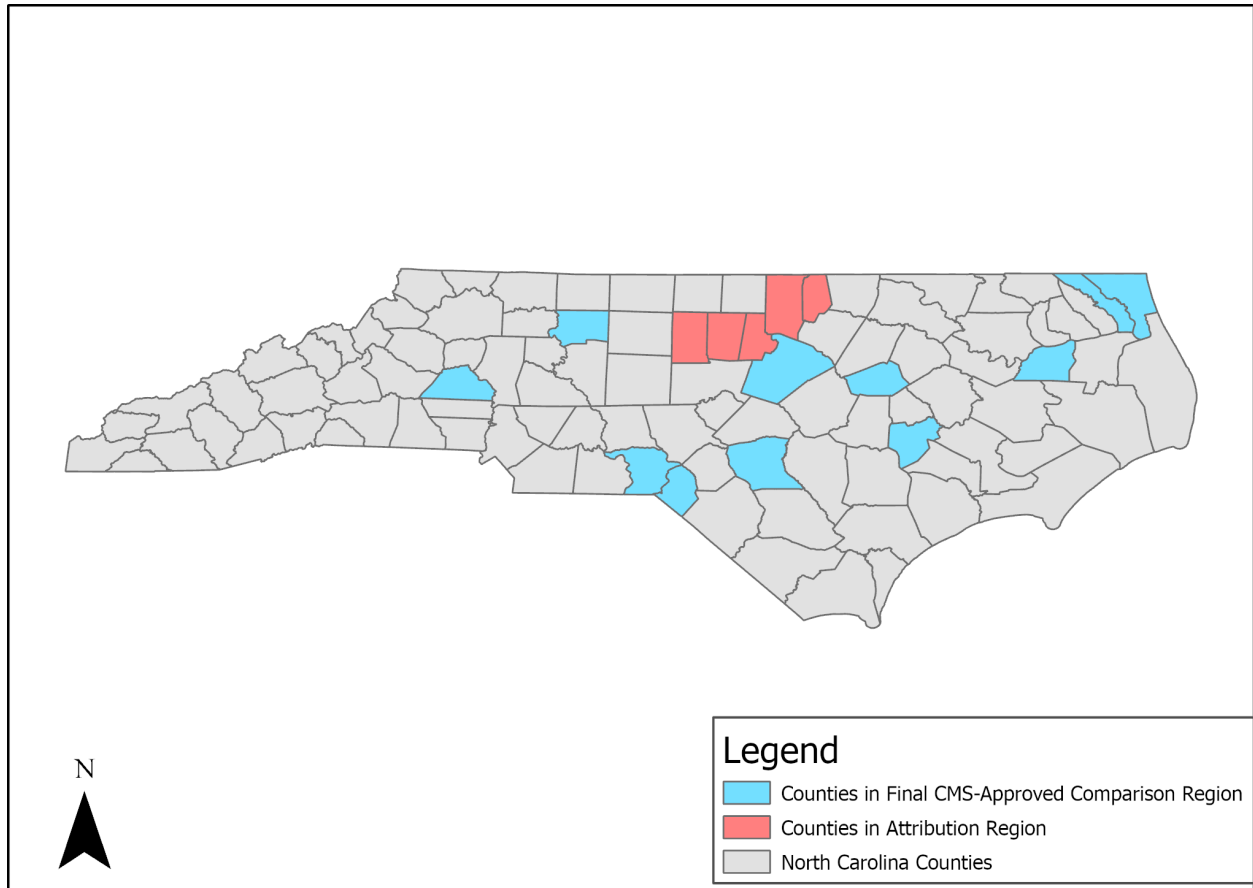
Community Context

Local Context

Exhibit 7.17 provides sample demographic characteristics of the NC InCK region.

Exhibit 7.17. Demographic Characteristics of the NC InCK Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees in the InCK Model Region[a]	
Enrollees who are Black	41.9%
Enrollees who are Hispanic	26.4%
Enrollees who are Asian American/Pacific Islander	1.8%
Enrollees who are 18-20 years old	7.7%
Characteristics for All Residents[b]	
Median household income[c]	$55,879
Residents living in a rural county[d]	14.5%
Residents speaking limited English[c]	3.5%
Residents who are food insecure[e]	15.4%
Residents with some college or more[c]	66.2%
Area deprivation index[f]	4.51
Homeownership[g]	60.0%
Severe housing problems[h]	14.8%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

NC InCK leadership, medical and CCS providers, and caregivers all described similar access challenges for beneficiaries and families trying to obtain needed medical care, supportive therapies, and social services.

> *I have learned how to navigate the system and get what I need for my child on my own. I speak English, but I think about all the parents who don't. One of the things that would make a lot of difference is for doctors to have that cultural tolerance and respect. It wouldn't hurt to learn a little.*
>
> - Caregiver in NC InCK region

1. **Certain types of providers and services are not reliably available.** The supply of physical health providers is sufficient; however, limited Medicaid-enrolled providers offer behavioral health and supportive services. Rural areas have the fewest resources. The supply of providers who speak Spanish or provide care in a culturally-informed manner is insufficient.

2. **Children and families sometimes do not or cannot maintain engagement in services**. The primary barriers to long-term engagement for families include lack of awareness of available resources, the complexity of the system, and challenging life circumstances.

3. **The system is complex and often overwhelming to navigate.** Accessing CCS and social supports is more difficult for families than accessing medical care. Families often rely on case managers and informal networks of friends, peers, and faith-based

organizations to get information and the help they need. These networks may not be comprehensive, accurate, or equally accessible to all.

One integration consultant shared a photo[43] of a fruit stand (**Exhibit 7.18**) that she felt represented the experience of families trying to navigate complex systems to obtain services. The photo depicts a local fruit stand with various unmarked boxes of fruit. There is no signage and it is not clear how much things cost or who to ask for help. She described the chaos of the system and difficulties in knowing what is available. She used the fruit stand as a metaphor for a patient who has 12 different providers but still doesn't know who to ask for help. Even when resources are available, families need help navigating them.

Exhibit 7.18. A Local Fruit Stand Serves as a Metaphor for Challenges that Families Face Navigating the System

Available Resources

Overall, providers and families reported ample access to physical health providers but greater difficulty accessing behavioral health providers, particularly in rural areas and providers that speak languages other than English. Some described difficulty accessing specialty providers that accepted new patients covered by Medicaid. **Exhibit 7.19** includes detail on the Medicaid-certified providers in the InCK Model region, by specialty.

Exhibit 7.19. Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Community mental health center or federally qualified health center	4.78
Nurse practitioners – Pediatric specialties	75.2
Pediatricians – All pediatric subspecialties	108.7
Family practice – Pediatric/adolescent	70.8
Internal medicine – Adolescent	<1
Dentist – Pediatric	7.68
Neuropsychology – Pediatric	9.60

Notes:
a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files*.

Medicaid Policy Context and Related Initiatives

The NC InCK attributed region includes five counties—two rural and three urban—in the Raleigh-Durham metro area. It includes 104,176 Medicaid beneficiaries from birth up to age 21. The majority of Medicaid-enrolled children in the region already receive clinical services at either Duke or UNC.

North Carolina has not expanded Medicaid under the Affordable Care Act. As of fall 2021, caregivers of young children must earn under 42 percent of the federal poverty level to be eligible (expansion states offer coverage to adults up to 138 percent of the poverty line). Many caregivers of InCK-eligible children do not have health insurance and may have unmet medical needs; these factors create additional barriers to the services children need.

NC passed legislation to transition the state from fee-for-service to managed care in 2015. As a result of both administrative issues and the COVID-19 PHE, the state delayed the transition to managed until July 1, 2021. The transition affects NC InCK's design and approach to implementation. While the delays to implementation caused uncertainty and complexity, the ability to design the InCK Model within the context of the managed care transition created opportunities for cooperation that may not have existed otherwise. For example, NC InCK was able to work with local MCOs to align screening for social needs with the requirements for the InCK Model.

As part of an overall strategy to address social drivers of health, North Carolina applied and received a 1115 waiver from CMS called the Healthy Opportunities Pilot (HOP), with an effective date of March 15, 2022. The waiver will allow Medicaid funds to pay for enhanced case management activities and services, such as tenancy support, food, and non-emergency transportation, specifically to help children and their families experiencing interpersonal violence. Initially, NC will implement this waiver in a smaller number of counties with the goal to spread it statewide if it is successful.

Planned Approach and Progress to Implementation

Exhibit 7.20 highlights key components of NC InCK's planned approach and progress NC InCK made during the pre-implementation period by Model domain.

Exhibit 7.20. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress in the Pre-implementation Period
Alternative Payment Model (APM) Design	• NC InCK will implement one pediatric APM: Children's Primary Care First Model Care management with upside/downside risk. • NC InCK will explore one or two additional APMs during Model Year 3, which may include a foster care APM, children with medical complexity APM, two generation early childhood bundled payment, population-based payments, or braided funding.	• NC InCK partnered closely with North Carolina Medicaid and other key stakeholders to develop the pediatric APM. • Local MCOs worked toward integrating the NC InCK APM into their contracts with providers.

Domain	Planned Approach	Progress in the Pre-implementation Period
Integrated Case Management	• NC InCK will assign beneficiaries in SIL 2 and SIL 3 to integration consultants based on need and where the child receives services. The integration consultant will determine an appropriate family navigator to serve as the single point of contact for the family, create the shared action plan with the family, and coordinate medical care and social supports for the beneficiary. Integration consultants will be responsible for monitoring a panel of 700-800 beneficiaries in SIL 2 and SIL 3 and supporting family navigators.	• NC InCK hired and onboarded 14 integration consultants, all of whom have clinical and social work backgrounds and experience providing case management. • NC InCK began to create mechanisms to share information between integration consultants, Family Navigators, other providers, and patients and families.
Key Partnerships and Partnership Council	• NC InCK will capitalize on a partnership between Duke University and UNC, which have an existing information-sharing infrastructure. • The NC InCK Partnership Council will include representatives of CCS organizations across the five InCK Model counties, Legal Aid, representatives of local health systems, MCOs, other community partners, and family and youth advisory groups.	• Partnership Council met quarterly via virtual meetings. • NC InCK created sub-committees that engage specific members on specific activities.
Mobile Crisis Response (MCR)	• NC InCK will build on the existing Medicaid managed care infrastructure and use Daymark Recovery Services, a local organization that provides behavioral health services, to provide families with a single crisis response access number in the InCK Model region. • Daymark will either respond to the caller directly or triage to other MCR services as needed.	• NC InCK reviewed the existing MCR providers in the region and decided to contract with Daymark to create a single access number for beneficiaries and their families.
Person- and Family-Centered Care	• Family navigators will be responsible for establishing the shared action plan with the family and their care team for beneficiaries assigned to SIL 3 and a sub-set of beneficiaries in SIL 2. One family navigator will work with a family for up to a year.	• NC InCK analyzed 120 distinct types of care plans to determine essential components, held interviews with healthcare providers and CCS entities, and engaged Partnership Council members and the Family Advisory Group in reviews of initial drafts before creating a final template. • NC InCK then created the shared action plan template with the goal of making sure it was: 1) simple and strengths based; 2) centered on the family voice; and 3) accessible to families.

Domain	Planned Approach	Progress in the Pre-implementation Period
Screening and SIL Stratification	• NC InCK will use a hybrid approach for SIL stratification. NC InCK will combine in-person or telephone food and housing insecurity screening with data from Medicaid claims, juvenile justice, and education to assign SIL. • State managed care plans will conduct the food and housing insecurity screening.	• NC InCK established data use agreements with the Departments of Education and Juvenile Justice to support SIL stratification. • Local MCOs partnered with NC InCK to develop processes to access screening data. With a delay in receiving the results of food and housing insecurity screens from the managed care companies, NC InCK revised its approach to use the social deprivation index as a proxy for this data until they can access the data from managed care companies.

Outstanding Questions[44]

1. NC InCK is primarily using administrative data to assess children's SIL eligibility. Providers and integration consultants will then review SIL assignments and make changes as needed. *How will the NC InCK team assess how the stratification process is working and what, if any, adjustments will NC InCK make to the stratification process the coming year? How will the planned SIL stratification process identify children with less historical healthcare utilization?*

2. The NC InCK approach to integrated case management relies on the family navigator serving as the single point of contact, with the integration consultants monitoring children's progress and providing training and support to family navigators. *How will the partnership between integration consultants and the family navigator work in practice? Are some family navigators more successful than others and, if so, what variables affect that success? How are the family navigators implementing model-related services despite not receiving InCK Model funds? Integration consultants are responsible for monitoring services for a large number of beneficiaries, how will that work in practice?*

7.5   NEW JERSEY (NJ) INCK

Overview

Characteristic	Description
Lead Organization	• Hackensack Meridian Health (HMH), in partnership with Visiting Nurse Association of Central New Jersey and the New Jersey Health Care Quality Institute
Location	• Central New Jersey (NJ)
Goals and Targets	• Promote holistic care through integration of social, behavioral, and medical models of care • Implement an enhanced screening process and targeted case management • Facilitate data sharing across healthcare systems • Provide community-based care management that integrates with the pediatric health care system
InCK Model Region	• Two contiguous coastal counties in central New Jersey: Monmouth and Ocean (Exhibit 7.21)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 146,536
Include Pregnant Beneficiaries Aged 21+	• No
Include Children's Health Insurance Program	• Yes
Selected Comparison Region	• Two counties in New Jersey: Middlesex and Burlington (Exhibit 7.21)
Focus of AR Stratification Approach	• Individuals will be stratified into SILs using a hybrid approach that produces a medical complexity score based on Medicaid claims data and a social complexity score based on a comprehensive health needs assessment (referred to as the NJ Health Story). The scores will generate a preliminary SIL stratification that frontline NJ InCK staff will discuss with family members and primary care providers to determine a final SIL classification. • Care integration managers (CIMs) (the NJ InCK term for SICs) will triage SIL 2 and SIL 3 beneficiaries who elect to enroll in NJ InCK to advanced case management teams, consisting of a licensed social worker, community health workers, a family peer specialist, and a child life specialist. The advanced case management teams will perform integrated care management services.

