The Future of CMS

Statewide Leadership Meeting

9 December 2017

OFFICE OF CHILDREN'S MEDICAL SERVICES
MANAGED CARE PLAN AND SPECIALTY PROGRAMS

CMS 3.0 "Moving Forward to the Past"

- CMS 1.0
  - Direct services through specialty clinics.
  - Children with medical complexity (CMC) had health insurance; we provided whatever else they needed through care coordination and PCS.
- CMS 2.0
  - DOH/CMS as a managed care organization.
    - Limits to what a state agency can accomplish as an MCO.

CMS 3.0 Quality and Access

- Quality “top-down”
  - Work with AHCA to help advance measuring quality for children with special health care needs (CSHCN), especially CMC.
- Support health care providers/families in building systems of care (“bottom-up”)
  - Regional Networks for Access and Quality (R-NAQs)
  - Statewide Networks for Access and Quality (S-NAQS)

Why Change?

- CMS has always changed and adapted to the challenges of the times (health care system)
  - Today, we are in the midst of moving to "value-based care" (outcomes/cost, not volume)
  - Every state is struggling with the question: "How do we ensure that CSHCN (especially CMC) have access to high-quality health care?"
    - No one knows for sure.
    - We are moving towards a solution for our state that was developed based on stakeholder engagement and expert opinions.

How Did We Get to the New Model?

- Stakeholder input
  - 2016–17 Public meetings, focus groups (families) and surveys
  - Spring 2017 RFI from vendors
  - CMS statewide leadership (Strategic Planning calls)
  - Children's hospitals, pediatric department chairs
  - Legislature, federal (MCHB) and state partners
  - Expert opinion (AMCHP, AAP, Title V)
  - Other state models (Texas, Colorado, Washington)
  - *Standards for Systems of Care for CYSHCN*
- This presentation represents our view on the best way to serve CSHCN, especially CMC, in Florida

Key Strengths and Challenges

- Strengths of CMS
  - Care coordinators
  - Provider network
  - CMS experience in regional and local offices
- Challenges
  - Caseloads, flexibility with staffing
  - Provider reimbursement rates (pay for complex patients)
  - Multiple components of system; limited data
  - Difficulty in demonstrating quality - difficulty meeting/exceeding benchmarks (HEDIS)

