Integrated Care for Kids (InCK) Model: Evaluation Report 2

Contract # HHSM-500-2014-000261/T0005

February 2024

About this Report

Integrated Care for Kids (InCK) Model Evaluation: Report 2

Abt Associates | 6130 Executive Boulevard | Rockville, MD 20852

In partnership with:

Bailit Health

Westat Insight Policy Research

Disclaimer

Citation
Abt Associates Inc. (2024). *Integrated Care for Kids Model Evaluation: Report 2*.

Table of Contents

List of Exhibits

List of Acronyms and Abbreviations

ACE-Q	Adverse Childhood Experience - Questionnaire
ACO	Accountable care organization
ADHD	Attention-deficit/hyperactivity disorder
ADI	Area deprivation index
AHC	Accountable Health Communities
AHHN	All Hands Health Network
AIAN	American Indian/Alaskan Native
APM	Alternative Payment Model
ASPE	Assistant Secretary for Planning and Evaluation
BE-InCK NY	Bronx Equity InCK New York
CBO	Community-based organization
CCO/HH	Health Homes serving individuals with intellectual developmental disabilities
CCS	Core Child Services
CHIP	Children's Health Insurance Program
CMARC	Care Management for At-Risk Children
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CRG	Clinical Risk Group
CSOC	Children's Systems of Care
DUA	Data use agreement
ED	Emergency department
ELE	Express Lane Eligibility
FFCRA	Families First Coronavirus Response Act
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Limit
FQHC	Federally qualified health center

HHSC	Health Homes Serving Children
HRSN	Health-Related Social Needs
ICD-10	International Classification of Diseases, 10th Revision
InCK Model	Integrated Care for Kids Model
MAGI	Modified Adjusted Gross Income
MCE	Medicaid managed care entity
MIT	Massachusetts Institute of Technology
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NH/PI	Native Hawaiian and Other Pacific Islander
NOFO	Notice of funding opportunity
NQF	National Quality Forum
NSCH	National Survey of Children's Health
OhioRISE	Ohio Resilience through Integrated Systems and Excellence
OOHP	Out-of-home placement
PFK	Partners for Kids
PHE	Public health emergency
PMCA	Pediatric Medical Complexity Algorithm
PMPM	Per-member-per-month
PRISM	Practical, Robust, Implementation, and Sustainability Model
PSC	Pediatric Symptom Checklist
Q	Quarter
RAF	Retrospective Attribution File
RCF	Retrospective Comparison File
RIF	Research Identifiable Files
SIC	Service Integration Coordinator
SIL	Service Integration Level
SMA	State Medicaid Agency
SNAP	Supplemental Nutrition Assistance Program

SPA	State plan amendment
SOP	Standard Operating Procedure
SWYC	Survey of Well-being of Young Children
T-MSIS	Transformed Medicaid Statistical Information System
TAF	T-MSIS Analytic Files
TANF	Temporary Assistance for Needy Families
TBD	To be determined
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Key Terms

Term	Definition
Alternative Payment Model (APM)	A payment approach that gives providers 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 beneficiaries ages 0 – 20.
Attributed population	The population of Medicaid beneficiaries ages 0 – 20 years who reside in an InCK attributed region and are attributed to a local InCK Model; some award recipients also include Children's Health Insurance Program (CHIP) beneficiaries ages 0 – 20 and/or pregnant Medicaid beneficiaries ages 21 and over in their attributed populations.
Award recipient	An organization awarded a cooperative agreement from CMS to participate in the InCK Model, either a Lead Organization or State Medicaid Agency (SMA).
Core Child Services (CCS)	Health and health-related 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 (2022-2026), in which award recipients implemented the InCK Model.
Lead Organization	An organization designated to administer its local InCK Model in partnership with its SMA.
Local model	The model approach designed and implemented by an InCK Model award recipient in accordance with general CMS model requirements and tailored to the local community's needs and capacity.
Medicaid administrative churn	The process by which beneficiaries temporarily lose and regain Medicaid coverage due to the eligibility redetermination process.

Term	Definition
Needs assessment	The approach award recipients use to identify health and health-related social needs of beneficiaries in their attributed populations to facilitate preventive care and inform Service Integration Level (SIL) stratification.
Out-of-home placement (OOHP)	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 CCS 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.
Service Integration Coordinator (SIC)	An individual who serves as, or facilitates access to, the single point of contact for a beneficiary's integrated care coordination and/or case management of all CCS.
Service integration level	The level of InCK Model services a beneficiary is eligible to receive based on results from their local model's initial needs assessment and any further screening processes, with more intense integrated care coordination and case management available for beneficiaries in SILs 2 and 3.
Service integration level stratification	The process by which InCK award recipients stratify attributed beneficiaries into one of three SILs, according to the type of severity of their needs.
Two-generation approach	A care delivery approach that combines interventions for children and their caregivers or other family members, recognizing the health and well-being of children and their caregivers are inextricably linked.

Abstract

Abstract

The Centers for Medicare & Medicaid Services (CMS), through their Center for Medicare and Medicaid Innovation, funded seven award recipients for the implementation period of the Integrated Care for Kids (InCK) Model. The InCK Model aims to improve the integration of health and health-related services and address unmet needs for Medicaid beneficiaries (ages 0 – 20). Two award recipients opted to include beneficiaries 21 and over who are pregnant or postpartum. Other goals of the model include reducing Medicaid expenditures and avoidable out-of-home placements.

This second evaluation report provides an overview of award recipients' progress toward implementing key model components in 2022, the first year of model implementation (Chapter 1). It also includes a detailed description of each award recipient's approach to assessing beneficiary needs and assigning them to Service Integration Levels (SILs) based on those needs (Chapter 2) and their alternative payment model (APM) design and implementation (Chapter 3). Finally, it describes the local, state, and national policy contexts relevant to InCK Model award recipients' model implementation. This includes the policy context for medical and health-related social needs, referred to as Core Child Services (CCS) in InCK Model states and local areas (Chapter 4).

All but one award recipient began implementing their approach to needs assessment and SIL stratification in early 2022. All award recipients use or will use a combination of administrative data and data collected via screening to identify needs, but each implemented a unique process. Award recipients' approaches influenced the number of beneficiaries they were able to successfully screen and stratify.

APM design and implementation required more time and effort than most award recipients anticipated. Six of the seven recipients designed APMs with per-member-per-month payments and financial incentives tied to quality. These APMs leverage existing provider organization relationships, incorporate APMs into existing managed care contracts, and use quality measures to incentivize providers in domains such as preventive care, care coordination, and social determinants of health. The seventh award recipient designed a shared savings APM that is aligned with accountable care organization (ACO) contracts that pre-date the InCK Model. Most award recipients will fully implement their APMs in 2024. Future reports will include an update on APM design, implementation, and impact.

The availability and accessibility of medical care and CCS in award recipients' states have the potential to influence the design and implementation of local InCK Models and to mitigate model impacts. Provider supply varies substantially across InCK Model attributed regions; low supply creates obstacles for InCK Model Service Integration Coordinators

(SICs) to successfully connect beneficiaries to needed services. InCK Model states also vary in policies that influence access and availability of other CCS programs, such as food assistance and public/affordable housing. Limited CCS availability may diminish the model's potential to improve children's health if there are limited to no resources to which to refer a family. Future reports will include details on historical utilization of CCS for some services and the extent to which CCS utilization changed in InCK attributed regions.

As the implementation period progresses, future evaluation reports will provide updates on award recipients' approaches to key model components, describe utilization of CCS, and ultimately assess the impact of the model. The evaluation will assess the impact of the InCK Model on healthcare utilization, out-of-home placements, and Medicaid expenditures.
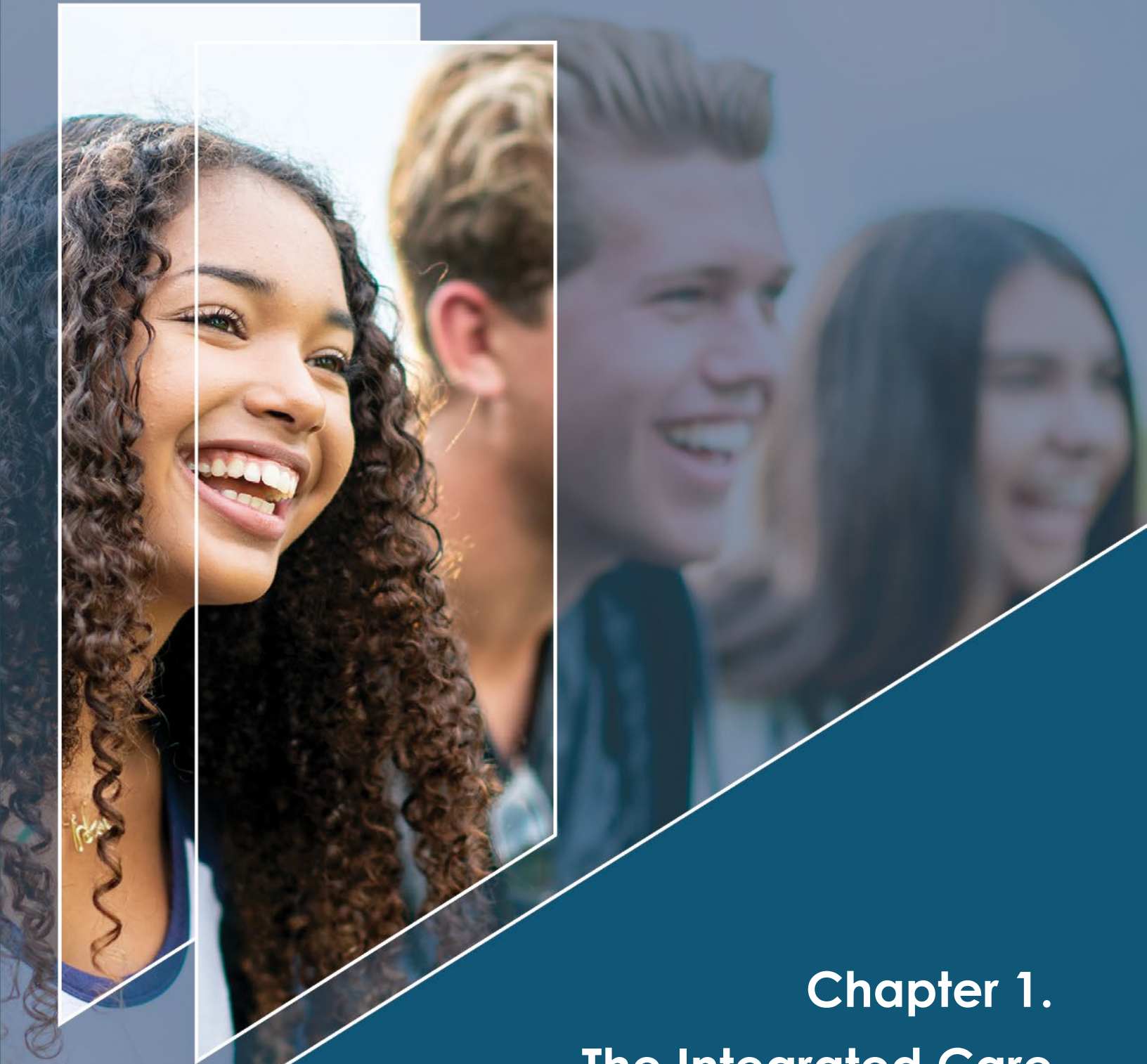
Chapter 1.
The Integrated Care for Kids Model: Overview and Evaluation