Exhibit 7.21. Map of NJ InCK Attribution and Comparison Regions
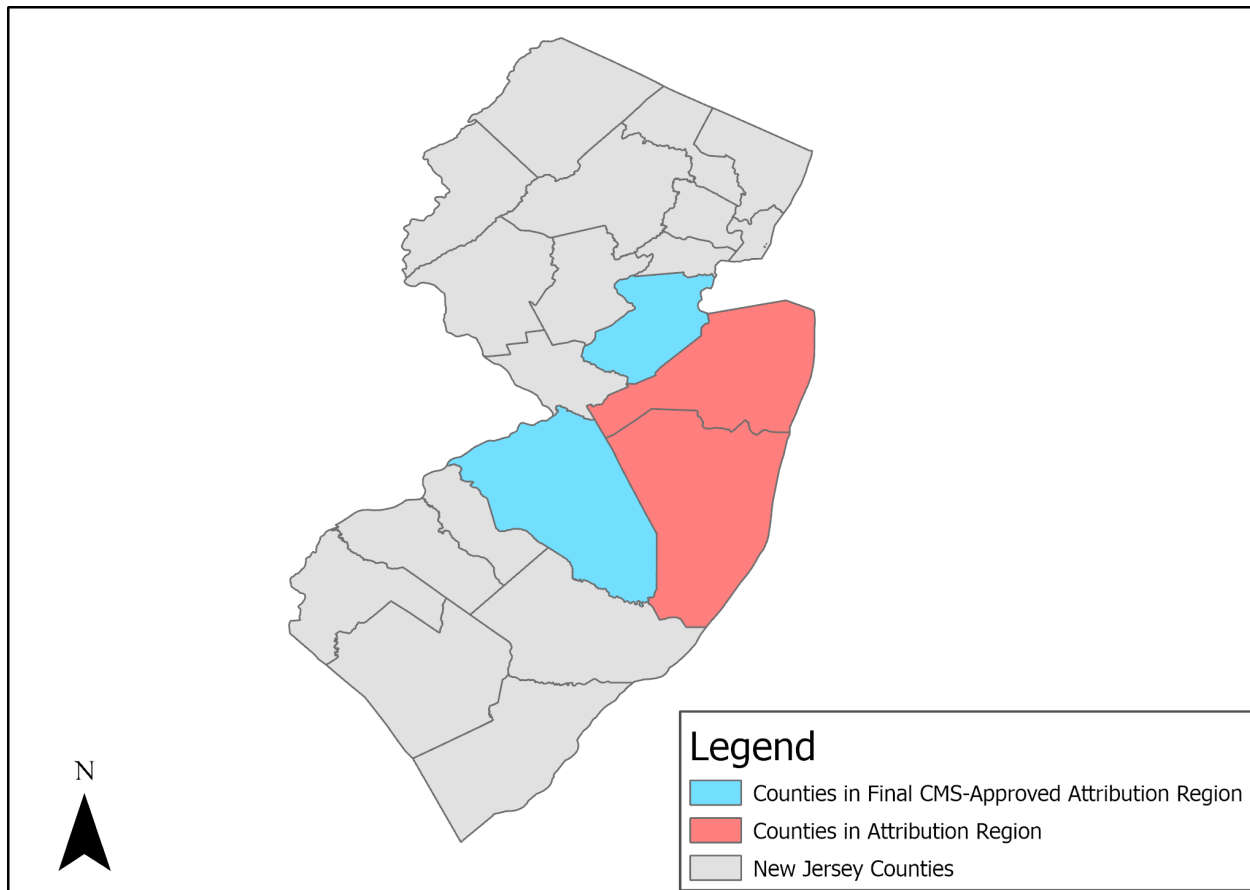
Community Context

Local Context

Exhibit 7.22 provides sample demographic characteristics of the InCK Model region. At the time of the NJ InCK Model award notification, approximately 63 percent of NJ InCK beneficiaries were in Ocean County, which is home to a large Orthodox Jewish community primarily concentrated in the town of Lakewood. The number of immigrants and the proportion of the population who have limited English proficiency are also increasing.

Exhibit 7.22. Characteristics of the NJ InCK Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees in the InCK Model Region[a]	
Enrollees who are Black	9.7%
Enrollees who are Hispanic	22.8%
Enrollees who are Asian American/Pacific Islander	1.5%
Enrollees who are 18-20 years old	7.3%
Characteristics for All Residents[b]	
Median household income[c]	$82,218
Residents living in a rural county[d]	0.0%
Residents speaking limited English[c]	2.8%
Residents who are food insecure[e]	8.5%
Residents with some college or more[c]	63.6%
Area deprivation index[f]	4.98
Homeownership[g]	76.8%
Severe housing problems[h]	18.1%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

NJ InCK leadership, CIMs, and Partnership Council members, including CCS providers, identified several challenges for beneficiaries and their caregivers with accessing physical care, behavioral health care, and social services.

> *The majority of places that I would call and even their old pediatrician they can't give you an appointment after 3:30 or 3:45 and that's hard to do as a single parent. I have four kids and I need to constantly ask my boss – I need to leave early on this day or that day. . . . Basically as a single parent you have to choose are you going to take care of your family or keep your job.*
>
> - Caregiver in NJ InCK region

1. **The number of behavioral health providers in the InCK Model region is not sufficient to meet the demand for services.** A limited supply of providers exists, and interviewees agreed that low Medicaid reimbursement rates discourage providers from participating in Medicaid. The impact of the COVID-19 PHE increased demand for behavioral health services and created additional barriers to care by extending already lengthy waitlists.

2. **There are few bilingual and culturally competent providers, and the population of individuals with limited English proficiency is growing.** There is a significant shortage of providers and practitioners who can speak Spanish and the other non-English languages spoken in the region. There is a need for more culturally competent and representative providers in the region.

3. **Transportation is a barrier for many to access services.** Medicaid-covered transportation services are sometimes underutilized as patients may not feel comfortable with the transportation or understand how to access it. Access to public

transportation in the region is also a challenge. The distribution of providers varies within counties, creating different transportation needs and barriers across the InCK Model region.

4. **Needs assessments and service delivery are fragmented and may not be able to meet the needs of many beneficiaries and their families.** New Jersey's managed behavioral health system (Children's System of Care) and Medicaid MCOs provide care coordination and care management services. Availability of funds, eligibility criteria, and low beneficiary enrollment in MCO-provided care coordination programs contribute to lack of access.

5. **Individuals in the NJ InCK region experience high rates of food insecurity and other social needs.** Many small stores, restaurants, or other locations where residents could get healthy foods closed during the COVID-19 PHE. Community-based organizations and faith-based centers offset some of the food shortage needs, but the needs are greater than they can address.

One CIM shared a photo[45] (**Exhibit 7.23**) of the inside of Lunch Break, an organization that serves hot meals, provides life skills programs, and assists with fulfilling clothing needs and other wellness and health needs. Lunch Break also provides clients with hot meals and other food to take home. Lunch Break is an example of one program reaching families, but the need across the InCK Model region exceeds the capacity of community-based organizations. In addition, many families may not understand how to access available food supports or have a reliable transportation to travel to food support resources.

Exhibit 7.23. Lunch Break Extends Food Services

Available Resources

There are two children's hospitals in the InCK Model region: many small, independent private practices; three large primary care practices; and four federally qualified health centers. Primary care and medical specialties are readily available; however, communication across providers is disjointed and primary care providers do not have adequate resources to follow up on referrals. Caregivers and local providers reported that the supply of providers who accept Medicaid is limited. **Exhibit 7.24** includes details on the Medicaid-certified providers in the InCK Model region by specialty.

Exhibit 7.24. Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Family practice[b]	15.5
Nurse practitioners – All specialties	76.0
Pediatrician – All subspecialties	25.1
Internal medicine[b]	69.7
Emergency medicine[b]	20.7
Clinical psychologists[b]	12.9
Neuropsychology – Pediatric	<1

Notes:
   a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files*.
   b. Providers treat adults and children.

Medicaid Policy Context and Related Initiatives

The number of children enrolled in New Jersey Medicaid and Children's Health Insurance Program grew 11 percent from February 2020 to February 2021, increasing the estimated number of NJ InCK beneficiaries from 120,000 to 139,000.

A statewide mobile crisis response (MCR) system and local community-based care management organizations support individuals with complex behavioral health conditions and their families by connecting them to behavioral health and social services. Children with significant mental and behavioral health concerns may be eligible to receive county-based services. Local municipalities run school districts, public health departments, and other public programs under New Jersey's "home rule" structure[46]. Individual counties oversee other health and human services, such as education and child welfare services. The fragmented management structure contributes to operational silos among services.

Planned Approach and Progress to Implementation

Exhibit 7.25 highlights key components of NJ InCK's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.25. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress in the Pre-implementation Period
Alternative Payment Model (APM) Design	• The APM will have two components. The first is an incentive payment to primary care providers to review results of the assessments during a beneficiary's Early and Periodic Screening, Diagnostic and Treatment visit. The second component of the APM is a monthly, risk-adjusted payment to fund the advanced care management team.	• NJ InCK and NJ Medicaid discussed the APM rates and budget. New Jersey Medicaid agency agreed to assess the APM rates and budget six months following implementation to determine if modifications need to be made.
Integrated Case Management	• Individuals with a preliminary assignment in SIL 2 or SIL 3 will be assigned to a CIM to complete the intake process and make a final SIL determination. • Individuals in SIL 2 and SIL 3 will be assigned an advanced care management team. The team will work with beneficiaries and their families to address risk factors and ensure access to CCS and other needed resources in the community. The team will develop care plans with input from the primary care provider and the beneficiary/caregiver.	• The full advanced care management team includes a licensed social worker; a community health worker; a certified life specialist; and a family support specialist, who is a peer. All of the positions require certifications, trainings, or licenses. NJ InCK hired two CIMs and has one full advanced care management team in place. • NJ InCK developed (and in the process of finalizing) a consent form for caregivers to authorize CIMs to share completed NJ InCK Health Stories[47] and SIL classification with primary care providers.
Key Partnerships and Partnership Council	• NJ InCK's Partnership Council will include pediatricians; behavioral health providers; family advocates; Legal Aid; and essential state agencies, including the Medicaid agency, the Department of Children and Families (DCF), and DCF's Children's System of Care management organizations. • NJ InCK will contract with the New Jersey Chapter of the American Academy of Pediatrics to support provider engagement activities and work with a marketing firm to develop a website and other materials about NJ InCK.	• Partnership Council members supported the development of DUAs to obtain and share information from CCS providers. • Select pediatric primary care practices piloted the NJ InCK Health Story to determine if modifications should be made prior to the launch. • NJ InCK connected with more than 20 practices that serve approximately 80% of the eligible InCK population. • NJ InCK worked with the state's five Medicaid MCOs to distribute NJ InCK materials and informed enrollees about the NJ InCK Health Story and the benefits of NJ InCK.
MCR	• NJ InCK will coordinate with the statewide children's MCR system, which includes a central intake process and referrals to county-based care management organizations.	• NJ InCK established strong relationships and worked through communication protocols with the providers in the country while working towards the electronic exchange of information.

Domain	Planned Approach	Progress in the Pre-implementation Period
Person- and Family-Centered Care	• Under CIM oversight, the advanced care management team or existing care coordinators will work with beneficiaries and their families in the community using family-centered, integrated case management to address the child/youth's identified risk factors and priorities and ensure access to CCS and other resources in the community. • The care plans will identify clinical and social needs and goals. Advanced care management teams will work with beneficiaries and their families to identify action steps to support achievement of the goals.	• NJ InCK developed the NJ InCK Health Story, which was designed to promote a more comprehensive approach to caring for beneficiaries and to understand the needs of the entire family.
Screening and SIL Stratification	• NJ InCK will implement a hybrid approach combining Medicaid claims data and a self-reported comprehensive health needs assessment, the NJ InCK Health Story, to produce a preliminary SIL classification. After preliminary stratification into SIL 2 or 3, NJ InCK CIMs will review the results of the NJ InCK Health Story and complete an intake with the InCK beneficiary to make a final SIL determination.	• NJ InCK shared claims files for the population and NJ InCK began to apply the medical complexity algorithm to the claims data to inform SIL classification. • NJ InCK finalized the Health Story process, which will be available for patients and families to complete and submit to NJ InCK beginning in January 2022. • NJ InCK trained staff on the NJ InCK Health Story to support families with the completion of this assessment.

Outstanding Questions[48]

1. *NJ InCK's hybrid stratification model produces a preliminary SIL classification that CIMs will review with caregivers and primary care providers before determining the final SIL.* How is this hybrid process working? How often are preliminary SIL classifications adjusted? Are there any trends or patterns (e.g., common social or medical service needs, demographics) among beneficiaries with adjusted preliminary SIL classifications?

2. *NJ InCK intends for all InCK beneficiaries in the region to complete the NJ InCK Health Story. Assessing the substantial number of InCK Model beneficiaries is likely to uncover significant unmet needs.* How is the system prepared to meet these needs? How will NJ InCK ensure that SIL 1 beneficiaries, which will be the largest group, are able to access the services they need? Given large numbers, will InCK Model beneficiaries be able to access needed services in a timely manner?

3. *The NJ InCK technology platform and ability to share information with primary care providers, CCS providers, community-based organizations, and families is central to the NJ InCK Model's success.* Will NJ InCK be able to implement the platform as desired? How are families and providers engaging with the system?

4. *One of NJ InCK's goals is to integrate community-based care management with pediatric primary care providers. The NJ InCK APM is designed to bolster capacity of pediatric*

primary care providers by providing an incentive payment for screening and assessment and funding for an extended care team that will work closely with practices. How are pediatric primary care providers using the care management platform and engaging with the CIMs and advanced care management teams? How are pediatric primary care providers integrating the comprehensive assessment results into their discussions with beneficiaries and families during well-child visits?

5. *Access to linguistically and culturally competent care for NJ InCK beneficiaries is limited. There is a large and growing population with limited English proficiency and a large Orthodox Jewish community in the InCK Model region. How will NJ InCK ensure services are offered in a culturally informed manner?* How will NJ InCK use data or other strategies to monitor how it is serving or not serving groups that have been economically or socially marginalized and individuals with limited English proficiency? How is NJ InCK leveraging the Partnership Council to promote health equity in NJ InCK?

7.6   OHIO (OH) INCK

Overview

Characteristic	Description
Lead Organization	• Nationwide Children's Hospital (NCH)
Location	• Eastern Ohio (OH)
Goals and Targets	• Improve outcomes in healthcare quality measures • Reduce behavioral health-related inpatient hospitalizations and emergency department use, as well as out-of-home placements • Eliminate duplicative services across agencies to conserve state resources and minimize confusion for beneficiaries and their caregivers
InCK Model Region	• Two counties in eastern Ohio: Licking and Muskingum (Exhibit 7.26)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 35,080
Include Pregnant Beneficiaries Aged 21+	• Yes
Include Children's Health Insurance Program	• No
Selected Comparison Region	• Six counties located throughout Ohio: Lake (northeast), Belmont (east), Athens (south), Scioto (south), Pickaway (central), and Putnam (northwest) (Exhibit 7.26)
Focus of AR Stratification Approach	• OH InCK will use historical healthcare utilization and data from the Ohio Department of Medicaid and Ohio Department of Job and Family Services to initially identify beneficiaries potentially eligible for SIL 2 and SIL 3. Service integration coordinators (SICs) will follow up with beneficiaries potentially eligible for SIL 2 or SIL 3 and screen them for additional needs to finalize SIL assignments. • Service integration will be provided by non-clinical service providers, such as managed care plans and community-based mental health providers designated as single point of contact organizations.

Exhibit 7.26. Map of OH InCK Model and Comparison Regions
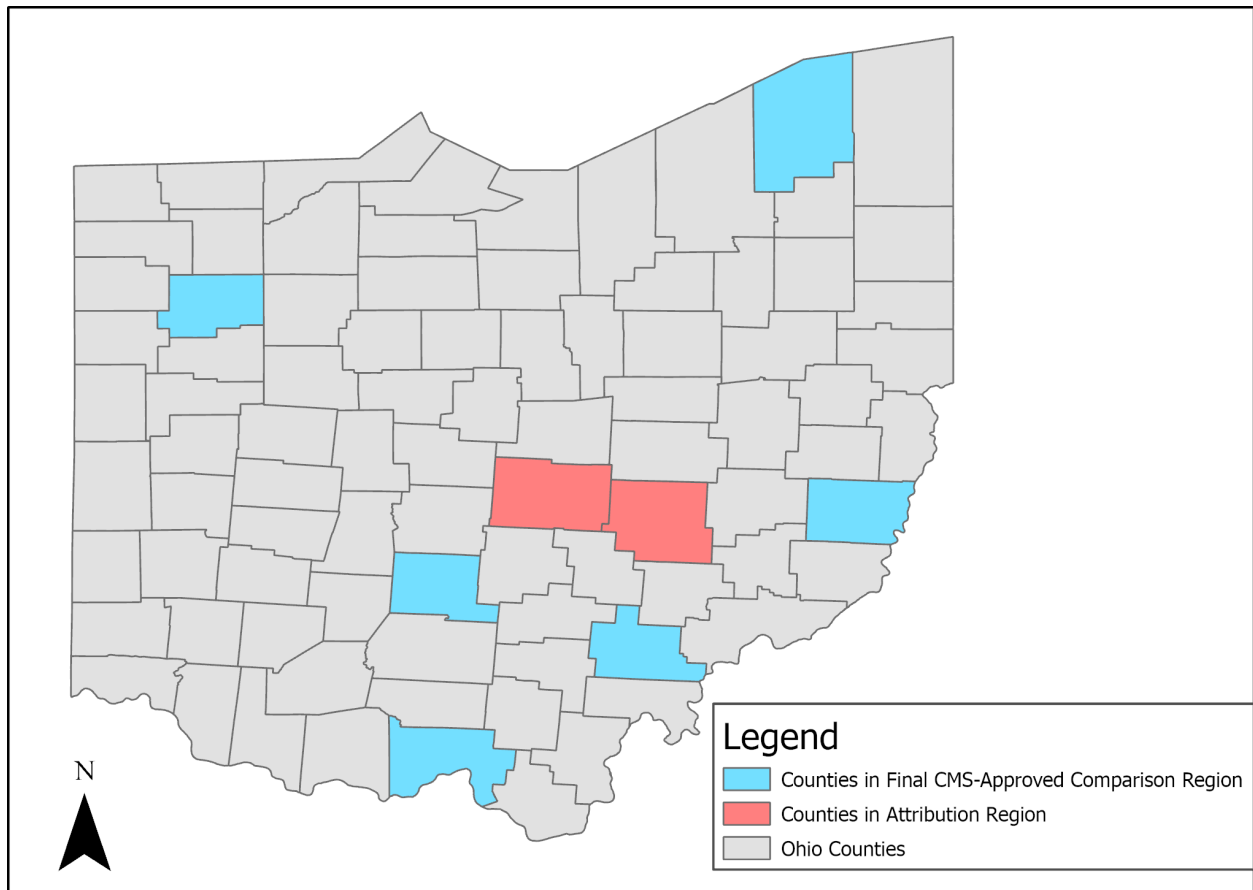
Community Context

Local Context

Exhibit 7.27 provides sample demographic characteristics of the InCK Model region.