Value-Based Care (VBC) and Florida

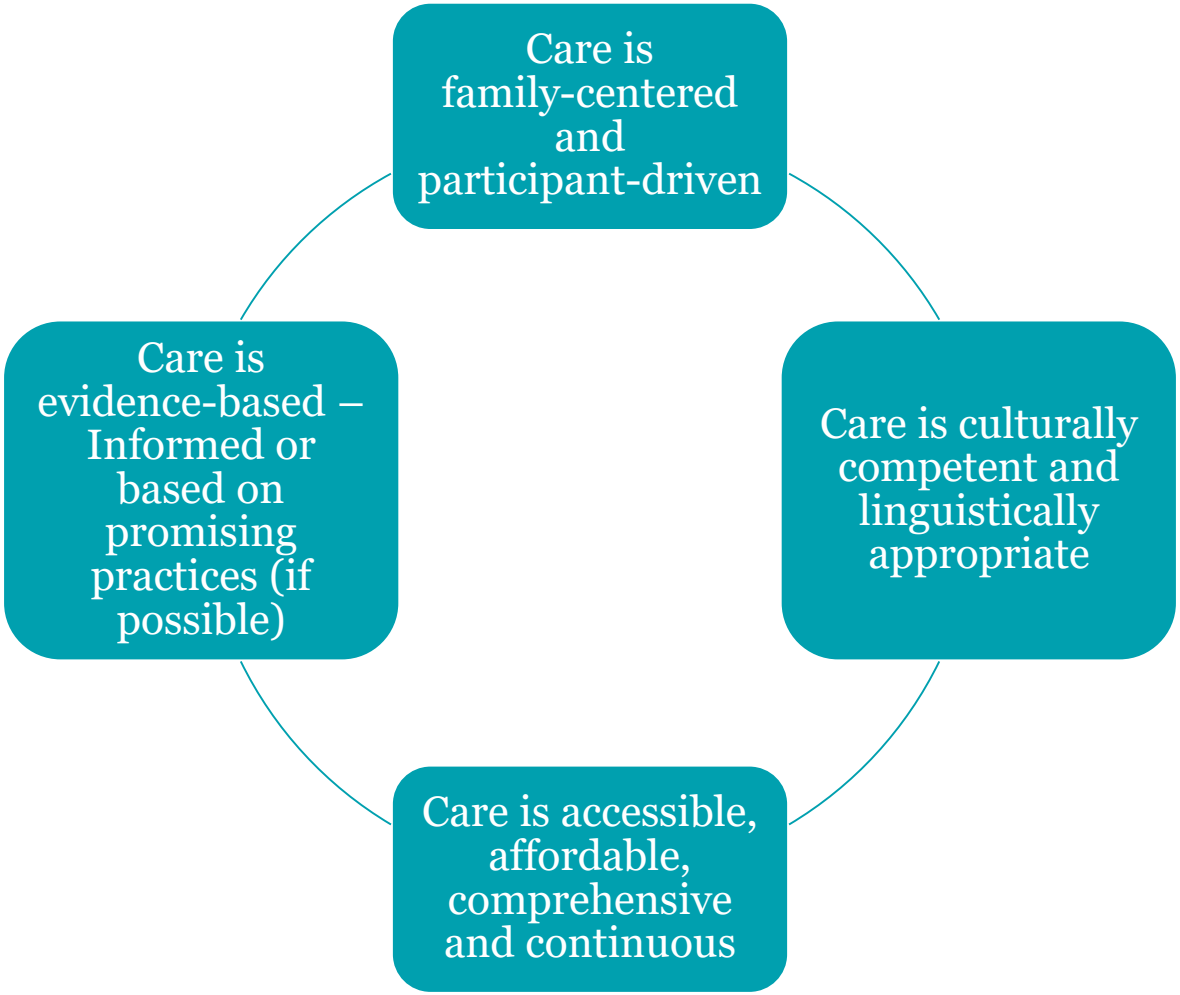
- One approach is to mix CMC in with all other children
  - Florida includes adults in Medicaid MCOs, which makes this approach harder (PMPM, network issues).
- Texas and others have dedicated MCOs for CMC
  - Provider network needs to be highly specialized to meet the needs of 13,000 rare conditions.
  - Care coordination requires higher level of expertise.
  - Quality measures for typical children not most relevant.
- Florida
  - MCOs and providers (hospitals, MDs) have relatively little experience with VBC.
  - Vast regional differences.
  - Multiple children's hospitals in the same region.