1. Overview and Evaluation

1.1   INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS), through their Center for Medicare and Medicaid Innovation, launched the Integrated Care for Kids (InCK) Model in 2020. They awarded cooperative agreements to eight organizations, seven of which progressed to the model implementation period. The seven organizations and the regions they serve are described in Exhibit 1.1. The InCK Model is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children ages 0 – 20 covered by Medicaid. Some programs also include pregnant individuals ages 21 and over. The primary goals of the InCK Model are to improve early identification and increase treatment of behavioral and physical health needs. The InCK Model aims to achieve these goals by assessing the physical and behavioral health and social needs of children and then providing targeted integrated care coordination and case management services to those in greatest need. InCK Model award recipients have developed state-specific alternative payment models (APMs) to align payment with care quality and support the sustainability of model activities.

Exhibit 1.1. InCK Model Award Recipients Include a Diverse Set of Organizations.

InCK Model Award Recipient	Lead Organization	Attributed Region
All Hands Health Network (AHHN)	Ann & Robert H. Lurie Childrens Hospital	Two ZIP codes in Cook County, Illinois
Bronx Equity InCK New York (BE-InCK NY)	Montefiore Medical Center	Three ZIP codes in North-Central Bronx, NY
Connecticut (CT) InCK Embrace New Haven	Clifford W. Beers Guidance Clinic	Three ZIP codes in New Haven, CT
New Jersey (NJ) InCK	Hackensack Meriden Health System	Monmouth and Ocean counties in central New Jersey
North Carolina (NC) InCK	Duke University	Alamance, Durham, Granville, Orange, and Vance counties in central North Carolina
Ohio (OH) InCK	Nationwide Children's Hospital	Licking and Muskingum counties in eastern Ohio
Village InCK	Egyptian Health Department	Gallatin, Hamilton, Saline, Wayne, and White counties in southern Illinois

1.2 EVALUATION IN BRIEF AND DATA SOURCES FOR SECOND EVALUATION REPORT

CMS has contracted with Abt Associates Inc. and its partners, Bailit Health and Westat Insight Policy Research, to evaluate the implementation and impact of the InCK Model for each of the model's award recipients. The evaluation team acquires, collects, and analyzes qualitative and quantitative data to answer five primary research questions for the model's implementation period (Model Years 3-7, 2022-2026):

1. How was the InCK Model implemented by each award recipient?
2. How has the InCK Model implemented by each award recipient affected children and families in the following four areas: navigation and coordination, utilization and expenditures, quality of care, and beneficiary and caregiver experience of care?
3. To what extent did service changes or disruptions occur in the InCK Model, and what impact did they have on care delivery by each award recipient?
4. What is the return on investment of the InCK Model per each award recipient?
5. To what extent do the effects of the InCK Model vary?

Each chapter of the Second Evaluation Report provides findings addressing Research Question 1, as described in Exhibit 1.2.

Exhibit 1.2. The Second Evaluation Report Provides Insights for the Evaluation's Research Questions.

Chapter	Relevant Research Question
Chapter 2. Approach to SIL Stratification and Early Results	1
Chapter 3. APM Design and Implementation	1
Chapter 4. Core Child Service Context	1

The evaluation uses a mixed-methods approach to assess the implementation and impact of the InCK Model. Evaluation activities in each year of the five-year implementation period will provide insight into both the model progress and corresponding outcomes that are specific to that operational phase. During the first year of the implementation period (Model Year 3, 2022), the evaluation:

- Explored award recipients' local contexts and conducted interviews to characterize model implementation, and both the Lead Organizations' and State Medicaid Agencies' (SMAs') experiences.

- Assessed Medicaid and CCS data availability and quality, reviewed standard operating procedures, developed guidance for award recipients on required data specified under the terms of InCK Model participation, then validated each award recipient's submitted data, and provided support to award recipients to improve data quality.

> For more information on the evaluation activities in Model Year 3, see Appendix B.
>
> For details on evaluation activities planned for Model Year 4, see Appendix J.

1.2.1 Data Sources for this Evaluation Report

This evaluation report presents findings from mixed-methods analysis of Medicaid claims; publicly available data; model documentation submitted by award recipients; interviews conducted with Lead Organization staff, their associated SMAs, and CMS Project Officers; and environmental scans of peer-reviewed and grey literature. Additional details on the methods used to produce this report are included in Appendices A, B, F, and G.

1.2.2 The Evaluation Framework and the Role of Equity in the Evaluation

The Practical, Robust, Implementation, and Sustainability Model (PRISM) provides the framework guiding the overall InCK Model evaluation research design. PRISM prioritizes beneficiary and provider perspectives and emphasizes that successful implementation is dependent on state and local context (see Exhibit 1.3).

Stakeholders increasingly recognize how complex interactions between people and communities affect health outcomes. Social, economic, and environmental conditions contribute to health inequities. One goal of the InCK Model is to break down traditional silos in care for children and promote health equity through better integration of medical and behavioral health care with CCS.

To align with PRISM, the evaluation captures details about award recipients' interventions; the context of implementation, including historical service gaps; the alignment of the local model with that context; and the individual characteristics of the local attributed populations.

Exhibit 1.3. PRISM Framework Centers the Voices of Award Recipients, Providers, Beneficiaries, and Their Families.
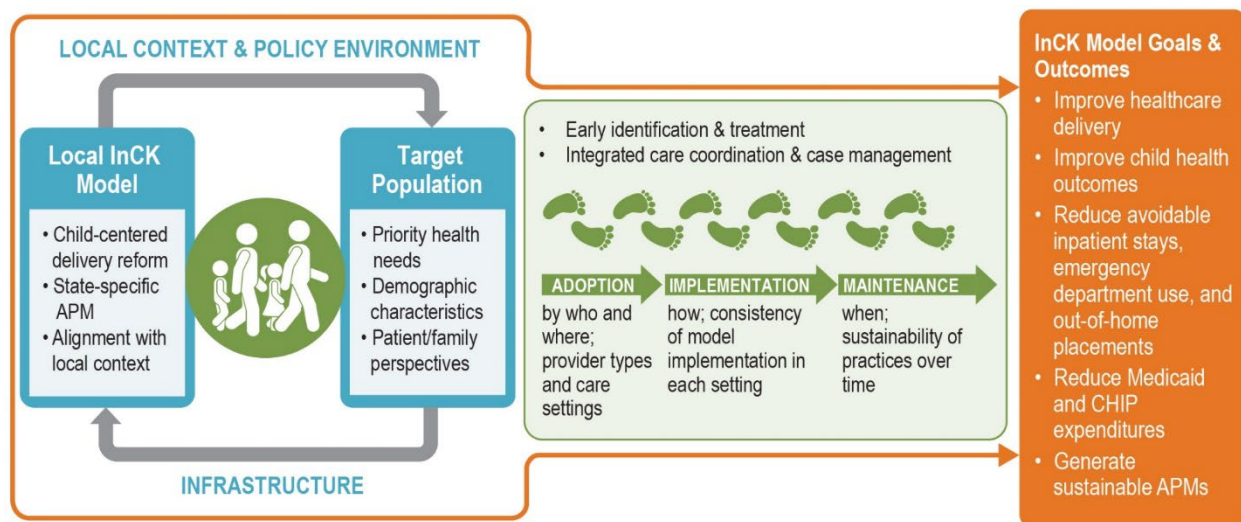
Note: PRISM=Practical, Robust, Implementation and Sustainability Model. APM=Alternative Payment Model. CHIP=Children's Health Insurance Program

1.3 INCK MODEL IMPLEMENTATION YEAR 1 (2022) ACTIVITIES

After a two-year pre-implementation period (2020-2021), the first InCK Model Implementation Year began on January 1, 2022. The implementation period will last five years (2022-2026). Seven award recipients in six states conducted numerous model activities, including expanding infrastructure and establishing staffing approaches; developing and initiating needs assessments and SIL stratification approaches; partnering with local organizations for service integration; establishing data use agreements (DUAs); and working with CMS, SMAs, and Medicaid Managed Care Entities (MCEs) to design and operationalize APMs.

1.3.1 Award Recipients' Characteristics

Each award recipient's attributed population and broader community context influenced model design, priorities, and goals. Exhibits 1.4-1.6 present characteristics of each award recipient and its attributed region in the first year of

> For more information on the InCK Model, see the Evaluation Report 1.

model implementation. The descriptive statistics in Exhibits 1.4 – 1.6 are based on the evaluation team's analysis of award recipient-submitted data files, administrative data from the Transformed Medicaid Statistical Information System (T-MSIS), and publicly available secondary data sources.[a] Award recipients' 2022 attributed populations varied in terms of size, demographic characteristics, and social needs:

- **Population Size**: Attributed populations ranged from 10,334 (Village InCK) to 154,176 (NJ InCK) beneficiaries (Exhibit 1.4). Award recipient's attributed populations were larger in 2022 than anticipated due to the continuous coverage provisions enacted in response to the COVID-19 public health emergency (PHE). (See Evaluation Report 1 for the estimated number of beneficiaries that award recipients originally anticipated for their attributed populations.) The number of beneficiaries assigned to each SIL varies by award recipient. There is additional detail about award recipients' approaches to SIL stratification in Chapter 2.

---

[a] The award recipient-submitted data on the number of beneficiaries in the attributed region and the race and ethnicity of the beneficiaries for OH InCK and Village InCK were not final at the time this report was written. In Exhibits 1.4 – 1.6, we supplemented the award recipient-submitted data on the number of beneficiaries in OH InCK and Village InCK's attributed regions, and beneficiaries' race and ethnicity, with demographic and enrollment data from the 2022 Interim T-MSIS Analytic Files (accessed through the CMS Chronic Conditions Warehouse on May 31, 2023).

Exhibit 1.4. Early SIL Stratification Results Vary Across Award Recipients.