Exhibit 7.27. Demographic Characteristics of the OH InCK Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees in the InCK Model Region[a]	
Enrollees who are Black	9.4%
Enrollees who are Hispanic	1.8%
Enrollees who are Asian American/Pacific Islander	2.7%
Enrollees who are 18-20 years old	8.2%
Characteristics for All Residents[b]	
Median household income[c]	$56,905
Residents living in a rural county[d]	33.3%
Residents speaking limited English[c]	0.4%
Residents who are food insecure[e]	13.1%
Residents with some college or more[c]	52.7%
Area deprivation index[f]	5.17
Homeownership[g]	71.1%
Severe housing problems[h]	11%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

OH InCK leadership, medical and CCS providers, and caregivers described similar challenges families face in accessing needed medical care, supportive therapies, and social services.

1. **The supply of behavioral health providers in the InCK Model region is limited.** Families often need to travel long distances to access behavioral health, especially any kind of specialty behavioral health care, which is burdensome and often unsustainable. Some providers and caregivers reported that children use emergency departments, juvenile detention centers, or foster homes until they can get needed care.

[Providers] aren't available locally. It's extremely hard to find child psychiatrists, it's like next to [impossible]. The ones that she does see aren't child psychiatrists…they are nurse practitioners… and when she was at [the hospital], we did see a psychologist, and one time for two seconds, a psychiatrist. But mostly the evaluation is 'summed up' by other people and the psychiatrist goes through all of the paperwork…and makes the diagnosis…That the hardest thing – finding an actual person, that has a degree, who really knows how to deal with kids' mental health.

- Caregiver in OH InCK region

2. **Social risk factors are prevalent, and significant silos exist between health care and social services.** Housing instability and lack of transportation are common in the InCK Model region. Both are difficult to address and make it harder for families to stay engaged in services. Providers and caregivers agreed that care is often siloed which can lead to either "fall[ing] through the cracks" or redundant care.

3. **Caregivers and families are reluctant to seek out or stay engaged in services.** Some providers identified stigma as a barrier to seeking behavioral health or asking for any kind of help. A caregiver's own substance use disorders or mental health needs are another barrier for a child's engagement in care.

One SIC shared this photo[49] of a tree as a metaphor to talk about the advantages of stable housing (**Exhibit 7.28**). Another agreed that stable housing is critical to successful engagement in services and shared that "when people don't have a permanent place to live or [are] in fight or flight mode, it can be really hard to see that sort of growth, physically, mentally, emotionally, [and] educationally."

Exhibit 7.28. A Tree Serves as a Metaphor for the Advantages of Stable Housing

Available Resources

The rural OH InCK region has a shortage of behavioral health providers and inpatient behavioral health capacity. Families are typically referred to NCH, which is located over an hour away, making ongoing engagement to services unsustainable. **Exhibit 7.29** includes details on the Medicaid-certified providers in the InCK Model region, by specialty.

Exhibit 7.29. Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Family practice – Pediatric subspecialties	25.1
Internal medicine – Adolescents	<1
Nurse practitioners – Pediatric subspecialties	47.3
Pediatricians – All subspecialties	9.98
Dentist – Pediatric	<1
Emergency medicine[b]	<1
Neuropsychology – Pediatric	<1
Occupational therapy – Pediatric	<1
Physical therapy[b]	1.43

Notes:

a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files*.

b. Providers treat adults and children.

Medicaid Policy Context and Related Initiatives

The OH InCK region is two rural counties (Licking and Muskingham) in eastern Ohio and includes 35,080 Medicaid beneficiaries up to age 21. These counties are part of NCH's pediatric accountable care organization catchment area. Both counties have higher rates of Medicaid and non-Medicaid children in the custody of the state's child service agencies than the rest of Ohio.

Since 2005, Ohio mandated managed care enrollment for Medicaid beneficiaries. The state recently re-procured their contracts with managed care plans, and there will be four operating in the InCK Model region during the implementation period.

Most children enrolled in Ohio Medicaid receive their services through a comprehensive managed care plan, which covers acute, primary, specialty, mental health, and substance use services. Ohio is concurrently implementing OhioRISE (Resilience through Integrated Systems and Excellence), which provides specialized comprehensive managed care for youth with complex behavioral health needs. This statewide program will overlap with OH InCK. OH InCK leadership are still determining coordination between the two programs.

OH InCK will build on NCH's pediatric accountable care organization, Partners for Kids, as the APM. OH InCK will also use Partners for Kids' existing communication channels to support provider engagement in OH InCK.

Planned Approach and Progress to Implementation

Exhibit 7.30 highlights key components of OH InCK's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.30. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress during the Pre-implementation Period
Alternative Payment Model (APM) Design	• OH InCK will leverage NCH's existing accountable care organization to implement an InCK Model-specific APM. • The APM will most likely include bonus payments for pay for reporting or pay for performance benchmarks and an enhanced per-member, per-month payment.	• The new managed care organizations contributed to the design the draft APM. OH InCK will accommodate changes arising from the managed care plan re-procurement (re-procurement will be finalized in July 2022).
Integrated Case Management	• Staff from managed care plans and community-based mental health providers will serve as the single point of contact for beneficiaries in SIL 2 or SIL 3 and their families. Beneficiaries will be assigned based on their managed care plan enrollment, existing provider relationships, and current service needs. • SICs will oversee the work of frontline providers and monitor the care plans to make sure beneficiaries are receiving needed services. • OH InCK will develop and rely on Apricot 360, a new data sharing platform, to support information sharing among providers and with families.	• OH InCK SICs with knowledge of the region and beneficiary social needs. • SICs received training for their role to oversee all integrated care management activities. • OH InCK established a memorandum of understanding with the organizations that will serve as the single point of contacts for families and engaged the organizations in planning and design work during the pre-implementation period.
Key Partnerships and Partnership Council	• The OH InCK Partnership Council will include representatives of 25 organizations from both Licking and Muskingum Counties. • NCH and Ohio Department of Medicaid will serve as "anchor partners," which are the primary partners to implement the model's activities.	• Partnership Council members maintained strong engagement throughout the pre-implementation period, despite a pivot to virtual meetings. • OH InCK also engaged the single point of contact organizations in the design work.
Mobile Crisis Response (MCR)	• OH InCK will build on existing MCR services in the region and will align with efforts for statewide MCR through the 988 number.	• Existing MCR providers in attribution counties worked with OH InCK to ensure current services align with model requirements and expected changes to services as the state moves toward implementing the statewide 988 number.

Domain	Planned Approach	Progress during the Pre-implementation Period
Person- and Family-Centered Care	• Single point of contact organizations will support work with beneficiaries in SIL 2 and SIL 3 (and their caregivers) to develop a care plan that encompasses beneficiary goals. • Single point of contact organizations will hold monthly case conferences for individuals in SIL 3 with all providers on the care team.	• OH InCK established MOUs with the single point of contact organizations and engaged them in the InCK Model planning process. • OH InCK developed the Apricot 360 platform to support information sharing among providers and created a self-serve portal, which will allow beneficiaries and families to review care plans and engage with providers.
Screening and SIL Stratification	• OH InCK will use administrative data from Medicaid and Department of Jobs and Family Services to complete an initial SIL assignment for beneficiaries • SICs will conduct in person or telephonic screens of beneficiaries presumed to be in SIL 2 or SIL 3 to confirm placement and identify additional needs.	• OH InCK established DUAs with the Ohio Department of Jobs and Families. OH InCK is still pursuing data use agreements with the Ohio Department of Mental Health and Addiction Services and the Department of Education. They hope to incorporate data from those agencies into SIL stratification in the future.

Outstanding Questions[50]

1. The implementation of OhioRISE at the same time as the implementation of the InCK Model presents a challenge. *How will OH InCK leverage OhioRISE to ensure that beneficiaries and caregivers receive streamlined care coordination? How will OH InCK ensure that the InCK Model activities do not duplicate care delivery and payment models that are already in place?*

2. The OH InCK Model aims to streamline the care coordination that a child receives so that provider organizations are not providing duplicate services or unneeded services. *Are there sufficient resources (e.g., funding, time, partners) in place for single point of contact organizations and SICs to properly implement and evaluate this component?*

3. CCS providers in the InCK Model region highlighted that they have ongoing workforce shortages and have been unable to hire additional staff to support the role of being a single point of contact organization. *How successful will OH InCK be in ensuring that beneficiaries have access to services through the single point of contact organizations? Will implementation of OH InCK reduce wait times for services that currently exist?*

4. Several CCS providers indicated that the Apricot 360 system may duplicate documentation processes and complicate their workflow. *How will providers use Apricot 360? Will it meet its goals of capturing all necessary data in an easy-to-read format to coordinate care across providers and with beneficiaries and families?*

7.7   VILLAGE INCK

Overview

Characteristic	Description
Lead Organization	• Egyptian Health Department (EHD)
Location	• Southern IL
Goals and Targets	• Increase utilization of preventive physical healthcare services and well-child visits • Expand and improve mobile crisis response services • Enhance substance use disorder prevention, treatment, and recovery services
InCK Model Region	• Five adjacent, rural counties in southern IL: Gallatin, Hamilton, Saline, Wayne, and White (Exhibit 7.31)
Number of Beneficiaries in InCK Model Region (as of December 31, 2021)	• 11,184
Include Pregnant Beneficiaries Aged 21+	• No
Include Children's Health Insurance Program	• No
Selected Comparison Region	• Twelve demographically comparable counties in mid and southern Illinois: De Witt, Edwards, Franklin, Fulton, Greene, McDonough, Montgomery, Pike, Pope, Pulaski, Scott, and Shelby counties (Exhibit 7.31)
Focus of AR Stratification Approach	• Village InCK will use a hybrid approach to stratify beneficiaries into a service integration level (SIL). They will combine Medicaid claims and foster care data with results from social drivers of health; adverse childhood experiences; and housing, nutrition, and education needs screenings. • SICs will serve as the single point of contact for beneficiaries in SIL 2 and SIL 3. EHD-employed family resource developers and existing wraparound coordinators will support the SICs.

Exhibit 7.31. Map of Village InCK Attribution and Comparison Regions
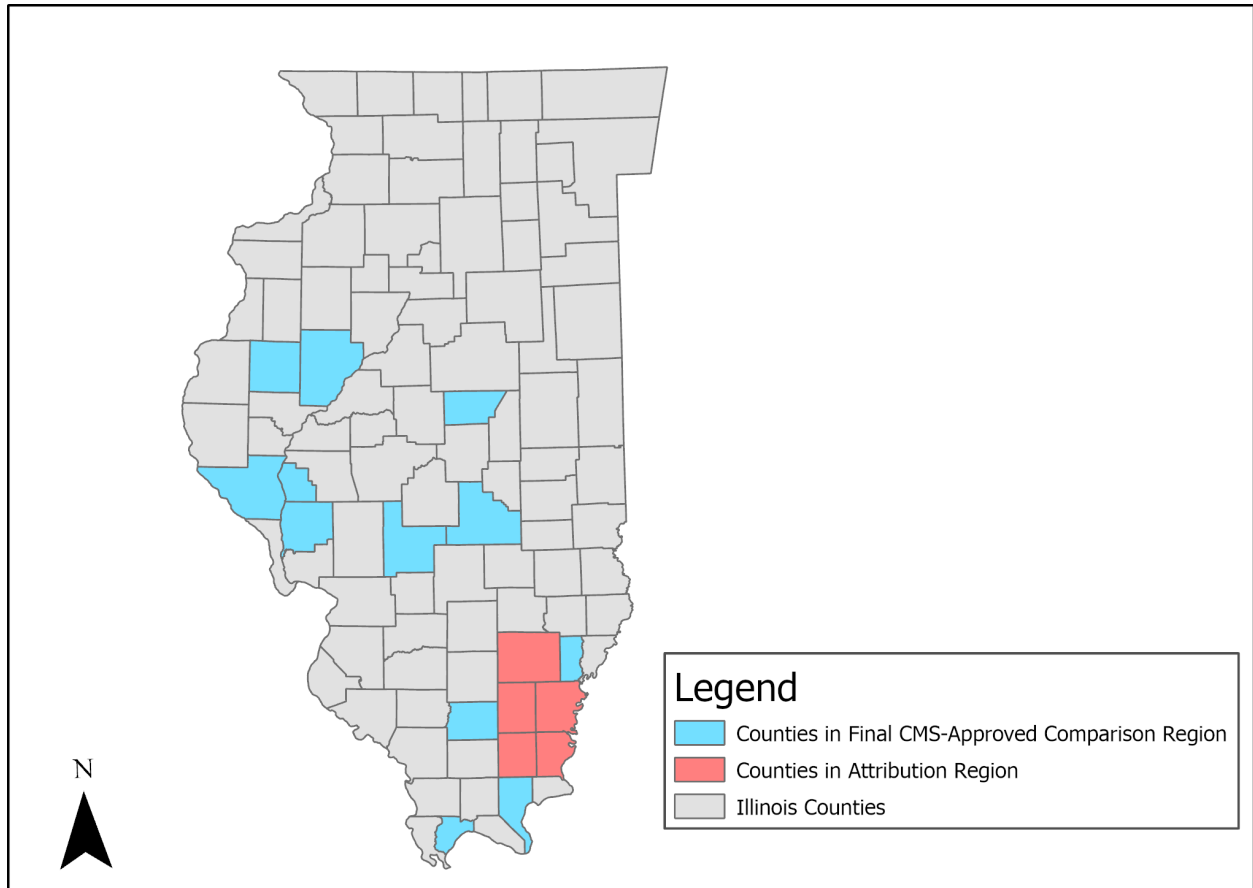
Community Context

Local Context

Exhibit 7.32 provides demographic characteristics of the InCK Model region.

Exhibit 7.32. Demographic Characteristics of the Village InCK Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees in the InCK Model Region[a]	
Enrollees who are Black	4.6%
Enrollees who are Hispanic	1.3%
Enrollees who are Asian American/Pacific Islander	0.8%
Enrollees who are 18-20 years old	6.7%
Characteristics for All Residents[b]	
Median household income[c]	$46,603
Residents living in a rural county[d]	100%
Residents speaking limited English[c]	0.6%
Residents who are food insecure[e]	12.4%
Residents with some college or more[c]	54.3%
Area deprivation index[c,f]	8.64
Homeownership[g]	75.7%
Severe housing problems[h]	9.1%

Notes: a-h: Please see source listing at the end of this chapter.

Common Service Gaps

Village InCK leadership and staff, clinical and CCS providers, and caregivers described similar service gaps in the InCK Model and comparison counties; they indicated that the rurality of the southern Illinois region exacerbates these gaps.