Expert Assistance: Mercer

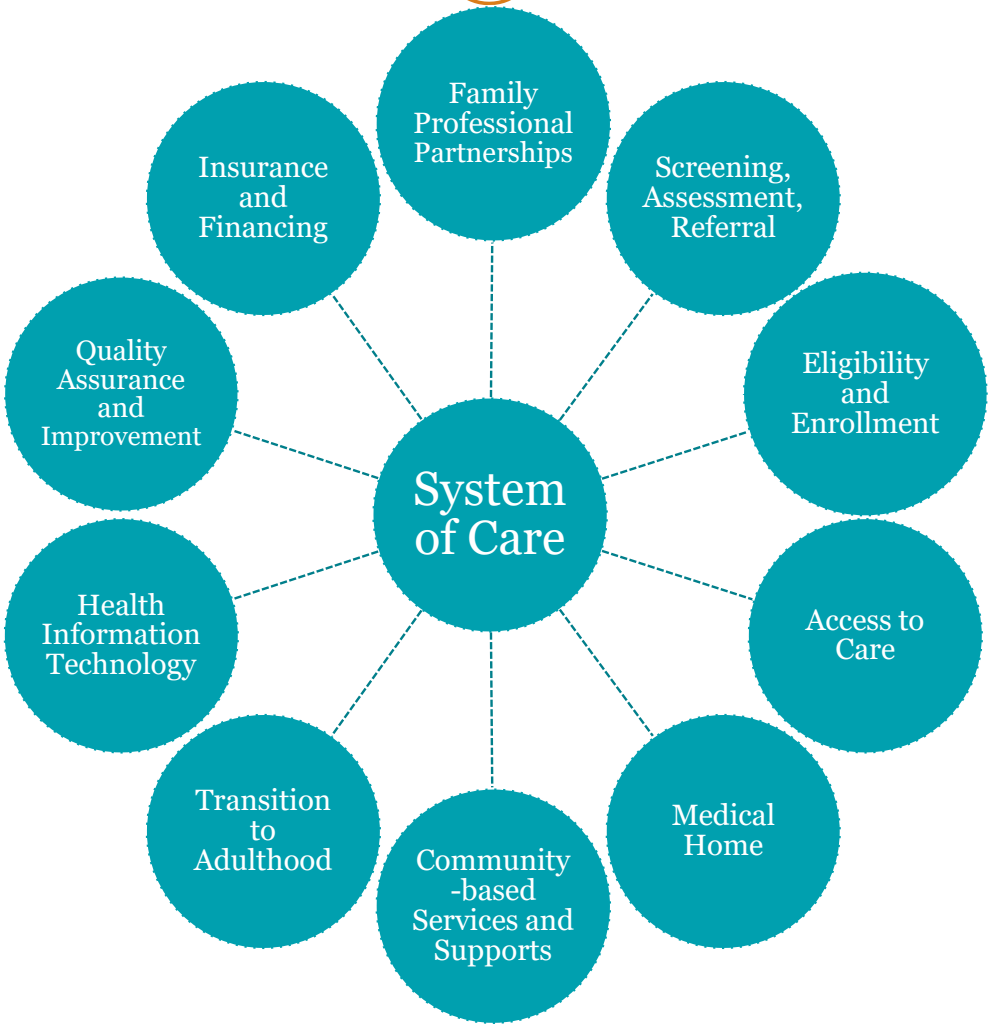
- Global consulting firm whose Government specialty practice provides a wide array of services to federal, state and local government health and human service agencies.
- Goal is to help purchasers of publicly-funded health care improve the access, quality and the cost effectiveness of health care through measurement, planning, and program innovation.
- Has over 25 years of experience assisting state governments with design, implementation and evaluation of public-sector health care programs.
- Has collaborated with many states in addressing the development and implementation of Medicaid managed care programs, including in the states of Delaware, Florida, North Carolina, Nebraska, New Jersey, New Mexico, New York, Ohio, Pennsylvania, and Tennessee, among others.