InCK Model Award Recipient Characteristics[1,2,3,a,b]	AHHN[c]	BE-InCK NY[d]	CT InCK Embrace New Haven	NC InCK	NJ InCK	OH InCK	Village InCK
Number of Beneficiaries in the Attributed Region	42,013	37,902	10,989	109,049	154,176	36,135	10,334
Attributed Beneficiaries Assigned to a SIL	38,470 (91.6%)	34,132 (90.1%)	0 (0.0%)	102,209 (93.7%)	84 (0.1%)	29,873 (82.7%)	343 (3.3%)
Beneficiaries in SIL 1[f]	35,876 (85.4%)	30,083 (79.4%)	-	94,880 (87.0%)	48 (0.03%)	25,682 (71.1%)	310 (3.0%)
Beneficiaries in SIL 2	1,959 (4.7%)	3,612 (9.5%)	-	3,859 (3.5%)	20 (0.01%)	3,366 (9.3%)	33[e] (0.3%)
Beneficiaries in SIL 3	635 (1.5%)	437 (1.2%)	-	3,470 (3.2%)	16 (0.01%)	825 (2.3%)	

Sources:
1. Number of beneficiaries in the attributed region for AHHN, BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK: Award recipient-submitted Retrospective Attribution Files, 2022
2. Number of beneficiaries in the attributed region for OH InCK and Village InCK: Abt analyses of Interim T-MSIS Analytic Files, 2022: Demographic and Enrollment.
3. SIL Data for all award recipients: Award recipient-submitted Quarter 1 (Q1) and Q2 SIL data files, 2022

Notes:
a. Each award recipient submits a Retrospective Attribution File (RAF) noting the number of individuals in the InCK Model population. The number of beneficiaries in the attributed regions for AHHN, BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK come from the RAFs submitted in 2023, with data as of September 2023. We have excluded beneficiaries who opted out of data sharing from these rows. The number of beneficiaries in the attributed region for OH InCK and Village InCK reflects the number of Medicaid enrolled individuals under age 21 who resided in the attributed regions according to the 2022 Interim T-MSIS Analytic Files.
b. Each award recipient submitted quarterly data on SILs assigned to beneficiaries in their attributed region. The SIL-related data in these rows reflect award recipients' Q1 and Q2 2022 SIL assignments; CT InCK Embrace New Haven did not submit Q1 and Q2 2022 SIL data. Additional details about how award recipients are conducting needs assessments and SIL assignments are included in Chapter 2.
c. AHHN = All Hands Health Network.
d. BE-InCK NY = Bronx Equity InCK New York.
e. We report the grouped number of beneficiaries assigned to SIL 2 or SIL 3 for Village InCK due to small numbers.
f. SIL=Service Integration Level

- **Race and Ethnicity**: Communities served by award recipients varied in racial and ethnic diversity (Exhibit 1.5). Less than 15 percent of beneficiaries in NJ InCK, OH InCK, and Village InCK are reported as Black or Asian American/Pacific Islander. In contrast, CT InCK Embrace New Haven and NC InCK both serve attributed regions where more than 40 percent of beneficiaries are indicated as Black or Asian American/Pacific Islander. Less than 2 percent of beneficiaries in OH InCK and Village InCK are reported as Hispanic, compared to roughly 20 percent or more of beneficiaries in the attributed regions of the remaining award recipients. However, missing data obscures the true racial and ethnic composition of InCK attributed regions. Roughly half of beneficiaries in

the InCK attributed population for AHHN, BE-InCK NY, and CT InCK Embrace New Haven are missing race data, and approximately two-thirds or more of beneficiaries in AHHN and NJ InCK are missing ethnicity data.

Exhibit 1.5. Demographic Characteristics of Beneficiaries Vary Across InCK Model Attributed Regions.

Characteristics of Beneficiaries in the InCK Model Attributed Region[1,2,a,b]		AHHN[c]	BE-InCK NY[d]	CT InCK Embrace New Haven	NC InCK	NJ InCK	OH InCK	Village InCK
Race	Asian American/Pacific Islander[1,2]	0.6%	9.1%	2.2%	2.0%	1.3%	5.1%	0.6%
	Black[1,2]	16.2%	24.5%	40.3%	41.7%	7.4%	9.9%	4.5%
	White[1,2]	32.2%	15.2%	9.3%	51.0%	59.7%	77.1%	84.1%
	Missing race[1,2]	50.6%	50.6%	48.1%	5.3%	31.6%	7.1%	9.1%
Ethnicity	Hispanic	19.7%	56.2%	19.0%	29.9%	19.6%	0.3%	1.2%
	Missing ethnicity[a]	63.4%	0.0%	0.0%	1.1%	80.4%	7.1%	9.1%
Young Adult: 18-20 years old		12.9%	13.7%	10.8%	11.1%	9.8%	11.0%	11.6%
Pregnant[e]		1.1%	1.4%	12.7%	1.3%	0.6%	1.1%	1.1%

Sources:
1. Race and ethnicity data for AHHN, BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK: Award recipient-submitted Retrospective Attribution Files, 2022.
2. Race and ethnicity data for OH InCK and Village InCK: Abt analyses of Interim T-MSIS Analytic Files, 2022: Demographic and Enrollment.

Notes:
a. Each award recipient submits a RAF noting the number of individuals in the InCK Model population. The number of beneficiaries in the attributed regions for AHHN, BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK come from the RAFs submitted in 2023, with data as of September 2023. We have excluded beneficiaries that opted out of data sharing from these rows. The number of beneficiaries in the attributed region for OH InCK and Village InCK reflects the number of Medicaid enrolled individuals under age 21 who resided in the attributed regions according to the 2022 Interim T-MSIS Analytic Files. Village InCK's RAF was not final by the time this report was written.
b. Each award recipient submitted quarterly data on SILs assigned to beneficiaries in their attributed region. The SIL-related data in these rows reflect award recipients' Q1 and Q2 2022 SIL assignments; CT InCK Embrace New Haven did not submit Q1 and Q2 2022 SIL data. Additional details about how award recipients are conducting needs assessments and SIL assignments are included in Chapter 2.
c. AHHN=All Hands Health Network.
d. BE-InCK NY=Bronx Equity InCK NY.
e. OH InCK did not indicate pregnant individuals in their 2022 RAF.

- **Geography**: The population density of the InCK attributed region differs substantially (Exhibit 1.6). All beneficiaries attributed to Village InCK live in rural counties. By comparison, none of the beneficiaries attributed to AHHN, BE-InCK NY, CT InCK Embrace New Haven, or NJ InCK live in rural counties.

- **Resource Need and Availability**: The Area Deprivation Index (ADI) is a composite measure of socioeconomic deprivation; severe housing problems, such as overcrowding, high housing costs, or inadequate housing; and food insecurity. Deciles (1 to 10) of ADI values provide a summary of a geographic area's deprivation, where one is least and 10

is most socioeconomically deprived. This measure varies substantially across award recipients (Exhibit 1.6), and all communities served by award recipients have needs in these core service areas.

Exhibit 1.6. Social Characteristics of Residents Vary Across InCK Model Attributed Regions.

Characteristics of all residents in the InCK Model Attributed Region[a]	AHHN[b]	BE-InCK NY[c]	CT InCK Embrace New Haven	NC InCK	NJ InCK	OH InCK	Village InCK
Median household income[1]	$47,332	$53,807	$48,147	$64,926	$93,660	$66,046	$50,967
Massachusetts Institute of Technology (MIT) Living Wage[2,d]	$101,131	$121,035	$99,694	$101,213	$116,022	$81,682	$86,278
Rural ZIP code/county[3]	0.0%	0.0%	0.0%	14.0%	0.0%	32.7%	100.0%
Limited English proficiency[1]	13.0%	13.3%	4.2%	3.0%	2.6%	0.3%	0.4%
Food insecure[4]	10.1%	17.5%	12.1%	13.4%	8.0%	13.3%	13.5%
Highest educational level: associate, bachelors, or graduate degree[1]	40.2%	49.7%	64.4%	51.5%	48.2%	35.1%	31.2%
Area deprivation index[5,e]	4.42	5.62	6.29	4.51	5.02	5.01	8.67
Own their home[6,f]	56.9%	19.7%	61.8%	60.1%	76.8%	71.6%	77.1%
Experiencing severe housing problems[7,g]	18.3%	31.0%	17.7%	13.9%	17.5%	10.9%	8.9%

Sources:
1. Census Bureau. (2021). American Community Survey. https://www.census.gov/programs-surveys/acs through the Agency for Healthcare Research and Quality. Social Determinants of Health Database. (2020). https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html.
2. Millennial Cities (2023). MIT Living Wage Calculator. MIT Living Wage Calculator – Millennial Cities
3. U.S. Department of Agriculture. (2010). Rural-Urban Community Area Codes. https://www.ers.usda.gov/data-products/rural-urban-commuting-areacodes.aspx through the Agency for Healthcare Research and Quality. (2018). Social Determinants of Health Database. https://www.ahrq.gov/sdoh/dataanalytics/sdoh-data.html
4. University of Wisconsin Population Health Institute. (2021). 2021 County Health Rankings. https://www.countyhealthrankings.org/
5. 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). 2020 Area Deprivation Index v3.2. Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/
6. American Community Survey (5-year estimates, 2015-2019) via the University of Wisconsin Population Health Institute. (2021). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/
7. Comprehensive Housing Affordability Strategy data, 2013-2017 through University of Wisconsin Population Health Institute. (2021). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/

Notes:

a. Averages across attributed ZIP Codes/counties are weighted by the population of each ZIP Code/county.
b. AHHN=All Hands Health Network.
c. BE-InCK NY=Bronx Equity InCK New York.
d. The MIT Living Wage Calculator estimates the real cost of living in the United States. For the purposes of this report, we annualized the living wage assuming a standard 40-hour work week (annual work hours: 2,080). We used a single-parent household with two kids to estimate the required living wage for Chicago, IL (AHHN); New York, NY (BE-InCK NY); New Haven, CT (CT InCK Embrace New Haven); Durham-Chapel Hill, NC (NC InCK); Monmouth County, NJ (NJ InCK); Muskingham County, OH (OH InCK); and Saline County, IL (Village InCK).
e. The ADI measures socioeconomic disadvantage at the U.S. Census tract level using income, education, employment, and housing quality measures contained in the 2016-2020 American Community Survey Five Year Estimates. The ADI is reported in national percentile rankings at the block group level from 1 to 100. The percentiles are constructed by ranking the ADI from low to high for the nation and grouping the block groups into bins corresponding to each 1 percent range of the ADI. A higher value indicates areas at a greater socioeconomic disadvantage.
f. Percentage of occupied housing units that are owned by occupant.
g. Percentage of households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

1.3.2 Utilization and Quality of Care Measures for Attributed Populations

Quarterly trends in healthcare utilization rates provide information about healthcare utilization in InCK Model Attributed Populations before the InCK Model (2017 – 2019) and during the pre-implementation period (2020 – 2021). These baseline trends provide detail on the context into which award recipients are implementing their InCK Model, including the effects the COVID-19 PHE had on healthcare utilization among InCK beneficiaries. The impact of the PHE may or may not persist as the award recipients continue to implement the model after the PHE declaration expired on May 11, 2023.