1. **Southern Illinois' rural counties have limited access to public transportation and the internet, making health care access difficult.** The geographic region served by EHD is large and isolated, with limited infrastructure, as illustrated in **Exhibit 7.31**. While the local bus system provides transportation to and from healthcare appointments, patients sometimes need to wait hours for a pick-up to return home. Many residents do not have reliable internet at home, resulting in barriers to using telehealth services and accessing or engaging in services more broadly.

> *It's more about getting the kids to be willing to accept the help. In our neighborhood, kids think it's bad for them to go talk to a counselor. They'll bottle it up until they do something stupid. In our neighborhood, a lot of kids come to our house to hang out because their lives at home aren't good.*
>
> - Caregiver in Village InCK region

2. **There is a lack of specialists in the area, especially dentists and behavioral health specialists, who accept Medicaid.** Individuals often travel hours and across state lines to access specialty care in person. Demand for the limited supply of behavioral health providers increased during the ongoing COVID-PHE, leading some providers to practice behavioral health services beyond their usual scope.

3. **Stigma and caregiver SUD may prevent children and families from receiving behavioral health services.** Despite recent efforts to reduce stigma, patients (including LGBTQ+ youth) are still hesitant to seek behavioral health services. Many families believe they should rely on prayer. Children with behavioral health needs may not receive services if their caregivers' substance use disorder and related health concerns take precedence.

One SIC shared a photo of a closed bridge that used to connect rural parts of southern Illinois[51] (**Exhibit 7.33**). This bridge has been closed for several years. The geographic region serviced by EHD is large and isolated from major cities, which makes accessing physical and behavioral health services challenging, especially for residents who lack reliable personal transportation or have limited public transportation options. In the case of this bridge, there is an alternate route, but it is several miles away.

Exhibit 7.33. A Bridge that Used to Connect Rural Parts of Southern Illinois is Closed, Exacerbating Rural Service Access Burden

Available Resources

In general, caregivers and providers reported a sufficient supply of physical health providers in the community, with many children accessing pediatric primary care through school-based clinics. However, specialists accepting Medicaid, particularly dentists and behavioral health providers, are limited. Patients needing certain specialty care are often referred to specialists in Missouri, Kentucky, or Indiana; these appointments require additional time, reliable transportation, and sometimes a place to stay overnight. Some states also limit the number of out-of-state Medicaid beneficiaries they accept. **Exhibit 7.34** includes details on the Medicaid-enrolled providers in the InCK Model region.

Exhibit 7.34. Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Family practice[b]	16.10
Internal medicine[b]	6.26
Nurse practitioners[b]	46.5
Pediatrician	<1
Clinical psychologists[b]	2.68
Emergency medicine[b]	9.84
Occupational therapy[b]	<1

Notes:
   a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files*.
   b. Providers treat adults and children.

Medicaid Policy Context and Related Initiatives

The Village InCK region is five counties in southern Illinois: Gallatin, Hamilton, Saline, Wayne and White. It includes 11,184 Medicaid beneficiaries up to age 21. These counties are all in EHD's clinical service area.

Illinois expanded Medicaid managed care to all counties in 2018. In 2020, all "youth in care" (i.e., children in foster care through the Illinois Department of Children and Family Services (DCFS)) were moved to the YouthCare Medicaid managed care program. In southern Illinois, providers estimated that approximately 70 percent of their patients under age 21 have Medicaid coverage.

The Illinois Department of Healthcare and Family Services (Illinois Medicaid) had originally planned to launch Integrated Health Homes (IHH), an initiative to integrate physical and behavioral healthcare coordination for adults and children with complex behavioral health needs, on July 1, 2021. EHD had planned to base Village InCK's APM on the IHH initiative's payment model. However, Illinois delayed its IHH launch multiple times, and as of November 2021, the launch date was unclear.

Planned Approach and Progress to Implementation

Exhibit 7.35 highlights key components of Village InCK's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.35. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress in the Pre-implementation Period
Alternative Payment Model (APM) Design	• Village InCK will develop an APM model that best meets provider and beneficiary needs.	• Village InCK pursued two APM options: an incentive-based payment model or an outcomes-based, per-member, per-month payment model. • They hired consultants and received technical assistance from the Lewin Group (InCK Implementation & Monitoring contractor) to help with APM development. • Village InCK filed a required 438 Preprint with CMS in late 2021, which identified the framework for the APM. Following CMS approval of the 438 Preprint, EHD will complete all necessary contracts with Medicaid MCOs.
Integrated Case Management	• Village InCK will utilize HealthEC platform for integrated case management, so that SICs, providers, and patients/families can access information and relevant documents (e.g., care plan, crisis plan, wraparound plan) in one online location. • SICs will serve as the single point of contact for beneficiaries in SIL 2 and SIL 3 and work with EHD-employed family resource developers and existing wraparound coordinators.	• Unite Us developed a referral platform and HealthEC developed the care management system in late 2021 and prepared to launch in early 2022. • Village InCK trained 11 SICs and other frontline Village InCK staff on case management roles, care coordination platforms, and available resources and clinical therapies for children.
Key Partnerships and Partnership Council	• Building off an existing relationship, the Office of Medicaid Innovation at the University of Illinois will partner and liaise between Village InCK and the Illinois Department of Healthcare and Family Services. • The Partnership Council will include external clinical and CCS providers.	• Partnership Council members participated in quarterly virtual meetings. Village InCK plans to recruit additional CCS providers and some participating Village InCK families for the Partnership Council in 2022. • Village InCK created sub-committees dedicated to Community Engagement, Compliance, Clinical, and Marketing/Promotions.
Mobile Crisis Response (MCR)	• Village InCK will leverage its role as the existing local MCR provider for three of the five Village InCK attribution counties. • Village InCK will include a peer support provider on all crisis calls in addition to the MCR behavioral health professional, allowing the peer support provider to immediately upload the patient's or family's crisis plan at the time of the call and begin setting up their referrals.	• Village InCK hired additional staff for EHD mobile crisis response services and established plans to work with MCR providers in the other two attribution counties and worked to integrated peer support providers into MCR response. • Village InCK leadership participated in daily MCR review calls and provided information back to Village InCK staff. They allowed some InCK staff access to daily crisis response data spreadsheet.

Domain	Planned Approach	Progress in the Pre-implementation Period
Person- and Family-Centered Care	• Providers will administer the IM+CANS screening tool to caregivers, if possible, in addition to beneficiaries, to see if caregivers should be flagged to receive additional services. • HealthEC will have a unique family identifier for members of the same family.	• Village InCK finalized the approach that SICs will manually identify members of the same family and group them under a unique family identifier. The manual process will help to match family members who cannot be matched automatically by same address or last name.
Screening and SIL Stratification	• Village InCK will use a hybrid approach for screening and SIL stratification, combining Medicaid claims and foster care data, social drivers of health and adverse childhood experiences screenings via NowPow (Unite Us), and Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) results via the HealthEC platform. SICs will review and manually confirm or modify SIL stratification for SIL 2 and SIL 3.	• Illinois Medicaid established a data use agreement with Village InCK to allow them to access Medicaid claims and enrollment data. • Village InCK worked on establishing a data use agreement with DCFS to obtain deidentified child welfare data.

Outstanding Questions[52]

1. The hybrid screening and SIL stratification process involves several steps, including screenings and a manual review by SICs to confirm SIL stratification recommendations. *How often will Village InCK reassess beneficiaries in the InCK Model area to determine if they should move to a different SIL? How will providers use NowPow (Unite Us) to administer screenings and assessments?*

2. SICs will work with existing care coordinators to provide integrated case management. *How do the roles of family resource developers and existing wraparound service coordinators overlap, if at all? How do they differ? How will SICs work with each of these provider types?*

3. Village InCK is using a two-generation approach to care; however, thus far, care delivery reforms seem focused on the children only. As of November 2021, Village InCK was planning to rely on providers' knowledge of the family to link children and their families/caregivers. *How will this approach work in practice? Are there specific types of children or families/caregivers for which this approach will not work as well? What services will Village InCK provide to other family members? Given Village InCK's two-generation approach, what is the reason for excluding pregnant adults?*

7.8   OREGON (OR) InCK[53]

Overview

Characteristic	Description
Lead Organization	• Oregon Health Authority (OHA), in partnership with Oregon Pediatric Improvement Project (OPIP)
Location	• Eastern Oregon (OR)
Goals and Targets	• Leverage existing work in the state and "knit together" child-serving programs and partners • Contribute to the shift toward population-based health management and away from system-specific silos of care
InCK Model Region	• Five counties in central Oregon and Willamette County: Jefferson, Deschutes, Crook, Marion, and Polk (Exhibit 7.36)
Number of Beneficiaries in InCK Model Region (as of May 2021)	• 103,204
Include Pregnant Beneficiaries Aged 21+	• No
Include CHIP	• Yes
Selected Comparison Region	• Eleven counties in West-Central Oregon: Benton, Clatsop, Columbia, Hood River, Washington, Yamhill, Jackson, Josephine, Malheur, Umatilla and Lincoln (Exhibit 7.36)
Focus of AR Stratification Approach	• OR InCK planned to use historical healthcare utilization (identified from Medicaid claims) to identify beneficiaries with physical and behavioral health needs. OR InCK planned to use Medicaid claims to flag caregiver substance use disorder(s), mental health issues, and incarceration to assess social risk. • Two system navigators (the OR InCK term for service integration coordinators, with one for each sub-region) planned to monitor SIL assignments and support integrated case management across partner organizations.

Exhibit 7.36. Map of OR InCK Attribution and Comparison Regions

f
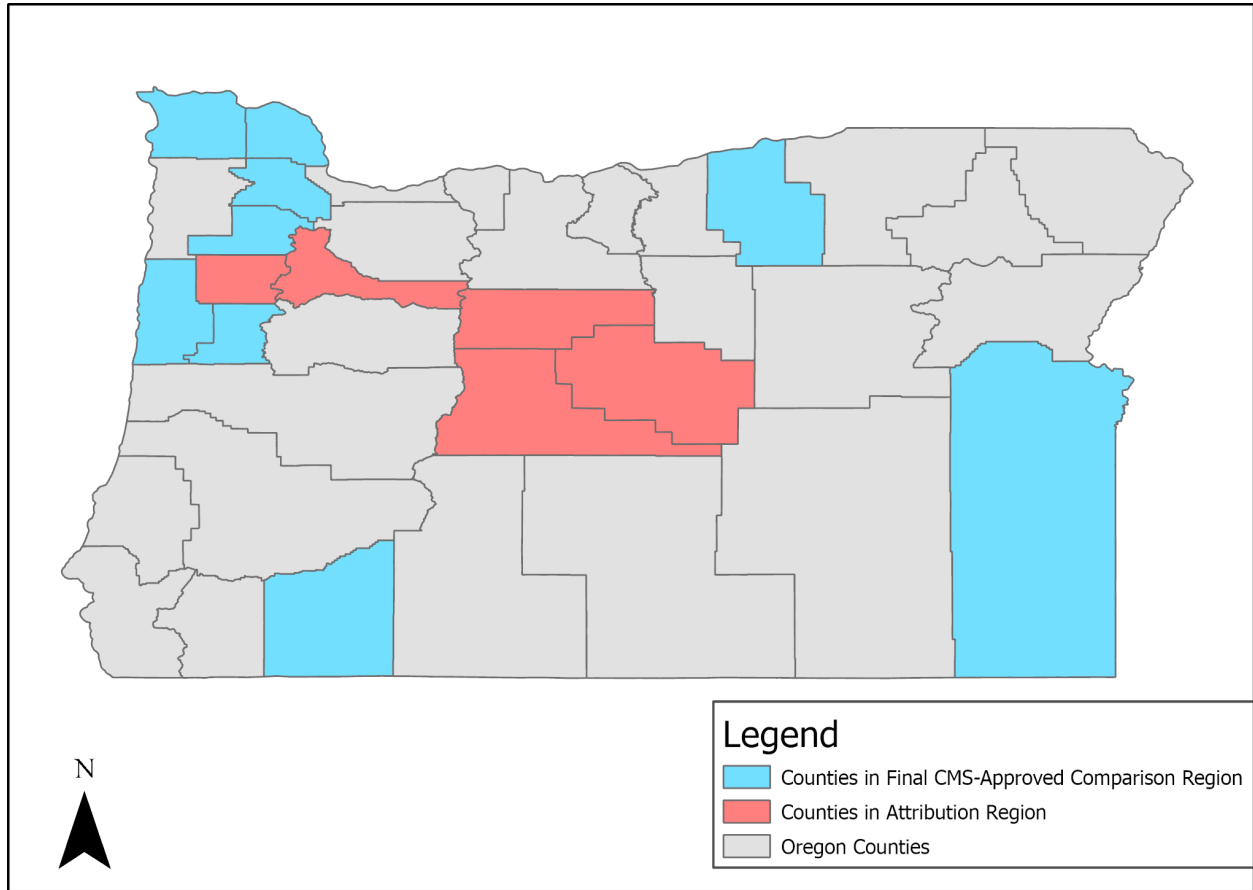
Community Context

Local Context

Exhibit 7.37 provides sample demographic characteristics of the OR InCK region.

Exhibit 7.37. Demographic Characteristics of the OR InCK Region

Characteristic	InCK Model Region
Characteristics for All Medicaid Enrollees in the InCK Model Region[a]	
Enrollees who are Black	1.1%
Enrollees who are Hispanic	55.8%
Enrollees who are Asian American/Pacific Islander	1.8%
Enrollees who are American Indian/Alaskan Native	2.8%
Enrollees who are 18-20 years old	8.5%
Characteristics for All Residents[b]	
Median household income[c]	$57,902
Residents living in a rural county[d]	7.1%
Residents speaking limited English[c]	3.2%
Residents who are food insecure[e]	11.6%
Residents with some college or more[c]	62.3%
Area deprivation index[f]	6.13
Homeownership[g]	62.7%
Severe housing problems[h]	15.0%

Notes: a-h: Please see source listing at the end of this chapter. Available Resources

Exhibit 7.38 includes details on the Medicaid-certified providers in the area, by specialty.

Exhibit 7.38. Medicaid-Certified Providers in the InCK Model Region, by Specialty[a]

Healthcare Market Characteristic	Per 10,000 Beneficiaries in the InCK Model Region
Clinical psychologist[b]	3.10
Dentist – Pediatric	29.2
Physical therapy[b]	53.5
Physician – All subspecialties[b]	192.1

Notes:
   a. Source: Centers for Medicare & Medicaid Services (CMS). (2021). *Interim Transformed Medicaid Statistical Information System (T-MSIS), Provider Files*.
   b. Providers treat adults and children.

Medicaid Policy Context and Related Initiative

The OR InCK region included two sub-regions: Central Oregon (Jefferson, Deschutes, and Crook counties) and the Willamette Valley (includes Polk and Marion counties). The InCK Model region also included four federally-recognized tribes and components of two tribal reservations.

Approximately 90 percent of Medicaid-enrolled children in the InCK Model region are enrolled in a comprehensive care organization (CCO), though the proportion of children on tribal lands in a CCO is significantly smaller (50 percent). Children not enrolled in managed care receive services via fee-for-service. Oregon has a longstanding and expansive CCO[54] infrastructure. In OR, CCOs operate on a global budget and receive a fixed monthly payment from OHA for care coordination and financial incentives based on performance. PacificSource Community Solutions (PSCS) is the single CCO that enrolls children in the InCK Model region.

Oregon employs a "no-wrong-door" approach to public benefit enrollment. One application (online, in person, or by phone) allows an individual to enroll in Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and other social support programs.

Planned Approach and Progress to Implementation

Exhibit 7.39 highlights key components of OR InCK's planned approach and the progress made during the pre-implementation period by InCK Model domain.