New Health Plan Model

Foundational Goals of the CMS Plan



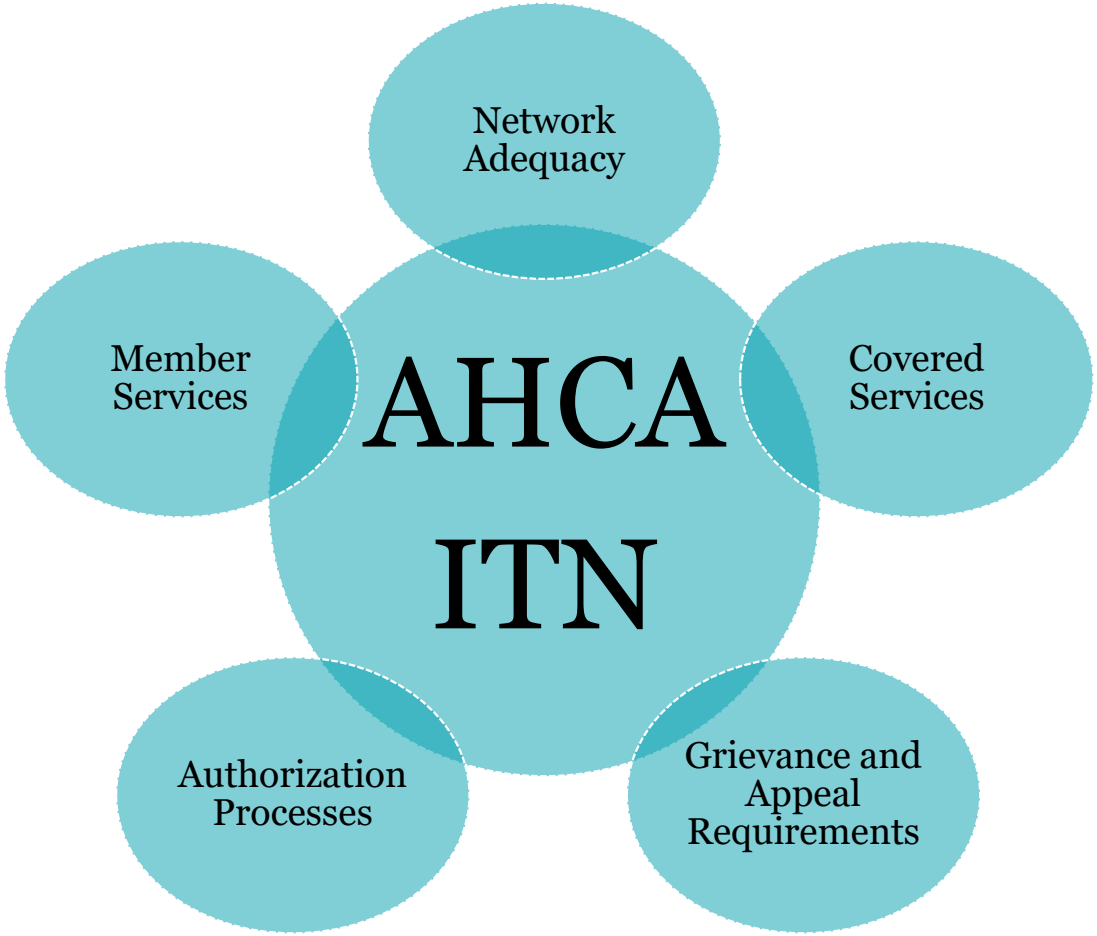
System of Care



Program Reform Goals

- DOH/CMS positions itself as a stronger leader in CSHCN in concert with stakeholders
- Improved satisfaction/health outcomes for families
- Streamlined model to improve access/support for families and providers
- Stability/leadership in the marketplace
- Improved satisfaction for providers

AHCA ITN is Basis of CMS ITN



CMS Plan — What's Not Changing

- DOH/CMS Plan Eligibility Criteria
- DOH/CMS Plan Continues to Determine Eligibility
- DOH/CMS Plan Safeguards Children

Features of Proposed New Model: CMS Role

CMS will continue governance to oversee the Vendor efforts to ensure high quality standards are met and the right care is delivered efficiently

CMS activities will include:

- Implementing Vendor performance measures specifically focused on the CMS population
- Adopting Member Quality of Life Experience surveys to ensure enrollee outcomes improve
- Employing local state ombudsmen to ensure excellent care coordination and quality of care

Features of Proposed New Model: Contracting

Goal: Statewide Vendor(s), including providers and partners, meeting the unique needs of various regions and local areas.

- Risk payment may be phased in over time with the Vendor(s) receiving capitation payments for an increasingly larger number of services.
- Bidders will have an option of full risk immediately or a risk phase-in.

Features of Proposed New Model

Feedback From Public Forums

"Expand access to care through telemedicine and field clinics"

"Provide flexibility for the administrator of the plan to offer providers in their network a competitive reimbursement within the market place"

"Increase reimbursement for special services such as private duty nursing"

Features of Proposed New Model: Expanded Access

The new ITN will emphasize expanding and improving access to high quality services by:

- Expanding availability and flexibility of telemedicine
- Permitting the Vendor(s) to negotiate reimbursement with providers
- Increasing access to clinical and specialty services

Features of Proposed New Model

Feedback From Public Forums

"Institute value-based contracts with providers"

"Involve providers in risk and cost savings tied to value-based outcomes"

Features of Proposed New Model: Value-Based Purchasing

The Vendor(s) will develop/implement a value-based purchasing program

To reduce potentially preventable events.

To increase reimbursement to pediatric physicians.