> The evaluation team stratified the quarterly trends in healthcare utilization measures (discussed below) for each award recipient by age and race/ethnicity of attributed beneficiaries.
>
> - Healthcare utilization rates differed between younger and older beneficiaries in each award recipient's attributed region.
> - Trends in utilization were similar for all ages, both before and after the onset of the PHE. For example, differences in rates of well-child and well-care visits across age groups appear to reflect the American Academy of Pediatrics' recommended schedule for well-child visits for newborns, children, and adolescents (e.g., visits at 2, 4, 6, 9, 12, 15, 18, and 24 months, and once each year from ages 3 to 21 years).
> - Rates of outpatient emergency department visits were highest among infants and children aged 1-2 years, followed by children aged 3-4, and young adults aged 18 to 20.
> - Hospitalization rates were highest among infants aged <1 year, followed by young adults aged 18 to 20.
> - Healthcare utilization rates also differed between beneficiaries of different races and ethnicities, but these differences were not consistent across the attributed regions. The differences persisted both before and after the onset of the PHE.

Well-Child Visits

Previous research has shown little to no change in rates of well-child visits among infants during the PHE,[1,2] and trends among Medicaid or Children's Health Insurance Program (CHIP) enrollees in InCK Model Attributed Populations were consistent with previous evidence (Exhibit 1.7 and Exhibit 1.8). Infant visits provide critical services that cannot be provided virtually, such as vaccinations and evaluations for normal development. Rates of well-child/well-care visits for older children and adolescents decreased and were at their lowest in April 2020, but they quickly rebounded to typical rates, maintaining seasonal variations observed before the PHE.[1,2] There was a notable decline in well-child visits in some attributed populations late in 2021. This may be due to regular seasonal variation and a rise in COVID-19 cases at that time.

Exhibit 1.7. InCK Well-Child Visits Among Children 30 Months or Younger Remained Stable in the InCK Model Attributed Populations Before and After the Start of the PHE.
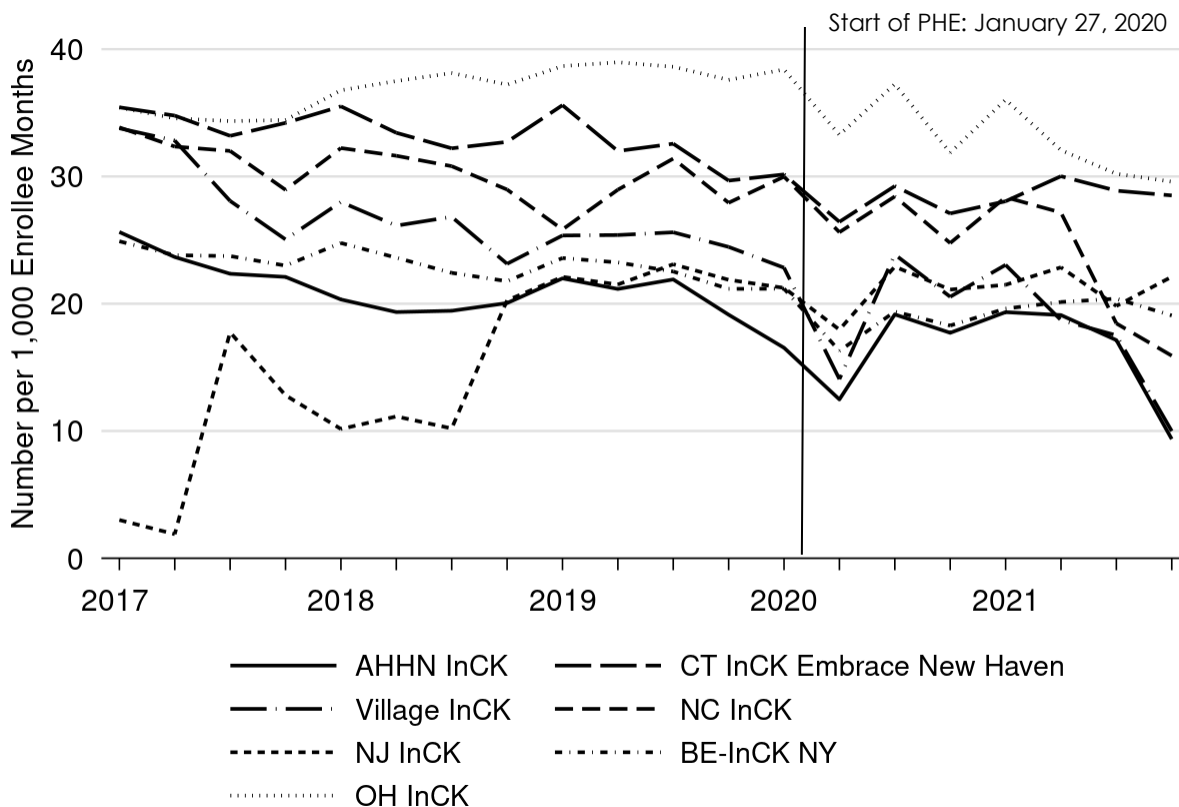
Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Other Services, Demographic and Enrollment.

Notes: Quarterly trends in well-child visits with a primary care practitioner in the first 30 months of life per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 0–30 months in each InCK Model Attributed Population and CHIP enrollees aged 0–30 months in CT InCK, NJ InCK, and NC InCK's attributed regions (trends for AHHN, BE-InCK NY, OH InCK, and Village InCK do not include CHIP enrollees). Sample sizes vary by quarter. PHE= Public Health Emergency.

Exhibit 1.8. Well-Care Visits for Children and Adolescents in InCK Model Attributed Populations Were at Their Lowest Rates Shortly After the PHE Began, Then Quickly Returned to Pre-PHE Rates.
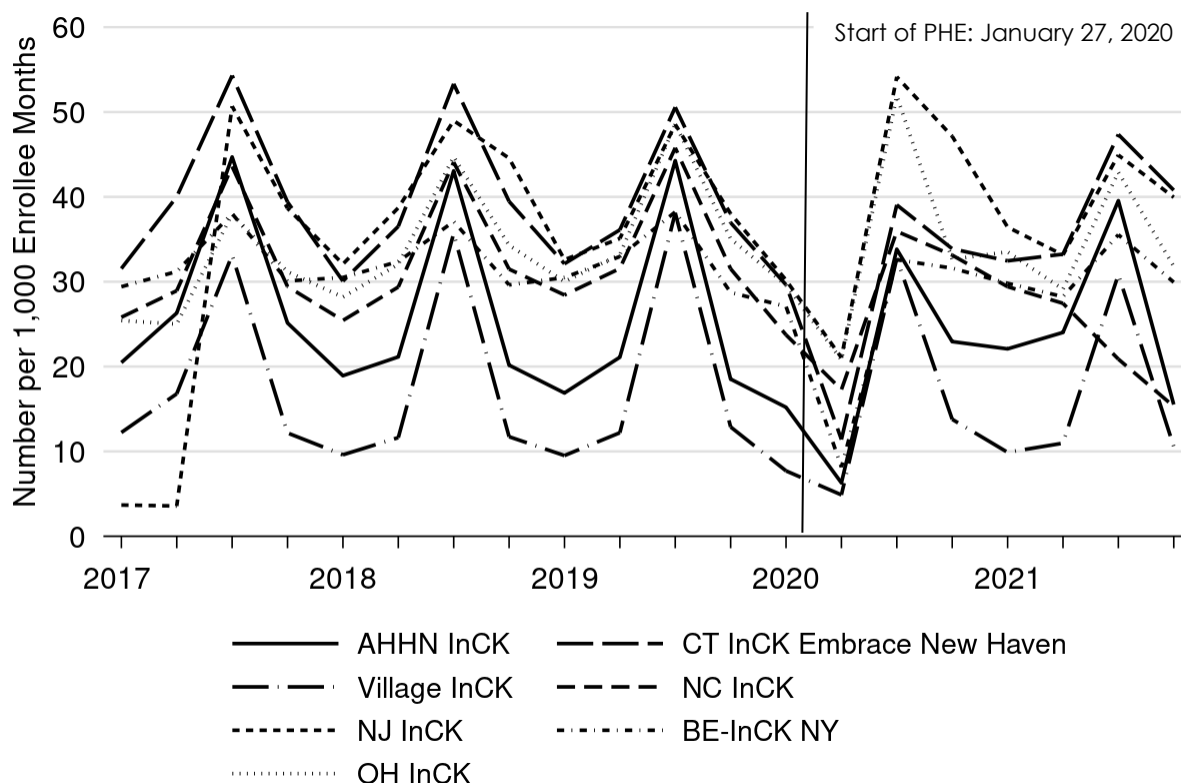
Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Other Services, Demographic and Enrollment.