Exhibit 7.39. Planned and Pre-Implementation Activities by InCK Model Domain

Domain	Planned Approach	Progress during the Pre-implementation Period Prior to Withdrawing
Alternative Payment Model (APM) Design	• OR InCK would have aligned the InCK Model APM with CCO contracts.	• OR InCK worked closely with PSCS to inventory their existing APMs and identify opportunities for alignment.
Integrated Case Management	• Service integration for beneficiaries in SIL 2 and SIL 3 would have primarily occurred through the PSCS staff and systems. Beneficiaries would have received care coordination through their primary care medical home and additional support from PSCS member services. • OR InCK planned to hire two system navigators who would monitor InCK Model beneficiaries and would have served as the single point of contact for beneficiaries not aligned with a primary care medical home.	• PSCS and OR InCK worked together to design the approach to service integration. • OR InCK did not hire system navigators during the pre-implementation period.
Key Partnerships and Partnership Council	• OR InCK would have developed separate Partnership Councils for each region and planned to establish a parent, youth, and young adult advisory group as part of the Partnership Council.	• OR InCK established two Partnership Councils – one for each sub-region (Central Oregon and the Willamette Valley), which met quarterly. • They also created 12 workgroups comprised of OR InCK, OPIP, and PSCS staff; workgroups focused on the design and implementation of specific model elements. • OR InCK did not establish a parent, youth, and young adult advisory group during the pre-implementation period, nor did they successfully engage tribal leadership.
Mobile Crisis Response (MCR)	• OR InCK would have leveraged a program that the state planned to implement, the statewide mobile crisis response stabilization service (MRSS), for children and families.	• OR InCK leadership met monthly with the team responsible for implementing the MRSS system to coordinate implementation efforts and lay groundwork for data sharing.
Person- and Family-Centered Care	• Beneficiaries in SIL 2 and SIL 3 would have received care coordination from existing PSCS care managers. For beneficiaries in SIL 3, the PSCS care manager would have been responsible for identifying members of the care team, developing a care plan, and convening the care team monthly.	• PSCS and OR InCK partnered closely to finalize their planned approach to care management.

Domain	Planned Approach	Progress during the Pre-implementation Period Prior to Withdrawing
Screening and SIL Stratification	• OR InCK planned to apply a data driven approach to screening and SIL stratification. They planned to use the Pediatric Medical Complexity Algorithm and Medicaid claims to stratify beneficiaries into SILs. • Providers use a variety of social needs screeners, but OR InCK did not intend to include findings from the screeners in the SIL stratification.	• PSCS and OR InCK established a DUA to share healthcare data to support SIL stratification, which would cover beneficiaries enrolled in the PSCS CCOs. • OR InCK decided not to pursue data sharing agreements with tribal governments or CCS providers during the pre-implementation period as a result of the ongoing COVID-19 public health emergency and other competing priorities.

Decision to Withdraw

OR InCK decided to exit the InCK Model in October 2021. Issues arose over the course of the pre-implementation period. Specifically, OR InCK:

• Did not have a plan to conduct universal SIL stratification for all Medicaid-enrolled children in the InCK Model region. They planned to limit screening efforts to children enrolled in the CCO, which would have excluded a sizable number of children living on tribal lands. This limitation introduced significant concerns about inequity in their planned approach.

• Did not have a mechanism to report individual-level data on key performance measures, such as depression screening, food instability, and housing insecurity.

• Did not have a strategy to incorporate CCS needs into their planned approach to screening and SIL stratification. Although their final application proposed developing a universal screening tool for social needs, the ultimate planned approach relied solely on claims data. The claims-only approach would have systematically underrepresented children who are a risk of out-of-home placements resulting from social needs or those without historical healthcare utilization.

Ultimately, OR InCK decided to exit the model.

SOURCE LIST FOR EXHIBITS 7.2, 7.7, 7.12, 7.17, 7.22, 7.27, 7.32, 7.37

a. Source: Centers for Medicare & Medicaid Services (CMS). (2019). Interim Transformed Medicaid Statistical Information System (T-MSIS).

b. Average across InCK Model ZIP Codes weighted by the population of each ZIP Code.

c. Source: Census Bureau. (2018). *American Community Survey.* https://www.census.gov/programs-surveys/acs through the Agency for Healthcare Research and Quality. (2018). Social Determinants of Health Database. https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html.

d. Source: U.S. Department of Agriculture. (2010). *Rural-Urban Community Area Codes.* https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx through the Agency for Healthcare Research and Quality. (2018). *Social Determinants of Health Database.* https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html.

e. Source: University of Wisconsin Population Health Institute. (2020). *County Health Rankings & Roadmaps.* https://www.countyhealthrankings.org/

f. Area deprivation index measures socioeconomic disadvantage at the United States Census tract level using income, education, employment, and housing quality measures contained in the 2015 American Community Survey Five Year Estimates; a higher value indicates areas at a greater socioeconomic disadvantage. Sources: Kind, A.J.H., Buckingham, W. (2018). Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. New England Journal of Medicine, 2018. 378: 2456-2458. And University of Wisconsin School of Medicine Public Health. (2019). *2018 Area Deprivation Index v3.0.* Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/.

g. Percentage of occupied housing units that are owned by occupant. American Community Survey (5-year estimates 2014 – 2018) via the County Health Rankings.

h. Percentage of households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Source: Comprehensive Housing Affordability Strategy data, 2012-2016 through University of Wisconsin Population Health Institute. (2020). *County Health Rankings & Roadmaps.* https://www.countyhealthrankings.org/

Appendices

Appendices

Separate appendices document the following:

A. [Pre-implementation period evaluation activities](#)

B. [Comparison group methodology](#)

C. [Case study methods](#)

D. [Case study master protocol](#)

APPENDIX A. PRE-IMPLEMENTATION PERIOD EVALUATION ACTIVITIES

Exhibit A.1 details the purpose (the rationale of the activity), the process (the steps that we took to conduct the activity), and the procedures (analytic activities to develop results and findings).

Exhibit A.1.   Complementary Data Provide a Comprehensive Understanding of the Implementation and Impact of the InCK Model

Data Sources	Planned Research Questions	Purpose	Process	Procedures (Analytic)
Award recipient document review	1-9	• Augment the evaluation team's understanding of each award recipient's (AR's) model • Classify the local context relevant to model operations • Identify changes during program implementation • Prepare site visit teams for interviews with ARs, model partners, and local providers and participants • Identify explanatory variables that could affect model implementation or outcomes	• Develop an inventory of materials • Identify key variables, develop abstraction tool, and create analysis plan to identify key themes aligned with the PRISM framework • Train team members on the inventory and process to extract data from AR documentation • Abstract information, analyze results, develop summary, and assess completeness of measures across ARs	• Conduct content analysis and synthesis of data abstracted into AR-specific abstraction tools • Review findings within and across AR evaluation teams
Environmental scan	1, 5, 8	• Provide insight into statewide and local activities that may influence implementation and impact of the model • Identify additional data and sources for potential moderating factors for Impact Study	• Assess the availability of national data sets and policy compendiums identified through the literature review • Refine parameters of the scan, search strategy, and sources • Assess materials, determine completeness, and further search as needed • Synthesize materials collected, identify gaps, summarize results, and finalize scan	• Conduct searches using defined scan parameters • Compile source materials into central repository (i.e., EndNote library) • Review source materials in full, extracting relevant information

Data Sources	Planned Research Questions	Purpose	Process	Procedures (Analytic)
Project officer (PO) and AR calls	1-5, 7-9	• Provide real-time insight into AR implementation activities • Identify further contextual factors that may influence local model design or implementation • Identify explanatory variables that could affect model implementation or outcome(s) • Identify successes and challenges	• Observe calls between PO and ARs monthly • Identify potential contextual factors or explanatory variables applicable to other aspects of the evaluation	• Develop detailed notes during each call and share with other evaluation team members as needed
Interviews with POs and case study activities	1-9	• Provide AR-specific information on model design, local context, implementation, provider and patient/family engagement, other care redesign activities, and facilitators and barriers to successful implementation • **Appendix C** provides detail on the case study activities	• Conduct preliminary calls with POs and AR lead agencies • In collaboration with AR lead agency, identify relevant individuals representing diverse roles for site visits in a given year (i.e., lead agency, state Medicaid agency, Partnership Council members, local providers, beneficiaries, caregivers) • Develop protocols for each respondent type or activity and customize questions to probe on AR-specific context and programming (see sample protocols in **Appendix D**) • Conduct site visits • Clean, code, and analyze site visit data using a universal, thematic codebook embedded in qualitative analytic software (Dedoose) • Analyze results, identifying within- and across-AR themes and findings	• Conduct within- and across-case thematic analyses using a universal codebook in qualitative analytic software (Dedoose) • Produce detailed case study reports summarizing each AR

Data Sources	Planned Research Questions	Purpose	Process	Procedures (Analytic)
Retrospective Attribution File (RAF)	1	• Obtain identifying information and Medicaid eligibility dates for the ARs' attributed populations • Link the Transformed Medicaid Statistical Information System (T-MSIS) and CCS data • Align the comparison group with the specific population targeted by the AR	• Acquire RAFs and related documentation that ARs provide to CMS • Review data and conduct analyses for quality control • Produce detailed memoranda that document data discrepancies, anomalies, and format-deviations; requests that ARs address issues • Submit the memoranda to CMS for CMS to release to the ARs • Repeat process as ARs respond to memoranda and resubmit files	• Conduct analyses for quality control • Produce detailed memorandums addressed to ARs • Use identifying information and eligibility dates to extract Medicaid eligibility, claims, and encounter data for attribution and comparison populations from T-MSIS files
T-MSIS	1	• Develop comparison group (see **Appendix B** for description of comparison group methodology) • Measure primary outcomes of the Impact Study during the baseline, pre-implementation, and implementation periods (accounting for the COVID-19 public health emergency) • Estimate the impact of the InCK Model on beneficiaries' use of healthcare services, total Medicaid spending, institutional stays, and quality of care • Identify beneficiary characteristics for risk-adjustment • Inform qualitative data collection activities	• Examine data quality in the Research Identifiable Files (TAF RIF) for InCK Model attribution and comparison regions, updating as CMS releases new TAF RIFs • Assess whether changes in data quality in new TAF RIFs could invalidate primary outcomes given existing measure specifications • Update analytic data sets with beneficiary outcomes and descriptive information using new TAF RIFs • Estimate the impact of the InCK Model on SILs 1, 2, and 3 using a difference-in-difference analysis	• Replicate data quality analyses conducted during pre-implementation • Compare results of data quality analyses to existing measure specifications • Rerun existing SAS programs to incorporate new data releases into the analytic data set • Estimate individual-level weights through entropy balancing • Use weighted, multivariate regression and a difference-in-differences approach to estimate the impact of the InCK Model on the primary outcomes of SILs 1, 2, and 3

APPENDIX B. COMPARISON GROUP METHODOLOGY

Objectives of the Comparison Group Feasibility Study

The Integrated Care for Kids (InCK) Model evaluation's Impact Study will use a quasi-experimental approach to estimate the effects of each award recipient's (AR's) model on key outcomes among InCK Model participants. The evaluation team intended for comparison group regions to represent the counterfactual scenario (in which the InCK Model was never implemented) against which to compare each AR's performance. Identifying a valid comparison group is a critical first step in the approach to estimate the impact of the InCK Model on 1) utilization, 2) costs of Medicaid-covered services, 3) quality of care, and 4) out-of-home placement.

In 2021, the evaluation team conducted a Comparison Group Feasibility Study (CGFS) to identify comparison groups for each of the eight ARs. The CGFS focused on identifying a suitable comparison group for the entire attribution population for each AR in the ARs' selected InCK Model regions. The attribution population includes all children younger than 21 years old covered by Medicaid (and Children's Health Insurance Program (CHIP) if ARs choose) and for specific ARs, pregnant people aged 21 and older.[55,56] Identifying a suitable comparison *group* (the collection of individuals in the comparison region who otherwise would be eligible for the AR's intervention) required identifying a suitable comparison *region*.

Criteria for the Comparison Groups

The Centers for Medicare & Medicaid Services required applicants to propose an in-state comparison region with a rationale for its suitability as part of their InCK Model applications. The comparison region was required to consist of contiguous counties or ZIP Codes. To develop optimal comparison regions, the evaluation team considered both non-contiguous areas as well as the contiguous areas proposed by ARs.

In addition to considering ARs' proposals, the evaluation team used three fundamental criteria to identify suitable comparison regions:

1. **Similar characteristics and trends:** Comparison regions need to have a similar Medicaid/CHIP-enrolled population as the InCK Model region and be in a similar healthcare market and policy environment. Additionally, trends in outcomes during the baseline period need to be similar to that of the InCK Model region so the evaluation team is as confident as possible that, in the absence of the InCK Model, the trends in the comparison region would have been similar to that of the InCK Model region during the implementation period. We tested four outcomes: 1) annualized rates of inpatient hospital admissions, 2) days hospitalized, 3) outpatient emergency department visits, and 4) total Medicaid expenditures.

2. **Sufficient sample size**: The population size of Medicaid and CHIP enrollees in the comparison region who meet ARs' eligibility requirements must be sufficiently large and balanced on individual-level characteristics to support analyses of factors that contribute to variation in outcomes in service integration level (SIL) 1 and, later in the evaluation, the smaller SILs 2 and 3. These factors included rural status, race and ethnicity, whether English is the person's primary language, and age.

3. **Data availability and quality**: Data of sufficient quality must be similarly available across the InCK Model and comparison populations so that the evaluation can match a comparison group to the InCK Model beneficiaries, compare outcomes, and control for factors that could bias impact estimates, particularly factors that led to the AR's self-selection into the program.

We considered AR-specific nuances, described below, before we determined the final recommendations for the comparison regions.

Mixed Methods Approach to Identify Suitable Comparison Groups

This section describes the data sources and approach the evaluation team used to identify a suitable comparison region for each AR.

Data Sources

We used both qualitative and quantitative data sources, as described in **Exhibit B.1**.

Exhibit B.1. Data Sources

Data Source	Purpose	Years Considered	Influence on CGFS
AR documents, environmental scans	Understand the AR target population, the comparison groups selected by the ARs, and the current policy and healthcare environment	2019-2021	Tailor the approach for each AR by excluding certain counties or ZIP codes and selecting the most important criteria upon which to match
Interviews with project officers and ARs	Determine nuances in AR selection of comparison groups	2021	
Publicly available data	Assess regional-level variables that reflect contextual factors that could influence implementation	2014-2020	Match InCK Model region to counties or ZIP codes with similar contextual factors
Transformed Medicaid Statistical Information System (T-MSIS)	Assess regional-level variables and measure outcomes related to healthcare utilization and costs	2017-2019	Test for parallel trends in outcomes between the attribution and comparison regions, a key assumption for the Impact Study

Approach

Interviews with ARs revealed that ARs considered nuances related to their local demographics, healthcare delivery systems, and policy environments when proposing a comparison region. Therefore, the evaluation team started the search by considering whether each AR's proposed comparison region met the criteria described above. The evaluation team preferred to retain an AR's proposed comparison region unless we found a preponderance of evidence for a more suitable set of counties or ZIP Codes in the state. Considerations such as the total number of counties in a state or low regional variation in key variables dictated the appropriate statistical approach for identifying each AR's recommended comparison region.

We took six steps to determine if a proposed comparison region met the criteria or whether there was an alternative set of counties or ZIP Codes that made a more suitable comparison region:

- *Step 1. Identify key characteristics of the AR's attribution groups on which to match regions.* The evaluation team collected information about the AR's local context and the intended InCK Model approach through document reviews, environmental scans, and AR interviews. Based on these data, we identified a brief list of variables to characterize contextual factors that could influence implementation.

  - *Demographic or socioeconomic factors* related to patient engagement and access to, or use of, healthcare services. These included factors such as rural status, race and ethnicity, whether English is the person's primary language, age, education, an area deprivation index (ADI), and the proportion of Medicaid/CHIP enrollees in a pregnancy-related eligibility group at any time in the year.