To enhance the quality of health outcomes.

Features of Proposed New Model: Benefits

The core benefits of the Agency for Health Care Administration (AHCA) ITN will be covered under the CMS contract, including pharmacy and the new AHCA ITN services

In-lieu of services, Expanded Benefits and Quality Enhancements will be included to meet the unique needs of children with medical complexity.

Features of Proposed New Model: Benefits

Examples of In-Lieu of Services:

- Emergency Respite
- Crisis stabilization units (CSU)
- Housing-related supports/modifications to divert or shorten an institutional stay
- Nursing facility in-lieu of hospital services
- Partial hospitalization
- Mobile crisis assessment and intervention
- Ambulatory detoxification services in-lieu of inpatient detoxification hospital care
- Community behavioral health services

Features of Proposed New Model: Benefits

Examples of Expanded Benefits

- Planned Respite outside of PACC/PIC:TFK
- Home maintenance and minor home or environmental adaptions
- Non-medical transportation
- Financial coaching/benefits counseling
- Parenting classes
- Education/Supports for Wellness
- Specialized recreational opportunities for wellness and community integration

Features of Proposed New Model

Feedback From Public Forums

"Identify an alternative to HEDIS measures and develop measurements specific to the class and conditions of the children the CMS Plan serves."

Features of New Proposed Model: Performance Measures

Total of 42 Performance Measures across various domains including 10 new proposed Child Health measures. The ten new measures include:

- ED visits per 1,000 member months
- Percentage of children ages 10–71 months receiving a developmental screening
- Rate of hospitalization for non-fatal injury per 100,000 children ages 0–9 and adolescents 10–19
- Percentage of adolescents with a preventive medical visit in the past year

Features of New Proposed Model: Performance Measures

New measures continued:

- Adolescent Depression–Screening for Depression
- New enrollees provided initial health assessment within 30 days and completed person-centered plan within 45 days of enrollment
- Use of Patient Centered Medical Homes
- Proportion of children receiving services in a medical home
- Percentage of youth reporting transition in place
- Quality of Life survey results reported

Current Care Coordination Structure

Care coordinators are mainly registered nurses

- Some regional CMS offices/regions utilize licensed practical nurses and social workers.

Current caseload sizes vary and average around 300+

Care coordinator activities to support providers include:

- Initial assessments and care plan development with semi-annual updates and generally occur by telephone.
- Telephonic contacts established by the CMS Acuity Tool (high — monthly, medium — quarterly, low — semi-annually).
- Primarily one-on-one CC, with some regions utilizing multi-disciplinary clinic opportunities.

Utilize outside care coordination agency to meet enhanced care coordination requirements

Current Care Coordination Challenges

Recruitment and Retention

- Nursing shortage
- Competition with other local nursing opportunities

Workload

- High ratios
- Disease management vs. case management
  - Current process does not allow time for face-to-face interactions
- Data and resource constraints

Features of Proposed New Model

Feedback From Public Forums

"Care Coordination is the foundation of the program"

"Care Coordinators are an extension of our family"

"Improve coordination and communication between Nurse Care Coordinators and families"

"Make care coordinators more prominent"

"Maintain home-visits for families"

Proposed Care Coordination Structure

Care Coordination at two levels	Child and family interactions at higher frequencies by	Multidisciplinary team structure
• Case Management • Disease Management	• Face-to-face contact • Telephonic contact	• Registered nurses • Licensed practical nurses • Social workers • Peers • Community health workers

Proposed Care Coordination Structure

Levels	Ratio	Components
Tier 1 Case Management • Includes children residing in a nursing facility at a minimum	1:15	• Initial and at least annual face-to-face assessments and care plans • 2 face-to-face visits monthly • 2 telephone contacts monthly • Semi-annual multidisciplinary team meetings • Monthly care plan review • Quarterly care plan updates
Tier 2 Case Management • Includes children receiving private duty nursing in the community at a minimum	1:40	• Initial and at least annual face-to-face assessments and care plans • Monthly face-to-face visits • Monthly telephone contacts • Semi-annual multidisciplinary team meetings • Monthly care plan review • Semi-annual care plan updates
Tier 3 Case Management	1:90	• Initial and at least annual face-to-face assessments and care plans • Quarterly face-to-face visits • Monthly telephone contacts • Monthly care plan review • Semi-annual care plan updates
Disease Management • For those opting out of case management	1:200	• Initial and annual face-to-face visit • Quarterly telephonic contacts • Initial and annual assessments and care plans