Notes: Quarterly trends in well-care visits with a primary care practitioner or obstetrician/gynecologist among children and adolescents per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 3–20 years in each InCK Model Attributed Region and CHIP enrollees aged 3–20 years in CT InCK Embrace New Haven, NJ InCK, and NC InCK's attributed regions (trends for AHHN, BE-InCK NY, OH InCK, and Village InCK do not include CHIP enrollees). Sample sizes vary by quarter. PHE=Public Health Emergency

Emergency Department Visits

Exhibit 1.9 presents quarterly trends in emergency department (ED) visits that did not result in hospitalization (i.e., outpatient ED visits) among Medicaid or CHIP beneficiaries in the attributed regions between 2017 and 2021. Rates of outpatient ED visits varied by quarter, but

> Appendix A details trends in all ED visits, including those that resulted in hospital admission.

the underlying trends held steady between 2017 and 2019. Outpatient ED visits declined substantially during the first half of 2020, then gradually returned to nearly pre-PHE levels by the end of 2021, a pattern consistent with studies of national trends in ED utilization before and during the PHE. These studies suggested that patients avoided the ED during the first wave of the PHE, instead seeking needed services from urgent care clinics or via telehealth.[3]

Exhibit 1.9. Outpatient Emergency Department Visits in the InCK Model Attributed Populations Declined Substantially During 2020, Then Gradually Returned to Nearly Pre-PHE Rates.
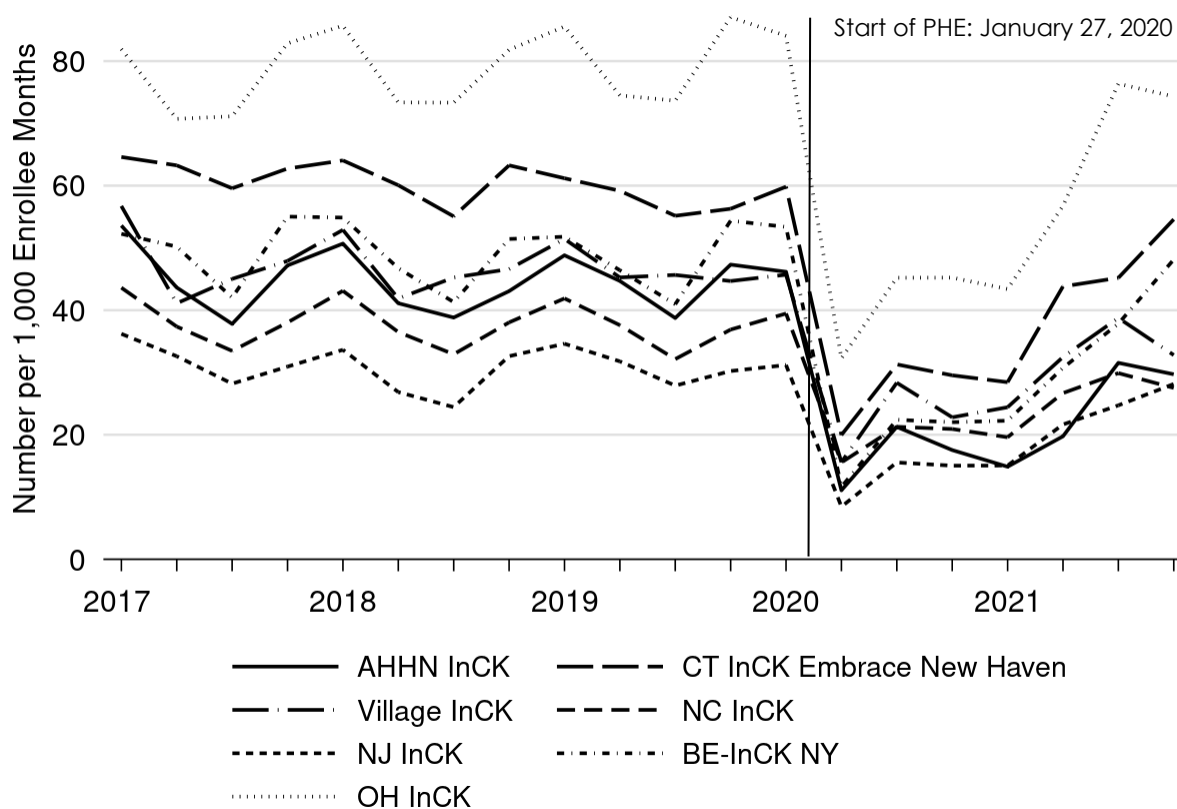
Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Other Services, Inpatient, Demographic and Enrollment.

Notes: Quarterly trends in ED visits not resulting in hospital admission per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 0–20 years in each InCK Model Attributed Population and CHIP enrollees aged 0–20 years in CT InCK Embrace New Haven, NJ InCK, and NC InCK's attributed regions (trends for AHHN, BE-InCK NY, OH InCK, and Village InCK do not include CHIP enrollees). Sample sizes vary by quarter. PHE=Public Health Emergency

Hospitalizations and Outpatient Observation Stays

Exhibits 1.10 and 1.11 show quarterly trends in days hospitalized and outpatient observation stays among Medicaid or CHIP enrollees aged 20 or younger in InCK Model Attributed Populations. In contrast to ED visits, rates of hospitalizations and observation stays were stable both

> Appendix A details trends in hospital admissions, which were like trends in days hospitalized.

before and after the PHE began. With the exception of the NJ InCK attributed region, rates of acute care hospitalizations decreased in InCK regions between 2017 and 2021. Rates of outpatient observation stays remained steady in each InCK Model Attributed Region through 2019, declined somewhat during the first half of 2020, then returned to levels close to or exceeding those observed before the PHE.

A Kaiser Family Foundation study of trends in overall and non-COVID-19 related hospitalizations in the United States found inpatient admissions for patients younger than 65 were approximately 30 percent below predicted levels during the first half of 2020 but returned to predicted levels by the end of 2021. Moreover, these patterns were similar across the U.S.[4] In contrast, the rates of hospitalizations and outpatient observation stays[b] remained relatively stable among Medicaid or CHIP enrollees aged 20 or younger in the InCK Model Attributed Populations between 2017 and 2021, likely because most hospitalizations in this age group are unplanned and unavoidable.[4] These trends suggest that, while older patients were reluctant to enter a hospital during the PHE, parents of children and adolescents in the attributed population did not avoid seeking necessary care at hospitals.[4]

Exhibit 1.10. Days Hospitalized in the InCK Model Attributed Populations Were Consistent Before and After the PHE Began.
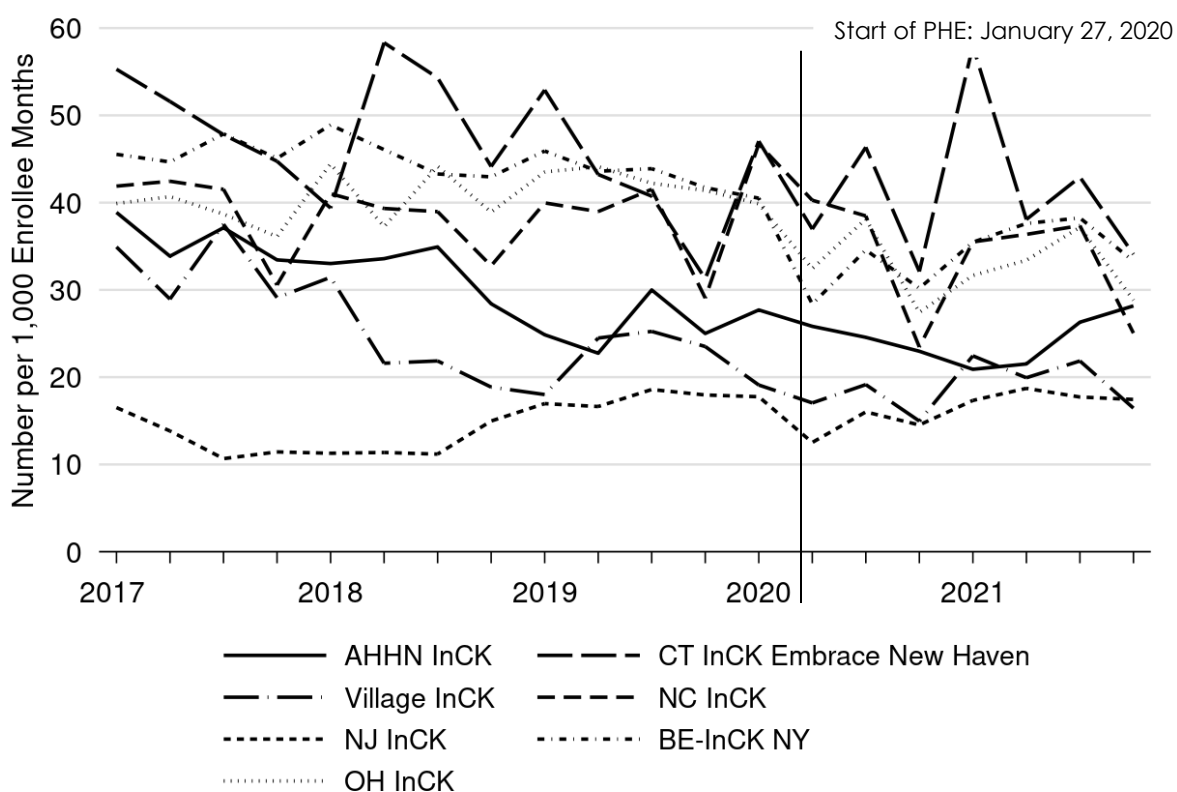
Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Inpatient, Demographic and Enrollment.

Notes: Quarterly trends in days admitted at an acute care hospital per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 0–20 years in each InCK Model Attributed Population and CHIP enrollees aged 0–20 years in CT InCK Embrace New Haven, NJ InCK, and NC InCK's attributed population

---

[b] Observation stays are hospital outpatient services a patient receives while a physician decides whether or not to admit a patient to the hospital or discharge them. Patients may receive observation services in the ED or another area of the hospital.

(trends for AHHN, BE-InCK NY, OH InCK, and Village InCK do not include CHIP enrollees). Sample sizes vary by quarter. PHE= Public Health Emergency

Exhibit 1.11. Outpatient Hospital Observation Stays in the InCK Model Attributed Populations Declined in 2020 Before Returning to Levels Close to Pre-PHE Trends.
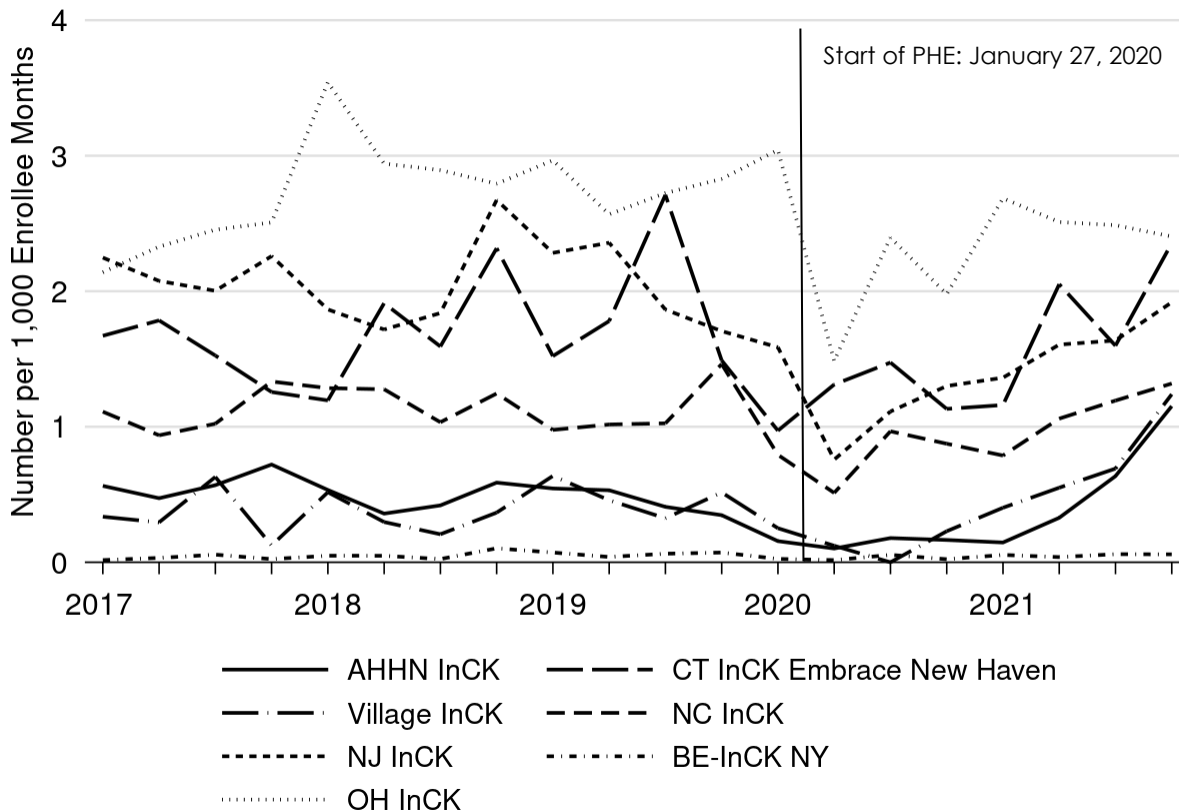
Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Other Services, Inpatient, Demographic and Enrollment.