    Ideally, the evaluation should match the InCK Model region with other regions based on concentrations of individuals that share a similar culture, ancestry, or historical experience. At the time of the CGFS, the evaluation team did not have granular data on race and ethnicity. Therefore, we used the information available in the American Community Survey and Transformed Medicaid Statistical Information System (T-MSIS) data to obtain regional-level data on race and ethnicity. The American Community Survey follows the Standards for Race and Ethnicity (1997) in accordance with the U.S. Office of Management and Budget (OMB). OMB Race Categories are comprised of American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. OMB Ethnicity Categories are comprised of Hispanic or Latino and Not Hispanic or Latino. The standardized T-MSIS measures for race and ethnicity are more granular but are of inadequate quality; the more targeted race and ethnicity categories (e.g., Korean, Vietnamese, Cuban, Puerto Rican) are coded less frequently than expected, and the "Hispanic or Latino Unknown" or "Ethnicity Unspecified" categories are coded more frequently than expected. Future evaluation activities will use more granular data to the extent available.

  - *Social drivers of health outcomes,* such as median household income, rates of food insecurity, foster care,[57] homeownership, severe housing cost burden, deaths related to drug overdose, and juvenile arrests.

  - *Supply of healthcare services* – including ratio of the population to primary care practitioners (PCPs), hospital beds per capita, Health Professional Shortage Area (HPSA) designation (mental health and primary care), presence of a psychiatric hospital or one that provides some psychiatric services, and presence of a hospital that provides rehabilitation services for substance use disorders.

  - Prevalence of COVID-19 during 2020, defined as COVID-19 cases per capita.

  Within these broad categories, variables that we considered particularly important for characterizing each AR's attribution group depended on specific AR factors. Some variables were available only at the county or ZIP Code level; thus, the specific set of variables that we used to characterize InCK Model regions differed depending on whether ARs defined their regions using counties or ZIP Codes. For example, we compared the percentage of the population with limited English proficiency (from the American Community Survey, or ACS) across counties and the percentage of the population who speak a non-English language at home (from the Agency for Healthcare

Research and Quality [AHRQ] Social Determinants of Health database) across ZIP Codes.

- *Step 2. Consider non-quantifiable factors that could potentially exclude a county or ZIP code from a suitable comparison group.* We used the findings of the environmental scans and the notes from the evaluation team's interviews with the ARs to identify InCK Model-like state or local initiatives that were active or soon-to-be-active in parts of the state. If such an initiative was not also similarly implemented in the InCK Model region, the comparison region could not serve as a counterfactual scenario for the attribution region, because we could not be certain whether the key assumption for the difference-in-difference (DID) model would be violated – i.e., the attribution and comparison regions would have similar trends over time if the InCK Model were never implemented. This violation could invalidate the impact estimates. Therefore, we excluded counties and ZIP Codes from the analyses if they were or are touched or will be touched by such an initiative (to the extent that this information is known at the time of the CGFS), and that initiative does not also touch the InCK Model region.

- *Step 3. Identify potential alternatives to the AR's proposed comparison regions.* CMS required the ARs propose a comparison region consisting of a set of contiguous counties or ZIP Codes. We relaxed this constraint to explore whether a combined set of non-contiguous counties or ZIP Codes better matched the key characteristics of the overall InCK Model region. We used both propensity scores (PS) and Mahalanobis distance scores for matching. For each county in an AR's region, we matched it to the three most similar counties in the state, with replacement.[58,59] For ARs using ZIP Codes to define their InCK Model region, we matched each ZIP Code to the three most similar ZIP Codes in the state, following a match with replacement process.

  We matched on the same set of covariates when using PS and Mahalanobis distance scores matching. After multiple iterations to identify the best model, we found that the best strategy to balance all variables in the larger list of key characteristics was to do the following:

  – Exactly match counties according to whether they were rural or non-rural, then match the counties on just four variables: ratio of the population to primary care practitioners (PCPs); hospital beds per 100,000 population; COVID-19 cases per 1,000 population during 2020; and either the Area Deprivation Index (ADI) or median household income.

  – Exactly match ZIP Codes according to whether they were rural or non-rural, then match the counties on just six variables: percentage of the ZIP Code population who are Black; percentage of the ZIP Code population who are Hispanic; percentage of population receiving Supplemental Nutrition Assistance Program (SNAP) benefits; median household income; ratio of county population to PCPs; and COVID-19 cases per 1,000 population in the county during 2020.

  Mahalanobis matching is sensitive to the number of covariates relative to the number of observations being matched, and it does not perform well when the covariates are not normally distributed. PS matching is less sensitive to the dimensionality and distributions of the covariates, but it is sensitive to a small number of observations in the treatment

group. As a result, there tended to be little, albeit some, agreement between the two sets of results. By using both approaches, however, we were able to explore the balance of key characteristics across several alternative comparison regions in the next step.[57]

- *Step 4. Compare the balance of key characteristics across the AR's attribution, proposed comparison, and matched comparison regions.* We calculated the difference in the population-weighted averages of the regional-level variables between the InCK Model region and the proposed comparison region.[60] We made the same comparisons between the InCK Model region and the potential comparison regions that were identified by PS, matching each attribution county/ZIP Code to one, two, and three similar counties/ZIP Codes, respectively. We did the same with the Mahalanobis-matched comparison groups. We then calculated and compared the variable means across regions separately for each year in the baseline period (2017–2019).

  We took an integrated approach to determine which of the potential comparison regions we would recommend for each AR's final comparison region. We considered a variable to be better balanced if there was a smaller absolute difference between the attribution and comparison regions' population-weighted averages.[61] We judged a comparison region to be more suitable than another potential comparison region if

  1. The number of InCK Model-eligible Medicaid/CHIP-enrollees in the region was equal to or greater than the number of InCK Model-eligible Medicaid/CHIP enrollees in the InCK Model region, and

  2. A greater number of the key variables were near equally or better balanced with the InCK Model region than they were for the next most-balanced comparison region.

  If the next most-balanced comparison region was the group proposed by the AR, then we looked for non-trivial improvements in covariate balance before we recommended substituting an alternative to the AR-proposed comparison region.

- *Step 5. Use the entropy balancing technique to assess the feasibility of constructing individual-level weights.* For the Impact Study, we will use entropy balancing to construct individual-level weights to balance the distributions of individual-level covariates more precisely between the comparison and attribution groups.[62] For the purposes of determining the comparison groups, we explored whether it will be feasible to use entropy balancing to weight the individuals in the candidate comparison group. In our exploration of the feasibility, we used a basic set of demographic variables available in the T-MSIS Analytic File (TAF) Demographic and Eligibility file: age, race, Hispanic ethnicity, receipt of public assistance, and whether English is the person's primary language.[63]

- *Step 6. Test for parallel trends in outcomes between the attribution and comparison groups during the baseline period.* We tested whether there were similar trends in the Impact Study's primary outcomes across the attribution group and potential comparison group during the baseline period, a key assumption of the DID model. We presumed that the more outcomes that exhibit parallel trends with only basic risk adjustment, the more likely it will be feasible to meet the parallel trends assumptions for most key outcomes for the Impact Study. We conducted parallel trends tests on four outcome measures:

1. Annualized rates of inpatient hospital admissions,

2. Days hospitalized,

3. Outpatient emergency department visits, and

4. Total Medicaid expenditures.

We weighted the data used to estimate parallel trends using the weights constructed in Step 5 and risk adjusted for the same basic demographic variables used to construct the weights. Like the tests for the feasibility of constructing weights, these are cursory parallel trend tests, using only basic risk-adjustment. For efficiency purposes and given that the analyses are preliminary to identify feasibility of the approach, we used a rudimentary approach to weighting and risk-adjustment to explore whether we will be able to satisfy the DID model's parallel trends assumption for the Impact Study once we collect more data and further develop the models for the outcomes and individual-level weights. We believe that we will be able to find parallel trends once we have more and better data and more detailed and deliberately constructed models for the outcomes and selection into the attribution group (i.e., the weights).

APPENDIX C. CASE STUDY METHODS

This appendix summarizes the data collection activities and analytic methods that the evaluation team used to inform the development of award recipient (AR) case study reports. These reports summarized the following:

- Local context, model design, and partners;

- An overview of the beneficiaries that ARs intend to serve and the experiences of providers, caregivers, and staff prior to the implementation of the model;

- The status of each AR's implementation of key model design elements, including how ARs prepared to implement their programs at the end of the pre-implementation period (January 2020 to December 2021).

Evaluation Framework and Key Research Questions Addressed

The evaluation team conducted various activities during the pre-implementation period to explore local context, policy environment, and pre-existing infrastructure in each AR's region. These elements helped identify variation among AR interventions, the context of AR implementation, and the size and characteristics of the InCK Model populations.

Case Study-related Evaluation Activities

The evaluation team undertook the following three activities to develop the case study reports:

1. Reviewed AR program documents and conducted an AR-specific environmental scan

2. Analyzed Medicaid claims and publicly available data

3. Conducted site visits with ARs

The evaluation team assigned AR-specific teams to conduct the above activities, with interpretation and analysis support provided across all team members.

AR Document Review and Environmental Scan

Timing
The evaluation team conducted a document review and environmental scan to examine data from the pre-implementation period.

Process
Step 1. Developed an inventory of AR-submitted documents. Evaluation team leadership reviewed (and continues to review) AR-submitted materials, including model applications, implementation and operational plans, quarterly and annual progress reports, and draft standard operating procedures. The evaluation team provided a draft list of data sources to the Centers for Medicare & Medicaid Services (CMS) project officer (PO) for feedback on completeness and relevance.

Step 2. Identified key variables, developed an abstraction tool, and created an analysis plan to identify key themes aligned with the [practical, robust implementation and sustainability model (PRISM) framework](#). The evaluation team developed an Excel-based abstraction tool to capture key information from AR documents, such as characteristics of the local model design, beneficiaries and their caregivers' characteristics, participant experience(s), and local context. The evaluation team aligned the PRISM framework to the extracted key variables and designed the analysis plan to synthesize critical information across these data sources.

Step 3. Trained full evaluation team, extracted data, and reviewed results. Evaluation leadership team trained all team members on the process, abstraction tool, and data sources. Each AR site visit team then abstracted data from AR documents into the abstraction tool, analyzed data across sources, shared findings with evaluation team leadership, and identified gaps.

Step 4. Identified publicly-available data sets and policy compendia, then conducted the scan. The evaluation team identified publicly-available materials as supplemental resources to capture information on AR-specific policies, programs, and local contexts, then extracted and synthesized data. If/where gaps remained, the AR site visit team made notes to add probes or customized questions to site visit data collection protocols.

Results

Exhibit C.1 lists documents and public-use data sources included in the document review and environmental scan.

Exhibit C.1.   Sources for Document Review and Environmental Scan

Document Review	Environmental Scan
• Implementation Plan Model Year 1 • Operational Plan Model Years 1 – 3 • Project Narrative 2020 • Quarterly Report Progress Reports: Model Year 1 Q1 – Q4; Model Year 2 Q1 – Q3 • Recipient Profile 2020 • SOPs for Needs Assessment & Service Integration (Draft)	• Annie E. Casey Foundation's Kids Count Data Center • Centers for Medicare & Medicaid Services (data.cms.gov; Medicaid.gov) • Food and Nutrition Service National Data Bank • Georgetown University's Center for Children and Families • Kaiser Family Foundation • National Institute of Justice's Office of Juvenile Justice and Delinquency Prevention's Census of Juveniles in Residential Placement • Social Security Administration • State Health Access Data Assistance Center

Information extracted during the document review and environmental scan informed subsequent data collection approaches and protocol development.

Analysis of T-MSIS Data and Publicly Available Data

As part of the Comparison Group Feasibility Report, the evaluation team assessed publicly available data, and Medicaid claims data available through CMS's Transformed Medicaid Statistical Information System (T-MSIS) to understand contextual variables and outcomes related to healthcare utilization and costs.

Timing

In spring 2021, the evaluation team analyzed T-MSIS data from 2017 – 2019 and publicly available data from 2014 – 2020.

Process

The evaluation team identified a brief list of variables to characterize contextual factors that could influence implementation:

- *Demographic or socioeconomic factors,* such as percentage of residents living in a rural ZIP Code, race and ethnicity, primary spoken language, age, education level, area deprivation index (ADI), and the proportion of Medicaid/CHIP enrollees in a pregnancy-related eligibility group at any time during the year.

- *Social drivers of health outcomes,* such as median household income, rates of food insecurity, foster care placements, homeownership, severe housing cost burden, deaths related to drug overdose, and juvenile arrests.

Results

Evaluation AR site visit teams reviewed the results of this analysis to tailor interview protocols and prepare for AR calls and site visits.

AR Interviews and Site Visits

Evaluation AR site visit teams conducted interviews with AR leadership, key partners, local providers, and caregivers in the InCK Model region though the activities listed below.

AR Calls
Timing

Between February and April 2021, the evaluation AR site visit team conducted a 60-minute interview with leadership from each AR to introduce the evaluation's AR site visit team, clarify questions that emerged from the previous document review and environmental scan, and gather information in preparation for site visits. Following this initial interview, one staff person from the AR site visit team participated in calls between the AR and their CMS PO monthly.

Process

Step 1. Developed and tailored protocols. Evaluation team leadership developed a generic interview template. AR-specific teams added probes and tailored questions based on analysis of the documents and the environmental scan.

Step 2. Conducted interviews. AR-specific teams conducted 60-minute interviews with each AR's leadership and management teams.

Results

Each AR site visit team shared findings with other members of the evaluation team to identify cross-cutting results and areas for follow-up during site visits.

Site Visits
Timing

AR-specific teams conducted virtual site visits with each AR between September 2021–April 2022.

Process

Step 1. Developed and tailored protocols. Evaluation team leadership used the PRISM framework to identify topics and participant types for interviews, focus groups, PhotoVoice sessions, and journey mapping activities.

Photovoice engages participants to document their experiences and perceptions through photos. Participants take and then present their photos to the group, followed by a collaborative discussion about why they took their photos, what they mean, how they represent their experiences and perceptions, and whether other group members have similar or different perceptions.

Journey mapping is a guided interview during which a researcher asks systematic questions to have a participant describe a typical episode of health care. The goal is to understand the process of seeking needed physical and/or behavioral health care and navigating the physical and behavioral health and social support systems from the perspective of a patient or caregiver.

From a **global question set**, each evaluation AR site visit team tailored protocols and added questions based on findings from the document review and environmental scan, participation in CMS PO calls, and AR calls. The evaluation team piloted the recruitment processes and protocols during the first site visit (conducted with North Carolina's (NC) InCK in September 2021) and then updated materials prior to conducting other site visits.

Step 2. Engaged interviewees. Evaluation AR site visit teams worked closely with the leadership of each AR to identify individuals who filled specific roles. **Exhibit C.2** provides a summary of respondent roles and target numbers of interviewees for each AR. The evaluation team asked the ARs to help identify caregivers to participate in interviews during the site visits. Many of the ARs asked the parents serving on the Partnership Council or Family Advisory Group to participate in interviews. A few ARs provided names and contact information for caregivers in the community whose children receive services from the Lead Organization or care delivery partners.