Care Coordination Opportunities

The proposed care coordination structure transitions Care Coordinators to the Vendor and would allow CMS families to be served by a system that includes:

- More competitive salaries
- Incentives to recruit and retain qualified staff
- More efficient hiring processes

The proposed structure would also allow Care Coordinators to access readily available data and comprehensive information such as hospital admissions and emergency room visits, drug prescriptions and refills, to provide more effective care coordination.

CMS Leadership Team: Next Steps

Review and provide feedback to the proposed care coordination structure

- Does it accomplish what we want it to?
- Does it align with our mission, vision, goals and values?
- Are there gaps/unknowns that need to be addressed?
- Additional feedback can be sent to CMSPlan@flhealth.gov

Begin working on communicating changes in our organization with staff and community

Assist in developing transition plans

- Training and workforce opportunities for current staff

Assist in enhancing existing and developing new CMS/Title V roles and functions

Future of CMS

- Transition to new Plan model:
  - Timeline allows for as smooth of a transition as possible.
  - Goal is to make it seamless for families and providers.
  - Leadership challenge for everyone in this room.
- How to ensure quality and access for every child with special health care needs in Florida, especially children with medical complexity.

Transition Timeline

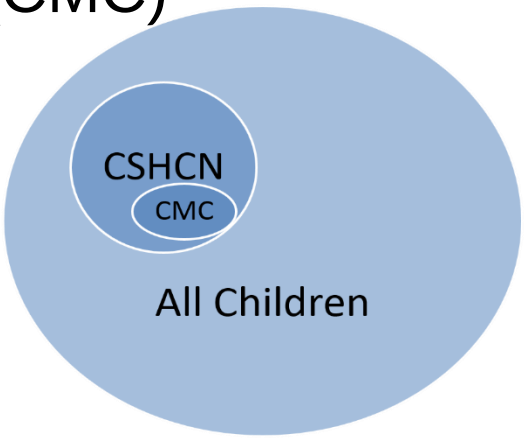
Target implementation timeline for the CMS Plan vendor(s)	
January 2018	Release ITN for vendor(s) to support new program design
April 2018	Proposals due from potential vendors
May 2018	Proposals evaluated and negotiated with potential vendors
June 2018	Vendor contract(s) awarded
June - November 2018	Vendor readiness and reviews
January 2019	Contract(s) begin/new model is implemented

Transition to CMS 3.0

- Preserve the essence of what's working in current CMS:
  - CMS care coordinators (relationships with families)
    - Vendor incentives to offer positions to CMS local area office employees to serve as care coordinators.
  - CMS statewide leadership (local systems knowledge)
    - R-NAQs and S-NAQs (not as DOH employees).
    - Participate in a statewide advisory groups.
  - CMS health care provider network (continuity of care)
    - Vendor(s) must preserve access for at least a defined time.

Florida's Children

- 4.1 million children – vast majority are healthy
  - Obesity, poverty, neighborhoods, schools
- 800,000 children with special health care needs
  - ADHD, asthma, and 13,000 other conditions
  - Title V CSHCN responsibility
- 80,000 children with medical complexity (CMC)
  - Serious and chronic medical conditions
  - Multiple specialists/medical technology
  - Require tertiary/quaternary medical system-level care
  - 2% of children, but 1/3 of spending
  - 40% of deaths



Reid, Keshia, Florida DOH, NSCH 2011-12
Cohen E et al Pediatrics 2017; Status Complexicus

CMS 3.0

- CMS 3.0 completes shift from providing services (clinics, care coordination) to advancing access to high-quality health care for all CSHCN, esp. CMC.