Notes: Quarterly trends in outpatient hospital observation stays per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 0–20 years in each InCK Model Attributed Population and CHIP enrollees aged 0–20 years in CT InCK Embrace New Haven, NJ InCK, and NC InCK's attributed population (trends for AHHN, BE-InCK NY, OH InCK, and Village InCK do not include CHIP enrollees in their attributed population). Sample sizes vary by quarter. PHE=Public Health Emergency

1.3.3 Implementation Progress in Implementation Year 1

In Implementation Year 1 (2022), award recipients began providing services to InCK Model Beneficiaries and caregivers. Award recipients collaborated with CMS program staff to develop their approaches to delivering integrated care.

> For more information on each award recipient's approach to fulfilling the model elements, see the Evaluation Report 1.

Award recipients conducted activities in six InCK Model component areas to strengthen their model designs:

1. Partnership Council
2. Information and data sharing
3. Needs assessment for early identification and service delivery
4. Person and family-centered care
5. State-specific APMs
6. Two-generation approaches

The evaluation team collected information about award recipients' progress toward implementation of model component areas through interviews with award recipients and their affiliated SMAs. The team also reviewed award recipients' progress reports and other model documentation. Below is an update on award recipients' design of each model element and their progress toward implementation.

Partnership Councils

Description: Groups made up of representatives from local CCS organizations, Medicaid payers, physical and behavioral health providers, beneficiaries, caregivers, and families.

2022 Implementation Status: Award recipients held Partnership Council and subcommittee meetings. The targeted activities included:

- Solidifying partnerships with community-based organizations and CCS providers

- Building tools and resources for engagement, referral processes, and InCK Model operations

- Conducting outreach to providers and beneficiaries and their caregivers

- Engaging health system providers and MCEs on APM development and implementation

Award recipients' activities to engage beneficiaries, caregivers, and families in the Partnership Council had varying success. All award recipients were able to find ways to include families at the beginning, but most were not able to maintain consistent youth engagement. All award recipients identified the importance of and intent to involve more youth and families in the Planning Council in Model Year 4 (2023).

Information and Data Sharing

Description: Data sharing across providers and beneficiaries and their caregivers to support SIL stratification; service integration and care coordination; and InCK Model program monitoring, auditing, and evaluation activities.

2022 Implementation Status: Data sharing and data integration between healthcare and social service systems is critical to achieving an effective, efficient, and integrated service system. Award recipients invested in technology platforms to support model implementation, track referrals, and share care plans with beneficiaries, their families, and other providers. Exhibit 1.12 describes the implementation and adoption status of technology platforms.

Exhibit 1.12. Implementation and Adoption of Technology Platforms Varied Across Award Recipients.

Award Recipient	Mechanism to Support Referrals and Information Sharing Between Providers		Mechanism to Share Information with Beneficiaries and Families	
	Platform	Implementation Status as of December 2022	Platform	Implementation Status as of December 2022
AHHN	NowPow/Unite Us	Functional, but not yet rolled out to community providers	Epic/MyChart	Fully functional
BE-InCK NY	TBD	In progress	N/A	Have no plans to develop this function
CT InCK Embrace New Haven	NowPow/Unite Us	Fully functional; only Service Integration Coordinators (SICs) using regularly	N/A	Have no plans to develop this function
NJ InCK	Navigator360 + New Jersey 211	Fully functional; only SICs using regularly	Navigator 360	In progress
NC InCK	NCCARE360	Fully functional, limited provider uptake	Virtual Health	On hold
OH InCK	Apricot360	Fully functional	N/A	Have no plans to develop this function
Village InCK	NowPow/Unite Us	Fully Functional	Health EC	Will be functional in Model Year 4

Key: Functional | In progress | No Plan | On hold

Note: Unite Us acquired NowPow in 2021. Some award recipients initially contracted with NowPow, but after acquisition was finalized, award recipients began transitioning to Unite Us products at the end of 2022.

Needs Assessment for Early Identification and Service Delivery

Description: A needs assessment conducted for all beneficiaries in the InCK Model Attributed Population conducted at least once annually to assess individual and family health and health-related social needs in 10 domains: Physical Health, Behavioral Health, Maternal and Child Health, Functional Symptoms, Functional Impairment, Special Education/Early Intervention, Child Welfare, Imminent or at Risk of Out-of-Home Placement (OOHP), Housing Instability, and Food Insecurity.

> For more information on the award recipients' approaches and results from the needs assessment and stratification processes, see Chapter 2.

2022 Implementation Status: Award recipients developed and implemented individualized approaches to needs assessment and SIL stratification. Award recipients' design was influenced by local context, existing practices, and data availability. Each award recipient's needs assessment approach then influenced the number of attributed beneficiaries assigned to each SIL. Award recipients developed unique definitions of health and related needs and SIL eligibility criteria for SILs 2 and 3.

Person and Family-Centered Care Delivery and Service Integration

Description: Integrated care coordination across medical care and other CCS providers to facilitate care delivery that is individualized, family- and child-driven, and culturally and linguistically appropriate. Service integration includes improved care coordination and management of medical care and other CCS through integrated, interdisciplinary care teams with a single point of contact for beneficiaries, with enhanced information sharing and tailored care plans.

2022 Implementation Status: Award recipients conducted outreach and engagement activities to increase beneficiaries' and caregivers' awareness of the InCK Model and their intention to promote person and family-centered care delivery and service integration. Activities included:

- Direct phone outreach to eligible families

- Marketing campaigns with billboards, pamphlets, and advertisements in bus shelters

- Multimodal outreach at community events, food pantries, and churches

Award recipients ramped up these activities throughout Implementation Year 1 (2022), with greater engagement in later quarters. One award recipient (CT InCK Embrace New Haven) did not start until mid-2022. All award recipients found that direct phone outreach was not a successful method for contacting a majority of beneficiaries and found more success through advertising, conducting community outreach, and engaging beneficiaries through trusted community partners.

Children in the InCK Model are often eligible for other care coordination programs in addition to InCK. In 2022, award recipients clarified their processes to determine eligibility and enrollment in these programs, how enrollment would influence the receipt of InCK care coordination services, and who would serve as the single point of contact for families.

- Most award recipients completed needs assessments and SIL stratification for attributed beneficiaries enrolled in other established care coordination programs. These children continued to receive care coordination services from their original program, and a care coordinator from that program served as the single point of contact. InCK Model Service Integration Coordinators (SICs) monitored these beneficiaries to ensure they received the services they needed.

- Some award recipients, such as OH InCK, decided not to assess needs or conduct SIL stratification of beneficiaries enrolled in other care coordination programs. These children continued to receive their already-established services, and InCK Model SICs did not engage with them.

- By the end of Model Year 3, some award recipients had yet to finalize details of how enrollment in other care coordination programs would influence service integration in the InCK Model.

Exhibit 1.13 presents a summary of each award recipient's planned approach to coordinate with other programs as of the end of 2022.

Exhibit 1.13. Beneficiary Enrollment in Other Care Coordination Programs Influences SIL Stratification and Service Integration for Some Award Recipients.

Award Recipient	Care Coordination Program	Excluded from SIL Stratification[a]	Single Point of Contact
AHHN	Pathways for Success	To be determined (TBD)	TBD
CT InCK Embrace New Haven	Intensive Case Management	Yes	Not applicable (N/A)
	Behavioral Health Home Model	Yes	N/A
	Care coordination program provided by Clifford Beers	No	TBD
BE-InCK NY	Health Homes Serving Children (HHSC)	No	HHSC care coordinator will serve as single point of contact
	Health Homes serving individuals with intellectual developmental disabilities (CCO/HH)	No	TBD
	Care coordination program provided by the managed care entity (MCE)	No	TBD
NJ InCK	Children's Systems of Care (CSOC)	No	CSOC care coordinator will serve as single point of contact
	Care coordination program provided by the managed care entity	No	TBD
NC InCK	Care Management for At-Risk Children (CMARC)	No	CMARC care coordinator will serve as the single point of contact
	Tailored plans for high need beneficiaries	No	The tailored plan care coordinator will serve as the single point of contact
OH InCK	Partners for Kids (PFK)	No	PFK care coordinator will serve as the single point of contact
	Ohio Resilience through Integrated Systems and Excellence (OhioRISE)	No	OhioRISE care coordinator will serve as the single point of contact
	Care coordination program provided by the MCE	No	MCE's care coordinator will serve as the single point of contact

Award Recipient	Care Coordination Program	Excluded from SIL Stratification[a]	Single Point of Contact
Village InCK	Pathways for Success	No	Pathways for Success care coordinator will serve as the single point of contact
	Care coordination program provided by the MCE	No	TBD

Notes:

[a] "Excluded from InCK SIL Assignment" indicates that beneficiaries enrolled in other care coordination programs will not be contacted to conduct needs assessment and SIL assignment.

State-Specific Alternative Payment Models

Description: Award recipients design and implement an InCK-specific pediatric APM for their attributed population to serve as a mechanism to reward healthcare providers with incentive payments for the quality of care they provide. APMs typically incorporate meaningful quality measures and incentivize providers to adopt high-value, patient-centered practices.[5]

2022 Implementation Status: Award recipients piloted their CMS-approved APM designs, negotiated contracts with MCEs, and refined APM approaches based on these activities. Most InCK Model Award Recipients are implementing population-based payment models that offer providers a per-member-per-month (PMPM) payment tied to performance. Engaging MCEs was particularly challenging for award recipients. Additional details on the design and implementation of InCK APMs are included in Chapter 3.