Exhibit C.2. Site Visit Respondent Types and Data Collection Methods

Respondent Role	Method	Target Number of Respondents Per AR	Topics Covered
InCK Model leadership	Small group interview(s)	4-6 individuals	• Local model design, structure, and context • Partnership council structure and engagement • Implementation ramp-up, including investments to support adoption and maintenance in the implementation period • Influence of the COVID-19 Public Health Emergency (PHE) on plans of care, service delivery, and the sustainability of the changes
State Medicaid agency leadership	Small group interview(s)	2-3 individuals	• Local model design, structure, and context • Alternative Payment Model (APM) design • Progress toward implementing the State Plan Amendment (SPA) waiver • Implementation ramp-up, including investments to support adoption and maintenance in the implementation period • Influence of the COVID-19 PHE on plans of care, service delivery, and the sustainability of the changes
Partnership Council members/key partners – leadership, clinical staff, and Core Child Services	1:1 interviews / Small group interviews depending on availability	4-6 individuals	• Council members' role in the design and implementation of the InCK Model, data sharing, relationships and coordination, and shared challenges and barriers facing the beneficiaries and their caregivers • Changes to service utilization and provision as a result of the COVID-19 PHE – particularly provision and utilization of Core Child Services
Parents/caregivers of individuals in the target population/ potential InCK participants	1:1 journey mapping / Interviews	4-6 individuals	• Existing process and experience families have when seeking care and engaging with care/social service providers in the InCK Model service area • Barriers/challenges and facilitators to accessing care and services
Medical providers (note: this should include both physical and behavioral health providers)	1:1 journey mapping / 1:1 Interviews	3-9 individuals	• Existing care processes for children/adolescents in the target population, care coordination and data sharing activities, and other workflow processes, as well as challenges and facilitators in existing workflows • Exposure, if any, to the InCK Model during the pre-implementation period

Respondent Role	Method	Target Number of Respondents Per AR	Topics Covered
Frontline InCK staff (Service Integration Coordinators (SICs) or other)	Photovoice	Varies	• Experience providing care to beneficiaries in the InCK Model service area.
	1:1 interview or small group interview(s)	Varies	• Local model design from the perspective of frontline staff. • Role and experience in implementation to date. • Existing training, care coordination, data sharing, and other workflow processes, as well as challenges and facilitators in existing workflows. • Investments in staffing and staff training in advance of model implementation.

Step 2. Convened visits and cleaned notes. AR teams conducted virtual visits over a one-to-two-week period between late September 2021 and March 2022. A senior researcher led each interview, and a junior researcher took detailed notes of the discussion. If respondents consented, teams recorded the discussions to revisit when cleaning notes. The majority of respondents agreed to have interviews recorded. Only the Ohio state Medicaid agency declined.

Exhibit C.3 presents a summary of the number of respondents by AR in each interviewee category.

Exhibit C.3.   Site Visit Respondent Type by Award Recipient

Participant Type	Award Recipient						
	CT	IL-EHD	IL-Lurie	NC	NJ	NY	OH
Frontline InCK staff – SICs or other	7	5	2	4	2	3	8
Lead Organization – Data managers	2	2	2	2	2	4	6
Lead Organization – Leadership	4	2	3	3	4	2	4
Partnership Council – Leadership	3	2	1	1	6	5	5
Partnership Council – Core Child Services	4	2	4	4	4	6	3
Patient/Families – Parent/caregiver	2	3	1	5	4	4	2
Provider – Pediatric behavioral health	3	2	2	2	4	2	4
Provider - Pediatrician or family medicine	1	2	2	4	3	2	1
Provider - OB/GYN*	0	0	0	0	0	2	0
State Medicaid agency	2	2	4	2	4	6	3

Note: * OB/GYNs were included as a priority respondent type for site visits with BE-InCK NY and CT InCK Embrace New Haven, because they are including pregnant beneficiaries 21 years and older in their InCK Model population.

Step 3. Analyzed data. Following completion of each site visit, the evaluation team cleaned notes, then coded and analyzed the data in Dedoose[64]. Qualitative analyses assessed each AR's overall approach to InCK Model implementation and assessed both barriers and facilitators to successful implementation. The team used the same codes across all forms of site visit data to capture key findings consistently.

Results

Following the conclusion of each site visit and data analytic process described above, each evaluation AR site visit team developed a case study report using a standard template. Reports summarized findings to date, including a summary of AR documents; environmental scans; demographics, historical healthcare utilization, and social service needs of the community as identified by publicly available data, AR documents, and interview participants; and findings from the AR calls and site visits. The reports also summarized local context and model design, provider and parent/caregiver perspectives on needs of the local target population, and progress toward implementation in the pre-implementation period.

APPENDIX D. CASE STUDY MASTER PROTOCOL

Introductions and Background

1. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, AND INCK MODEL STAFF]: Please tell me your first name(s), the organization you represent, your role and how you have been involved in the implementation of the InCK Model so far.

2. [PARTNERSHIP COUNCIL MEMBERS AND PROVIDERS]: Please describe your organization, the scope of your practice, and the patient population you typically work with.
   a. What are the greatest service needs that the local InCK Model is trying to address with this model?
   b. Are they generally able to access the medical care and social services they need? What kind of services are most difficult to access?
   c. What, if anything, do you think could make it easier for your clients to access the services they need?

3. [PARENTS]: Please tell me a little bit about your child and the type of help they get in an ongoing way – this could be help they receive from medical providers, or help they receive in school or in the community.

4. [LEAD ORGANIZATION]: Why did your organization/agency apply to be part of the InCK Model?
   a. What are the challenges that your organization was trying to address with this model?
   b. What do you see as your InCK Model's primary goals and objectives?
   c. What are the greatest service needs of the target population?
   d. What are the current gaps in the provision of services?

5. [LEAD ORGANIZATION]: How did your organization/agency decide on [SELECTED InCK MODEL REGION]?

Planned Approach to InCK Model Components

6. [LEAD ORGANIZATION]: What is your approach to **hiring and training key InCK Model staff,** *including frontline staff such as care coordinators, service integration coordinators (SICs) or local equivalents, and other staff*?
   a. How did you decide on the required qualifications for SICs/integrated care coordinators (ICCs) and other frontline InCK Model staff?
   b. Beyond specific degrees or qualifications, what were the most important skills or past experience you were looking for in the care coordinators and SICs [OR LOCAL EQUIVALENT] you hired (or re-trained)?

7. [LEAD ORGANIZATION AND MEDICAID AGENCY]: Next, we'd like to discuss your approach to **screening eligible individuals** in the InCK Model region. How did you decide to use administrative data to identify eligible individuals? What factors influenced that decision?
   a. How did you determine which claims, data, or algorithm to use? Have you used this approach before?

b. What are the strengths of this approach?

c. What are the potential challenges with this approach?

d. Are there specific types of patients for which you think this screening and identification approach will work particularly well?

e. Are there specific types of patients for which this approach may not work as well?

f. How will you identify children/families who don't have a regular source of care?

g. Do (or did) you have to engage new partners to ensure individuals eligible for screening can be identified in the claims data? If so, how have you been able to do that?

h. What, if any, additional screening will you do to assess children and families need?

8. [LEAD ORGANIZATION]: I'd like to ask you a few questions about the data that you plan to use to conduct service integration level (SIL) eligibility. Walk me through the process of acquiring data to support SIL stratification.

a. Do you have any concerns about the quality of the data that you are receiving from [DATA PARTNERS]? If so, what are they?

b. Do you have any concerns about your ability to link data from different sources? If so, what are they?

c. Do you anticipate any challenges with this approach?

9. [LEAD ORGANIZATION]: Are there particular types of patients for which the planned approach to SIL stratification might not work as well?

a. Are there specific diagnoses or service needs that the existing data does not capture as well?

b. Are there specific cultural or linguistic groups about which the data may be less accurate?

c. Are there kids in a specific age range for whom this approach may not work as well?

10. [MEDICAID AGENCY]: How has your agency prepared to regularly share Medicaid claims, eligibility, and enrollment files data with [LEAD ORGANIZATION] to facilitate and support InCK Model implementation?

11. [LEAD ORGANIZATION AND FRONTLINE INCK STAFF]: The next few questions focus on **engaging individuals** based on the SIL eligibility results and what happens next.

a. What processes do you have in place to engage individuals who don't respond to initial attempts to contact them?

b. What will happen to patients/families who opt out of SIL 2 and SIL 3 services? Will you follow up with them at a later date? Will they receive any additional resources?

c. Are there particular types of patients or sub-groups which you anticipate may be more likely to opt out of SIL 2 or SIL 3 services? If so, which ones?

d. How, if at all, will SIL eligibility be shared with other providers such as pediatric primary care providers or pediatric behavioral providers?

e. How if at all, will SIL eligibility be shared with Core Child Service providers?

12. [LEAD ORGANIZATION AND FRONTLINE INCK STAFF]: Can you tell me a little bit more about the **role of SICs** [OR LOCAL EQUIVALENT]?

a. How do you anticipate that the [SIC OR LOCAL EQUIVALENT] will work with other case managers that may be engaged with children and families?

    b. How will the [SIC OR LOCAL EQUIVALENT]'s role as the single point of contact for patients and families be communicated to patients and families?

    c. How will the [SIC OR LOCAL EQUIVALENT]'s role as the single point of contact for patients and families be communicated to providers?

13. [LEAD ORGANIZATION AND FRONTLINE INCK STAFF]: I understand that you plan to use [DATA SHARING PLATFORM] to support case management. Is this platform new for the InCK Model?

    a. What is the current status of implementation? Do you anticipate any issues with being ready to support care management during the implementation period?

    b. Do you anticipate any issues with adoption from providers?

    c. How, if all, will information captured in this platform be incorporated into providers' EHR systems?

    d. Do you anticipate any issues with adoption among beneficiaries or families?

    e. How will patient preferences such as preferred language, pronouns, communication methods or special considerations be captured in the platform?

14. [LEAD ORGANIZATION AND FRONTLINE INCK STAFF]: How will you develop care plans for children and families in SIL 3 [AND SIL 2 if applicable]?

    a. What are the core components of the care plan?

    b. How will patients and families' goals be identified?

    c. How will these goals be incorporated and documented in the care plan?

    d. What is the process for re-assessing care plans?

    e. For individuals who have existing case management through other programs, how will the InCK Model care plan and care plans developed under other case management programs be reconciled? Whose responsibility is that?

15. [LEAD ORGANIZATION AND FRONTLINE INCK STAFF]: Once the care plan is finalized how will services be delivered?

    a. Do you think that the [SIC OR LOCAL EQUIVALENT] will be ready to provide these services in the implementation period?

    b. If not, what additional changes need to be made to support implementation?

    c. Are there sub-groups of patients for whom the care coordination model as designed will work particularly well?

    d. Are there sub-groups of patients for whom the care coordination model as designed may work less well?

16. [LEAD ORGANIZATION AND FRONTLINE INCK STAFF]: Beyond the care plans, are there other changes you plan to make to ensure services are patient and family centered?

17. [LEAD ORGANIZATION]: Tell us a little bit about your planned approach to ensure families in the InCK Model region have access to mobile crisis response.

    a. From the perspective of the mobile crisis response (MCR) provider, what, if anything, will they do differently if a client they see is potentially part of the InCK Model?

    b. How will SICs be notified if an InCK Model eligible child uses MCR services? What will happen once they are notified?

    c. How are providers notified if one of their patients uses MCR services? What will happen once they are notified?

d. [DATA LEAD]: Will you share information about InCK Model eligibility and SIL assignments with mobile crisis responders?

e. [MEDICAID AGENCY]: How does planned approach for MCR services in the InCK Model align with other MCR initiatives in your state?

18. [PARTNERSHIP COUNCIL MEMBERS AND PROVIDERS]: In your organization what type of staff is currently responsible for case management? If a child is identified has having medical needs, what happens?

a. If a child is identified as having social needs, what happens?

b. What works well about your approach to case management?

c. What challenges remain?

19. [PARTNERSHIP COUNCIL MEMBERS AND PROVIDERS]: How do you typically share information about patient/client needs with other providers?

20. [LEAD ORGANIZATION AND MEDICAID AGENCY]: One of the goals of the InCK Model is to streamline eligibility and enrollment for clinical and non-clinical services such as Medicaid, nutrition assistance or early intervention. What are the current challenges families face enrolling in Medicaid?

a. What are the current challenges children and families face enrolling in Core Child Services, such as food assistance programs or early intervention?

b. Have you made any change to streamline eligibility and enrollment across these services?

c. What, if any, barriers have you identified?

21. [LEAD ORGANIZATION AND MEDICAID AGENCY]: Tell me a bit about your Alternative Payment Model (APM) design.

a. Who was involved?

b. What role did the managed care companies play in the design of the APM?

c. What kind of education have you offered so far to providers about the APM?

d. Whose responsibility will it be to monitor provider performance on the APM?

i. What data will you use to monitor performance?

ii. Will you share individual-provider level data on APM performance with providers? If so, how often?

e. What role has the state Medicaid agency played in engaging managed care entities in the design and implementation of the APM?

22. [LEAD ORGANIZATION AND MEDICAID AGENCY]: I understand you are currently working to obtain/implement [RELEVANT WAIVER/SPA]. How did you determine which [WAIVER/SPA/OTHER] was most appropriate to implement the InCK Model?

a. Have you encountered any challenges in obtaining the [WAIVER/SPA/OTHER] from CMS? If so, what challenges?

Partnership Council

23. [LEAD ORGANIZATION]: Tell me a little bit about the Partnership Council.

a. How did you identify organizations to serve on the Partnership Council?

b. Are there any organizations that were not originally part of your Partnership Council that you later added?

i. Are there organizations or types of organizations that are still missing?

    c. What do you think has worked well about the Partnership Council so far? What challenge have you encountered?

    d. [PARTNERSHIP COUNCIL MEMBERS]: Outside of participating in meetings, how much of your time is spent on InCK Model related activities?

24. [LEAD ORGANIZATION]: What has been the role of the patient, youth, and family advisory group in the pre-implementation period?

    a. Was this group new for the InCK Model? Or did they exist prior to the InCK Model?

    b. Can you provide specific examples of the changes they have identified as needing to be made?

    c. What do you think has worked well about how you engage that patient and family advisory group?

    d. What challenges have you encountered in engaging patients and families?

    e. What will their role be in the implementation period?

25. [LEAD ORGANIZATION, MEDICAID AGENCY, AND PARTNERSHIP COUNCIL] What is the role [expected role] of Partnership Council members?

    a. Have you partnered with other organizations in the Partnership Council before or are these relationships new for the InCK Model?

    b. How are all you all working together? How is collaboration so far? How is it positive and productive? What things are not going as you'd expected?

    c. Do you expect the nature of this collaboration to change as the award progresses?

    d. Are there any stakeholders or types of organizations missing from the Partnership Council? If so, why is this the case?

    e. Have there been any changes to the partnership council over time?

Target Population

26. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, FRONTLINE INCK STAFF AND PROVIDERS]: Next, we'd like to ask some questions about [YOU/YOUR CLIENTS OR PATIENTS/THE INDIVIDUALS INCLUDED IN THE TARGET POPULATION]. How available are services to [YOUR CLIENTS OR PATIENTS/THE INDIVIDUALS YOU ARE TARGETING FOR INCK MODEL PARTICIPATION IN YOUR AREA]?

    a. Are [YOUR PATIENTS/CLIENTS/INCK MODEL TARGET POPULATION] generally able to access the medical care and services they need?

    b. What kinds of services and providers are harder for [YOUR CLIENTS OR PATIENTS/THE INDIVIDUALS YOU ARE TARGETING FOR INCK MODEL PARTICIPATION IN YOUR AREA]? Why do you think that is?

        i. Availability of providers? (Medical or social service providers)

        ii. Insurance coverage?

        iii. Geographic or transportation barriers?

        iv. Language barriers?

        v. Concerns about stigma?

        vi. Other social factors?

    c. How were care and services coordinated for this population before you started planning for the InCK Model? Please describe.

27. [PARENTS]: Thinking about your child, what kinds of services and providers are easy for you and your child to access?

a. What kind of services and providers are hard for you and your child to access?

b. Can you tell me a bit about your experience accessing [hard to reach] services? What are the challenges?

c. What would make accessing services easier for you?

28. [PARENTS]: Do you think there is enough help from your child's providers to meet your child's care and service needs or the needs of children like yours?

a. What do providers do that support you and your child? Can you give me a specific example of something a provider did recently to support you and your child?

b. What could providers do to better support you and your child?

29. [PARENTS]: Thinking about the last time you met with your child's providers, how did they ask you about your child's goals for your child? How did they ask about their needs? What kinds of questions did they have?

a. How if at all, did they ask about your needs or the needs of other family members in your household?

30. [PARENTS]: Do you feel like you are able to receive the care and services your child needs in a timely manner? Are there particular services that take a long time to get access to? Specific medical services? Other services?