1. Governance of the new CMS Health Plan
   a) Monitor vendor to safeguard enrollees

   Contract process measures, health quality outcomes, CMS-employed ombudsman ("family advocate"), and a role in utilization management

   b) Clinical eligibility
2. Quality and access for all CSHCN
   a) Defining/measuring quality (with stakeholders)
   b) R-NAQs and S-NAQs

Quality Measures

- What quality measures do we use to judge value?
  - Morbidity/Mortality (rare in most children)
  - HEDIS (EMR, process measures)
  - Family perception of care – access, communication
  - Child function – school attendance, QOL measures
- CMS sets quality outcomes (with stakeholder input)
  - General measures for all CSHCN (above 4 domains)
    - Start with new CMS Plan 3.0
    - Eventually work with AHCA for all MCOs?
  - Condition-specific
    - E.g., Asthma, SCD, HIV, congenital heart disease
    - Implement through S-NAQs?

R-NAQs and S-NAQs

- Regional Network for Access and Quality
  - Population served based on geography
  - What do CSHCN/CMC need in our region?
    - Needs assessment (with county health dept.?)
  - E.g., chronic complex clinic with satellites
- Statewide Network for Access and Quality
  - Populations served based on specific medical condition (e.g., CLP, CF, HIV, congenital cardiac)

R-NAQs and S-NAQs

- **Purpose:** To establish Regional and Statewide Networks that will be a community resource, provider, and leader in the system that supports CSHCN.
- **Goal:** To improve access and quality for CSHCN, especially those with medical complexity, no matter what insurance or where they live.
  - CMC needs not easily met through MCOs/value-based care.
  - Many providers need more support for CMC, especially regarding organizational efficiency and quality improvement activities.
  - Focus on research and quality improvement to start?

R-NAQs and S-NAQs

- Title V Priorities
  - Medical home for CSHCN
  - Behavioral health
  - Transition to adult systems of care
- Evidence of broad community collaboration
  - Families involved at all levels of policy/procedure
  - Major traditional children's health care institutions working together
  - County health department, schools, Early Steps, Early Learning Coalition, Healthy Start, CSCs, Help Me Grow, juvenile justice, foster care, etc.

R-NAQs and S-NAQs

- "Learning Collaboratives"
  - Evidence-based/data-driven
    - Common measures entered into a statewide or national database
  - Continuous quality improvement approach
  - Statewide meetings to share information/ideas
- Address Social Determinants of Health
- Framework/home institution
  - Hospital/medically complex clinic system
  - Universities
  - County Health Departments
  - Private, not-for-profit community organizations

R-NAQs

- Create and sustain local projects that improve access to health care and related services that are innovative and evidence-based (e.g., Telemedicine and co-location).
- Based on community needs assessment, an R-NAQ could focus on
  - Creating/expanding chronic/complex clinics
  - NICU discharges
  - Local case management
  - Support groups
  - Palliative care
  - Dental/oral health
  - Mental health