Two-Generation Approach

Description: A care delivery approach that combines interventions for children and their caregivers or other family members.

2022 Implementation Status: All award recipients used their needs assessment processes to assess the food and housing needs for children and their families. Award recipients also assessed maternal health needs of parents and caregivers of younger beneficiaries. Beyond these domains, some award recipients aimed to incorporate parent, caregiver, or sibling needs into their processes for needs assessment and SIL stratification but had not yet done so as of the end of 2022.

Village InCK and NC InCK have been working to link children, parents, or guardians, in the Medicaid claims data. NC InCK considers a beneficiary to have a maternal and child health need if their parents' Medicaid claim includes a diagnosis of prenatal depression and/or substance use disorder. Village InCK collects information about families' needs through a telephonic or electronic screening tool.

Two award recipients (BE-InCK NY and CT InCK Embrace New Haven) include pregnant beneficiaries 21 years and older in their attributed populations. BE-InCK NY leveraged its InCK Model Cooperative Agreement to support staff hours for its Healthy Moms Program,

which supports pregnant people and those up to three months postpartum. The staff at BE-InCK NY also collaborated with the Nurse-Family Partnership program, which provides access to a nurse for first-time parents. CT InCK Embrace New Haven was still determining their approach to service integration for pregnant individuals in 2022.

1.4 OVERVIEW OF EVALUATION REPORT 2

Evaluation Report 1 described award recipients' activities in the pre-implementation period (2020-2021). During pre-implementation, InCK Model 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 APM plans. Evaluation Report 1 also included descriptive statistics on each InCK attributed population.

This report (Evaluation Report 2) provides an update on model and evaluation activities for Implementation Year 1 (2022). The report offers deep dives into three primary topic areas that influence model implementation and each award recipient's ability to conduct model activities:

- **Needs Assessment and SIL stratification:** Chapter 2 documents the variation in approaches for needs assessment and SIL stratification, implementation during Implementation Year 1, and the influence of award recipients' approaches on early SIL results. This chapter draws on documentation and SIL data submitted by award recipients as of the end of quarter 2 of 2022. It addresses Research Question 1.

- **InCK APM Design and Implementation:** Chapter 3 details each award recipient's APM design, APM implementation status, and facilitators and barriers to APM design and implementation. This chapter draws on InCK Model award recipient documentation and interviews conducted with award recipients and their affiliated SMA. It addresses Research Question 1.

- **CCS Capacity and Policy Context:** Chapter 4 provides background on CCS capacity and policy context relevant to each InCK Model Award Recipient. The chapter includes a discussion of local CCS policy context and service availability, drawing on publicly available data and an environmental scan of peer-reviewed and grey literature. It addresses Research Question 1.
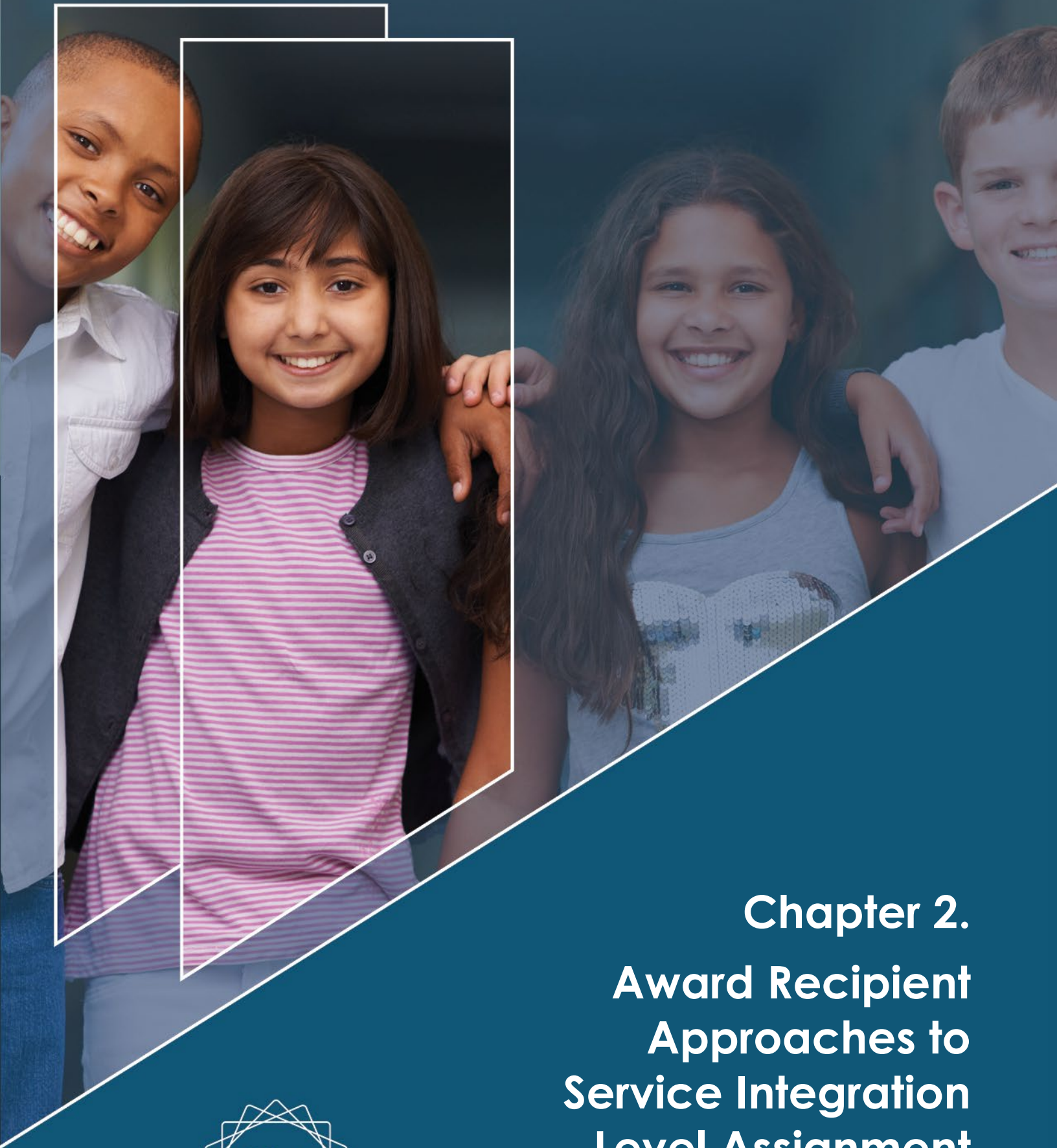
Chapter 2.

Award Recipient Approaches to Service Integration Level Assignment and Early Results

2. Award Recipient Approaches to Service Integration Level Assignment and Early Results

Key Findings

- InCK Model Award Recipients designed unique approaches to needs assessment and Service Integration Level (SIL) stratification within the flexibilities allowed by CMS. Award recipients created approaches that took into account local context, existing practices, and data availability.

- Beginning in January 2022, CMS required award recipients to report progress on needs assessments and SIL stratification quarterly. Implementation status varied substantially across award recipients by the end of the second quarter of 2022.

- Award recipients defined and measured health and health-related social needs differently. This variation aligns with the evaluation framework and requirement to evaluate each InCK Model separately.

- Award recipients' needs assessment approaches influenced the proportion of their attributed beneficiaries assigned to a SIL as of June 30, 2022. Award recipients that relied on administrative data for initial SIL stratification assigned over 90 percent of their attributed population to a SIL. Award recipients that relied on needs assessment screening tool data for SIL assignment assigned very small numbers of beneficiaries to a SIL.

2.1   INTRODUCTION

CMS requires that each InCK Model Award Recipient develop a needs assessment approach that identifies the health and related needs of beneficiaries in their attributed population (Exhibit 2.1). CMS specified that award recipients' needs assessment processes must include all 10 health and health-related CCS domains listed in Exhibit 2.1. Based on the results of beneficiaries' needs assessments, InCK Model Award Recipients stratify beneficiaries into one of three SILs tiered according to the type and severity of need (Exhibit 2.2).

> For more information on factors that award recipients considered in developing their approaches, see the [Evaluation Report 1](#)

This chapter details award recipients' approaches to needs assessment and SIL stratification. We document the implementation status of award recipients' approaches to needs assessment and SIL stratification halfway through the first implementation year (as of June 30, 2022), describe early results of the SIL stratification process, and discuss how award recipients included needs assessment methods in their initial SIL assignments. Award

recipients' approaches to needs assessment and SIL stratification will likely evolve as the implementation period progresses.

Exhibit 2.1. InCK Model Needs Assessments Include a Broad Set of Health and Health-Related Needs.
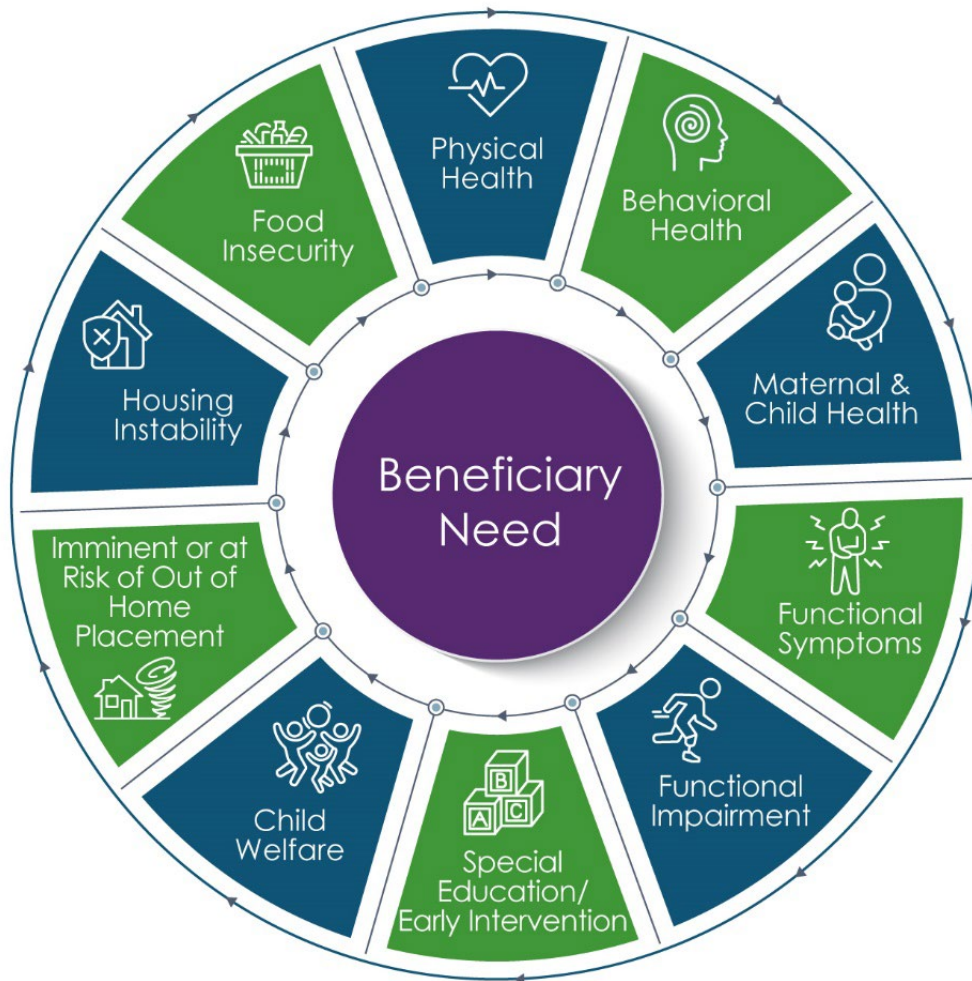
Sources: Centers for Medicare and Medicaid Services. Integrated Care for Kids: Notice of Funding Opportunity. March 14, 2019; and Centers for Medicare and Medicaid Services. Service Integration Level Data Elements and Guidance for Award Recipients. June 11, 2021.