31. [LEAD ORGANIZATION, MEDICAID AGENCY, FRONTLINE INCK STAFF, PARTNERSHIP COUNCIL MEMBERS, AND PROVIDERS]: What, if anything, makes accessing services easier for [YOUR CLIENTS OR PATIENTS/THE INDIVIDUALS YOU ARE TARGETING FOR INCK MODEL PARTICIPATION IN YOUR AREA]?

a. What, if any, other challenges do [YOUR CLIENTS OR PATIENTS/THE INDIVIDUALS YOU ARE TARGETING FOR INCK MODEL PARTICIPATION IN YOUR AREA] deal with that might make it difficult for them to get needed care?

32. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, FRONTLINE INCK STAFF AND PROVIDERS]: How have the children and families in your InCK Model region been impacted by COVID-19?

a. How, if at all, has the number of individuals *eligible* for InCK Model participation changed?

b. How, if at all, has the number of individuals you intend to *reach* for InCK Model enrollment changed?

c. How, if at all, have the service needs of individuals you are targeting for InCK Model changed?

d. How, if at all, have changes to Medicaid eligibility, (re) enrollment, or covered services impacted the population that will be served by your InCK Model?

e. How, if at all, has the way in which [YOUR CLIENTS OR PATIENTS/THE INCK MODEL TARGET POPULATION] interact with [THEIR] service and care providers changed because of COVID-19?

33. [FOR PARENTS]: Briefly, how did the COVID-19 public health emergency impact you and your child's ability to access the services you need?

a. Did you experience any changes in the services you receive? Or how you receive them?

b. Have you had any changes in your need for medical care, supportive services, or help with services such as housing, food, or transportation?
   i. If so, have you been able to access the support you need?

Staffing and Training

34. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, AND FRONTLINE INCK STAFF] Does your organization plan to hire any new staff to support the implementation of the InCK Model?
   a. If yes, what type of staff? How many full-time equivalent (FTE)? What is their background?
   b. If no, has your organization transferred or transitioned staff from other areas of the organization to working on the InCK Model? Please describe.
   c. [FOR FRONTLINE INCK STAFF]: Is your position new for the InCK Model? Have you worked in [your organization/care delivery site] before? What is your educational and professional background?
   d. Do you plan to hire any additional staff in the future?

35. [LEAD ORGANIZATION AND PARTNERSHIP COUNCIL MEMBERS] What type of training and orientation do you provide to new or reassigned staff? Who provides the training? How often is the training provided?

36. [FRONTLINE INCK STAFF AND PROVIDERS] What kind of training have you received/have you received any training on the InCK Model and new care processes to support implementation?

37. [FRONTLINE INCK STAFF]: How many hours of training have you received? Who provided this training and what did it consist of? Are there regular trainings or was this a one-time activity?

38. [LEAD ORGANIZATION, MEDICAID AGENCY AND PARTNERSHIP COUNCIL MEMBERS]: Beyond staff, what if any investments, does your organization plan to make to support implementation of the InCK Model?

Marketing and Outreach

39. [LEAD ORGANIZATION AND PARTNERSHIP COUNCIL MEMBERS]: How are you describing the InCK Model to local providers? How are you describing the InCK Model to children, families, and caregivers?
   a. How did you determine the best way to explain the program to children and their families?

40. [PROVIDERS]: What have you heard about the InCK Model? When did you hear about it? From what you know, do you think this will help improve care and outcomes for the children you work with/treat?

41. [FRONTLINE INCK STAFF]: How would you describe the level of engagement/enthusiasm for the InCK Model among the pediatricians and other providers you work with? Does it differ based on type of provider? Please describe what you've heard from providers.

42. [IF APPLICABLE] We understand that you have been educating providers about the InCK Model. How do you think the model has been received? What types of questions are you getting from providers about the model?
    a. Overall, how engaged do you think providers will be?
    b. Are there specific types of providers who you anticipate will be more engaged? Are there specific types of providers who you anticipate will be less engaged?
    c. [FOR MEDICAID AGENCY AND PARTNERSHIP COUNCIL]: What role has your organization played in provider/front-line staff education and engagement around the APM?
       i. What topics were covered in that education?

43. [IF APPLICABLE]: What are your plans for outreach to children and families about the InCK Model? How do you think the model will be received?
    a. How did you/will you determine the best way to communicate with families?
    b. What role did the youth/family advisory group play?

Expected Impact

44. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, FRONTLINE INCK STAFF AND PROVIDERS]: What impact do you think the InCK Model will have on the children you work with and their ability to access the medical care and other services they need?

45. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, PROVIDERS AND FRONTLINE INCK STAFF]: What impact do you expect the InCK Model services will have on the physical, psychosocial, and behavioral health of the children and young adults served by the InCK Model?
    a. Are there challenges or services gaps that are likely to persist?
    b. Are there particular clients or types of patients for whom you think the InCK Model will work particularly well?
    c. From your perspective, what part of the intervention holds the most promise for positively influencing outcomes?

46. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, FRONTLINE INCK STAFF AND PROVIDERS]: What other impacts are you anticipating?
    a. Impacts on care delivery and care coordination between medical providers and other service providers?
    a. Impacts on provider and patient satisfaction?
    b. Impacts on social service providers?
    c. Changes in the Medicaid/CHIP program (Probe for: costs, covered services, eligibility)?

47. [LEAD ORGANIZATION, MEDICAID AGENCY, PARTNERSHIP COUNCIL MEMBERS, AND FRONTLINE INCK STAFF]: As you prepare for the implementation, are there any limitations to the current model? Any areas that you think still need to be addressed?

[ALL]: Thank you for taking the time to speak with us today.

48. [ALL]: Do you have any questions for us?

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3   Streeter, R. A., Snyder, J. E., Kepley, H., Stahl, A. L., Li, T., & Washko, M. M. (2020). The geographic alignment of primary care Health Professional Shortage Areas with markers for social determinants of health. *PLoS One, 15*(4), e0231443.

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5   Anderko, L., & Pennea, E. (2020). Exposures to per-and polyfluoroalkyl substances (PFAS): Potential risks to reproductive and children's health. *Current Problems in Pediatric and Adolescent Health Care, 50*(2), 100760. doi:10.1016/j.cppeds.2020.100760.

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7   Warshaw, R. (2017). *Health Disparities Affect Millions in Rural U.S. Communities.* Retrieved from https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities.

8   Mandell, D. S., Wiggins, L. D., Carpenter, L. A., Daniels, J., DiGuiseppi, C., Durkin, M. S., . . . Kirby, R. S. (2009). Racial/ethnic disparities in the identification of children with autism spectrum disorders. *American Journal of Public Health, 99*(3), 493-498. doi:10.2105/AJPH.2007.131243.

9   Berry, J. G., Bloom, S., Foley, S., & Palfrey, J. S. (2010). Health inequity in children and youth with chronic health conditions. *Pediatrics, 126 Supplement 3*, S111-119. doi:10.1542/peds.2010-1466D.

10 Dettlaff, A. J. (2014). The evolving understanding of disproportionality and disparities in child welfare. In *Handbook of Child Maltreatment* (pp. 149-168). Springer, Dordrecht.

11 Medicaid and CHIP Payment and Access Commission [MACPAC]. *1915(c) waivers.* Retrieved from https://www.macpac.gov/subtopic/1915-c-waivers/.

12 Medicaid and CHIP Payment and Access Commission [MACPAC]. *Section 1115 research and demonstration waivers.* Retrieved from https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/.

13 American Academy of Family Physicians [AAFP]. (2019). *Section 1115 Demonstration Waivers*. Retrieved from Leawood, KS: https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/medicaid/BKG-Section1115Waivers.pdf.

14 The report uses the term "children" to refer to all beneficiaries up to age 21.

15 Association of Maternal & Child Health Programs [AMCHP], National Academy for State Health Policy [NASHP], & Lucile Packard Foundation for Children's Health [LPFCH]. (2017). *Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0*. Retrieved from https://www.nashp.org/wp-content/uploads/2019/10/Standards-for-Systems-of-Care-for-Children-and-Youth-with-Special-Health-Care-Needs-Version-2.0.pdf.

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[17] Coalition for Juvenile Justice [CJJ]. *National Standards: Family Circumstances and Unmet Needs.* Retrieved from https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-ii-efforts-avoid-court-4.

[18] American Academy of Pediatrics [AAP] Committee on Practice and Ambulatory Medicine, & Bright Futures Periodicity Schedule Workgroup. (2020). 2020 Recommendations for Preventive Pediatric Health Care. *Pediatrics, 145*(3). doi:10.1542/peds.2020-0013

[19] The report uses the term "beneficiaries" to refer to Medicaid enrollees who would enroll in the InCK Model.

[20] An alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. For more information on APMs, visit https://qpp.cms.gov/apms/overview.

[21] For the purposes of the InCK Model, out-of-home placement is defined as placement in a psychiatric hospital, residential care center, skilled nursing facility, correctional facility, foster care (including groups homes and therapeutic foster care), or juvenile detention (InCK Model NOFO, page 96).

[22] Abt will assess the impact of the InCK Model on a newly developed measure for OOHP; the measure was developed outside of the evaluation.

[23] During the pre-implementation period, CMS granted flexibility so that ARs could gradually roll-out implementation activities during the first six months of 2022.

[24] Each beneficiary will have an assigned service integration level (SIL) that will designate the level of integrated care coordination and case management appropriate for individual needs. As defined in the InCK Model NOFO (page 21),

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.

[25] Centers for Medicare & Medicaid Services. (2022). *Health Equity.* https://www.cms.gov/pillar/health-equity

[26] Feldstein, A. C., & Glasgow, R. E. (2008). A practical, robust implementation and sustainability model (PRISM) for integrating research findings into practice. *The Joint Commission Journal on Quality and Patient Safety*, *34*(4), 228-243.

[27] Nilsen, P. (2015). *Making Sense of Implementation Theories, Models and Frameworks.*

[28] Through a comprehensive analysis, the evaluation team identified substantial quality concerns related to the completeness, reliability, or usability of Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) data related to topics important to the InCK Model evaluation. TAF data quality varies significantly across topics, states, and time periods (and a state's data quality does not always improve over time).

[29] In October 2021, Oregon Health Authority informed CMS of their intent to withdraw from the model.

[30] During the pre-implementation period, NowPow was acquired by Unite Us. They will be a single organization in the implementation period.

[31] The first submission of CCS data in the areas of child welfare, foster care, and juvenile justice (optional?) was due on October 30, 2021. Only one AR (BE-InCK NY) submitted any CCS data by the deadline and two ARs (NC InCK and OH InCK) submitted data in November 2021. The remaining ARs (AHHN, CT InCK Embrace New Haven, NJ InCK, Village InCK) did not submit any CCS data by the end of the pre-implementation period.

[32] In July 2022, the National Suicide Prevention Lifeline changed from 1-800-273-8255 to the three-digit dialing code 988. The National Suicide Prevention Lifeline provides access to 24/7, free, and confidential support to people who are having suicidal thoughts or are in emotional distress.

[33] The evaluation team did not collect data from providers or caregivers in Oregon, so OR InCK was not included in the analysis or discussion of Finding 2.

[34] Bullinger, L.R., Raissian, K.M., Feely, M., Schneider, W.J. (2021). The neglected ones: Time at home during COVID-19 and child maltreatment. *Children and Youth Services Review, 131.*

35 During the pre-implementation period, Unite Us acquired NowPow. They will be a single organization in the implementation period.

36 As part of site visits, the evaluation team engaged the SICs in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a specific topic. The evaluation team asked resource coordinators to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as a resource coordinator.

37 The data includes providers billing to Medicaid in the two AHHN InCK Model ZIP Codes. Patients regularly seek care outside of these two ZIP Codes. These provider numbers do not reflect Lurie-affiliated providers.

38 This section provides selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

39 As part of site visits, the evaluation team engaged the SICs in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a specific topic. The evaluation team asked resource coordinators to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as a resource coordinator.

40 This section provides selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

41 As part of site visits, the evaluation team engaged the SICs in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a specific topic. The evaluation team asked resource coordinators to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as a resource coordinator.

42 This section provides selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

43 As part of site visits, the evaluation team engaged the integration consultants in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a specific topic. The evaluation team asked resource coordinators to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as an integration consultant.

44 This section provided selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

45 As part of site visits, the evaluation team engaged the SICs in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a specific topic. The evaluation team asked resource coordinators to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as a resource coordinator.

46 NJ is comprised of 567 independent municipalities with each town or township having a separate local government that oversees services such as education, child welfare, and public health.

47 NJ InCK Health Story is a web-based, age-specific assessment that will be electronically sent to NJ InCK beneficiaries one month prior to a well-child visit.

48 This section provides selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

49 As part of site visits, the evaluation team engaged the SICs in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a specific topic. The evaluation team asked integration consultants to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as an integration consultant.

50 This section provides selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

51 As part of site visits, the evaluation team engaged the SICs in an activity called PhotoVoice, a participant-driven research method. Respondents were asked to submit photos representing their experiences about a

specific topic. The evaluation team asked SICs to submit two photos. One showing what makes the lives of the families they work with easier or harder and one about their work as a SICs

[52] This section provides selected questions identified in the pre-implementation period that the evaluation team will investigate during the implementation period.

[53] In October 2021, Oregon informed CMS of its intent to withdraw from the model. Based on the timing of the withdrawal, the evaluation team did not conduct site visit activities with the Oregon InCK team. Therefore, limited information on the OR InCK approach existed for inclusion in the report.

[54] Comprehensive care organization (CCO) is the OR Medicaid term for managed care organization.

[55] The ARs in Connecticut and New York (CT InCK Embrace New Haven and BE-InCK NY, respectively) chose to target pregnant Medicaid beneficiaries 21 and older in addition to children younger than 21 years old.

[56] The evaluation team will create individual-level weights to match the individual characteristics of the comparison group more closely to those of service integration level (SIL) 1. Since the ARs will elevate children included in SIL 1 to SILs 2 and 3 (based on criteria that the ARs have yet to finalize), the evaluation team will develop the comparison groups for SILs 2 and 3 by re-weighting the comparison group for SIL 1 to match the individual characteristics of children in SILs 2 and 3.

[57] We intended to compare annual rates of foster care in the regions using data from the Adoption and Foster Care Analysis and Reporting System (AFCARS). The publicly available data censors the number of children in foster care when the number is fewer than 1,000. Most counties in a state have fewer than 1,000 cases, and there is hardly any variation in the measure, so it is not useful for matching or assessing covariate balance.

[58] Stuart, E. (2010). Matching methods for causal inference: A review and a look forward. *Statistical Science, 25*(1): 1–21.

[59] Matching with replacement means that two or more observations in the treatment sample can be matched to the same observation in the comparison sample.

[60] A population-weighted average is when each county or zip-code's contribution to the average was proportionate to the county or zip-code's share of all InCK Model-eligible Medicaid/CHIP-enrolled individuals in the overall attribution or comparison region.

[61] Balance is commonly assessed using absolute standardized mean differences of the covariates, which is equal to the difference in the mean between the treated and comparison groups divided by the average standard deviation across the two groups. While there is no clear consensus as to what value of a standardized difference denotes meaningful imbalance, a threshold of 0.1 is commonly used. Standardized differences tend to be noisy when matching a limited number of treated regions to comparison regions within a state (because of having few degrees of freedom). Both the numerator (sample means) and the denominator (sample deviation) are sensitive to the number of observations. Because the standardized differences were unreliable, we directly compared the means between the treated and control group to determine which comparison groups offered the best overall balance across key covariates.

[62] Hainmueller, J. (2012). Entropy balancing for causal effects: A multivariate reweighting method to produce balanced samples in observational studies. *Political Analysis*, *20*(1), 25-46.

[63] The Impact Study will use a larger, more complex set of covariates to balance the attribution and comparison populations, as the evaluation team gains access to Core Child Services data, develops the specifications and models for the full list of primary and secondary outcome measures to measure historical utilization, finalizes the ARs' attribution and comparison regions, and progresses with the development of the final design plan for the implementation period.

[64] Dedoose is a cloud-based software enabling intra-organizational data sharing and analysis of text and media data, as well as import and assignment of discrete data points (e.g., respondent demographics) to project data sources.