S-NAQ Example: Florida Perinatal Quality Collaborative

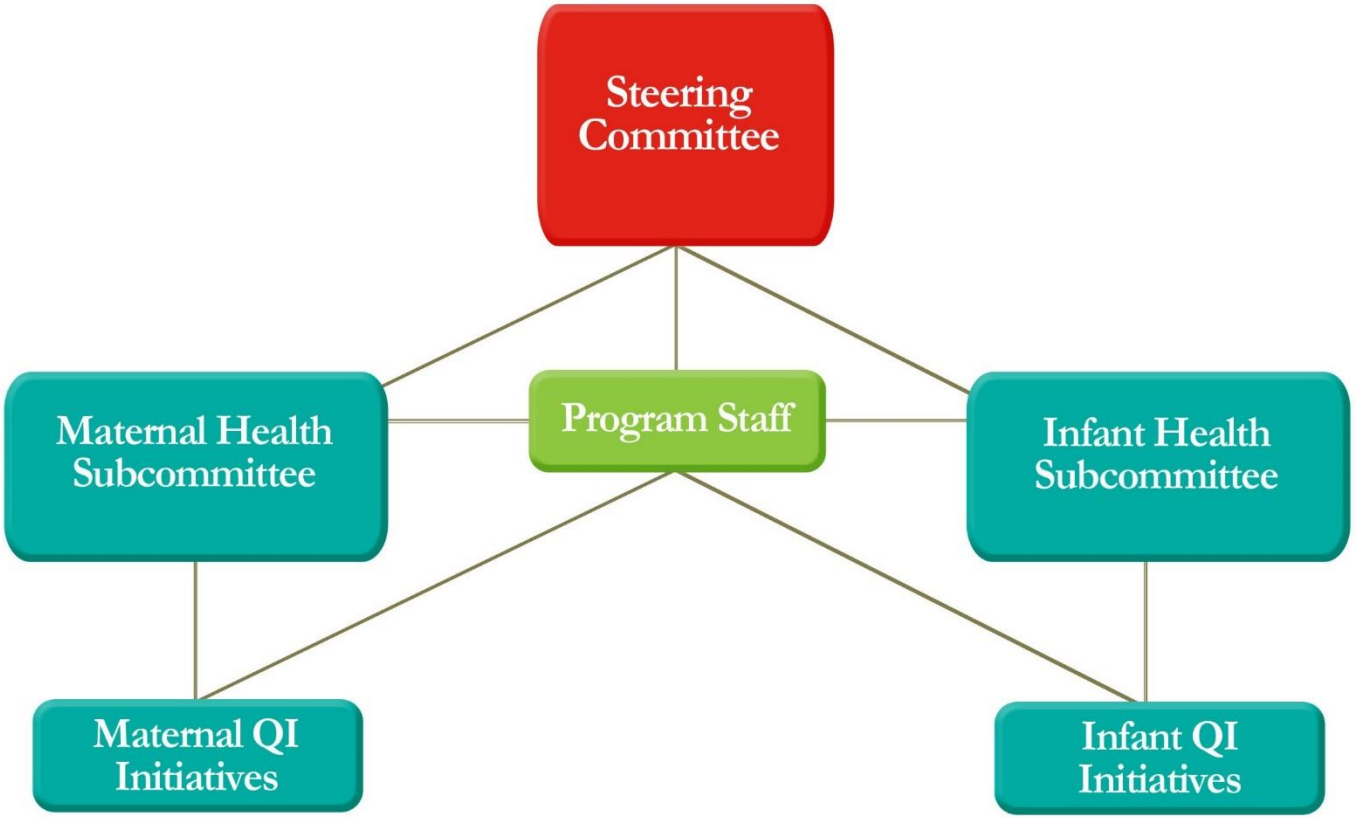
- Activities:
  - Proposes, researches and selects population-and evidence-based quality improvement initiatives.
  - Engages stakeholders in the design, implementation and evaluation of data-driven processes.
  - Encourages providers to educate and empower families and patient involvement in personal and community wellbeing.
- Output:
  - Effective evidence-based protocols for a variety of quality improvement processes.

Florida Perinatal Quality Collaborative

- Project Ideas:
  - Postpartum Hemorrhage
  - Severe Hypertension in Pregnancy
  - Non-Medically Indicated Deliveries less than 39 weeks
  - Low Risk Primary Cesarean Delivery
  - Failed Induction of Labor
  - Severe Maternal Morbidity
  - Unexpected Newborn Complications
  - Antenatal Corticosteroid Treatment

Florida Perinatal Quality Collaborative

FPQC Organizational Chart



http://health.usf.edu/publichealth/chiles/fpqc/governance

Role of CMS Central Office: R-NAQs and S-NAQs

- Provide forum for improving quality
- Provide technical assistance (central and local?)
- Provide funding for local programs
  - Title V (how we implement the state plan)
  - Grants through RFPs
- Facilitate communication and priority setting
  - Statewide meetings, conference calls, etc.
- Establish advisory structure to ensure continued forum for RMD, RND, RPA, family, stakeholders, etc. to share expertise and values
  - Provide advice on CMS decisions regarding health plan, quality measures, R-NAQs, S-NAQs

Let Us Hear From You

Send feedback and questions to CMSPlan.Info@flhealth.gov