2.1.1 *Award Recipients' Approaches to SIL Stratification*

Exhibit 2.2 outlines the eligibility criteria CMS provided in the InCK Model notice of funding opportunity (NOFO) for SILs 1, 2, and 3. Successful needs assessment and SIL stratification will enable award recipients to identify those in greatest need and assign them to either SIL 2 or SIL 3. Award recipients' care coordinators are then able to streamline targeted care coordination and case management services by identifying a single point of contact to work with these families.

Exhibit 2.2. Award Recipients Have Flexibility Within Guidance CMS Provided About SIL Eligibility.

SIL 3: Currently or at imminent risk of being placed outside the home or prolonged/multiple inpatient admissions.

SIL 2: Exhibit a functional symptom or impairment and needs in at least 2 additional CCS domains.

SIL 1: Medicaid beneficiaries from prenatal stage up to age 21 in the attributed region. May also include CHIP beneficiaries and pregnant Medicaid beneficiaries over the age of 21.
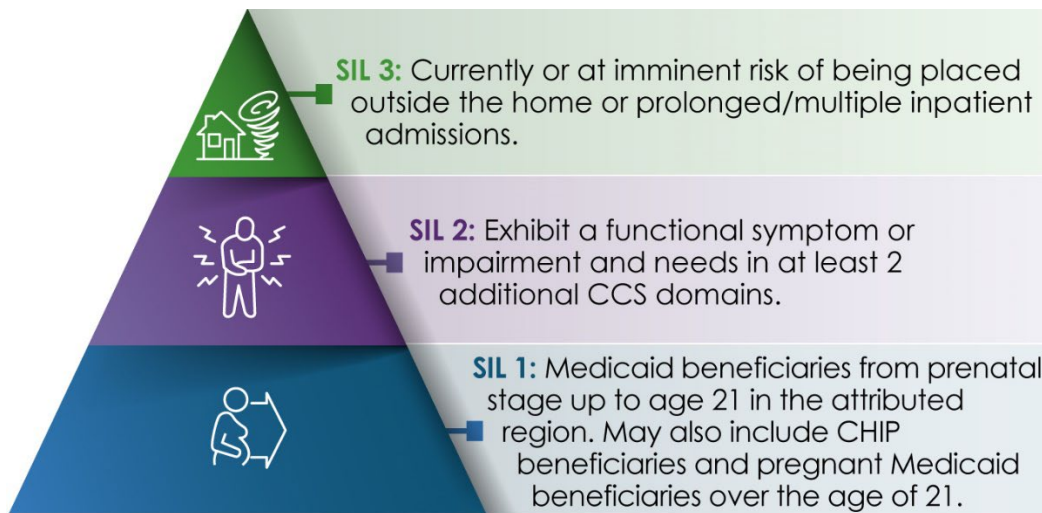
Sources: Centers for Medicare and Medicaid Services. Centers for Medicare and Medicaid Innovation Center in the Notice for Funding Opportunity, February 8, 2019.

Notes: 1. SIL=Service Integration Level. CMS=Centers for Medicare & Medicaid Services. CCS=Core Child Services. CHIP=Children's Health Insurance Program.
2. Generally, beneficiaries must meet the requirements of the SIL and the requirements of lower SILs. Some award recipients have specific SIL 3 criteria.

CMS requires that award recipients assess children for needs and risk factors across multiple CCS domains. By assessing multiple risk factors simultaneously, award recipients are able to assess for need in one domain that may exacerbate or interact with a need in another domain. For example, a family experiencing housing instability has a higher risk of not maintaining engagement in ongoing supportive services that are addressing a developmental delay or special education need.[6] Children are proactively streamlined into primary prevention when their needs are evaluated across broad health and health-related CCS domains, thereby improving both their short and long-term health outcomes.

CMS' guidance in the InCK Model NOFO was intentionally flexible to allow award recipients to design a needs assessment and SIL stratification process built on pre-existing practices and corresponding data availability. CMS specified the CCS that should be included in the needs assessment but allowed award recipients to select the tools appropriate for their attributed population and their planned approaches. In response, award recipients used tools that providers in their local community were already employing to assess needs in at least some CCS domains. For instance, providers in BE-InCK NY were already using the Accountable Health Communities Health Related Social Needs screening tool to assess needs that align with InCK Model CCS domains. At the outset, CMS recommended specific validated screening tools for some domains, such as the Children's HealthWatch Hunger Vital Sign and Children's HealthWatch Housing Stability Vital Sign measures to assess food insecurity and housing instability, respectively.

Building from guidance in the InCK Model NOFO, award recipients employed an iterative process for specifying their planned approach to needs assessment and SIL stratification during the pre-implementation period (2020 – 2021). Exhibit 2.3 documents key dates in this process. During the pre-implementation period, award recipients worked with CMS to refine their approaches to needs assessment and SIL assignment. In April 2021, CMS issued guidance that allowed the use of administrative data for the purposes of needs assessment and SIL stratification. This flexibility reduced the burden of primary needs assessment data collection, but it required award recipients to either select a validated assessment approach or develop a plan to validate their approach during the first year of the implementation period (2022). CMS provided additional flexibilities in September 2021, including a six-month provisional acceptance of all Needs Assessment and Stratification Standard Operating Procedures (SOPs) to allow award recipients to implement, test, and refine their planned approaches to needs assessment and SIL assignment.

> Variation in award recipients' approaches to needs assessment and SIL stratification offers the opportunity to identify promising practices for population-level early identification of need(s) using integrated data and assigning a single point of contact for streamlined linkage to resources for primary and secondary prevention.

Exhibit 2.3. CMS Introduced Model Flexibilities for Award Recipients' Approaches to Needs Assessment and SIL Stratification in the First Three Years of the Model.[a,b]

February 8
CMS issued InCK Model NOFO which included model requirements for needs assessment and SIL stratification

2019

June 10
InCK Model applications due

December 19
InCK Model Award Recipients announced

2020

Pre-Implementation Period

April 30
CMS issued guidance on needs assessment and SIL Assignment requirements including allowing award recipients to use screening tools or administrative data

September 30
CMS allowed award recipients a one year grace period for meeting requirement to conduct a needs assessment on 80% of the attributed population[b] and a six month provisional acceptance of planned approaches

2021

July 1
Award recipients submitted initial planned approach to needs assessment and SIL stratification

Implementation period

July 29
CMS removed the requirement to conduct needs assessments on at least 80% of the attributed population

2022

March 30
Award recipients submitted revised needs assessment and SIL stratification approach

October 17
Award recipients submitted additional revisions to needs assessment and SIL stratification plans

January 1
Award recipients submitted needs assessment and SIL stratification results for 2022

2023

Sources: Centers for Medicare & Medicaid Services (CMS) funding opportunity number CMS-2B2-20-0001. *CMS, Integrated Care for Kids (InCK Model),* https://www.cms.gov/priorities/innovation/innovation-models/integrated-care-for-kids-model *CMS, Integrated Care for Kids (InCK Model); Updated Fact Sheet.*

Notes:

a. NOFO=Notice of Funding Opportunity. 2. SIL=Service Integration Level.
b. This exhibit lists key dates in the development of InCK award recipients' standard operating procedures for needs assessment and SIL stratification.
c. The InCK Model Attributed Population includes all Medicaid-covered individuals aged 0 – 20 in the geographic area.

Award recipients experienced challenges when they began implementing their approaches in 2022. Challenges included difficulty obtaining administrative data, implementing new screening procedures, and both hiring and onboarding staff to administer screening tools. In response, award recipients continued to refine their needs assessment and SIL stratification approaches. In July 2022, CMS granted flexibilities that removed the requirement for award recipients to screen at least 80 percent of their attributed population, which meant award recipients relying on in-person or telephonic screening, notably with low response rates, could move forward without screening the entire attributed population.

By the end of 2022, InCK Model Award Recipients developed tailored SOPs for needs assessment and SIL stratification and began to assess needs to stratify beneficiaries into SILs. CMS flexibilities helped ease the burden on award recipients and enabled them to build their capacity for needs assessment and SIL stratification over time. Findings in this chapter reflect award recipients' documented approaches to needs assessment and SIL stratification as of the end of 2022, but only include beneficiaries' SIL assignments and needs assessment data submitted to CMS in the first two quarters of 2022.

Award Recipients' Approaches to Incorporating Needs into SIL Stratification

As of the end of 2022, award recipients' approaches to SIL stratification varied, with respect to how award recipients identified and confirmed needs in the various CCS domains; how needs informed SIL stratification; and the eligibility criteria used to assign beneficiaries to SIL 1, SIL 2, or SIL 3.

To identify health and related needs of attributed beneficiaries, all seven award recipients use a combination of administrative data (e.g., Medicaid claims) and a screening tool administered to beneficiaries either in person or telephonically. Four award recipients incorporate screening tool data sequentially and three assess it concurrently with administrative data (Exhibit 2.4).

Exhibit 2.4. Four Award Recipients Use a Sequential Approach to SIL Stratification. Three Use a Concurrent Approach.

Sequential

Assessments for all or some domains identified using administrative data

Yes — For those with identified need through administrative data, screen conducted for other domains

No — For those without identified need through administrative data, _no screen_ conducted in other domains

Concurrent

Assessments for select domain using administrative data

Assessments for select domain using screen(s)

Stratification level assigned

As award recipients designed and implemented their approaches to needs assessment and SIL stratification, they **made decisions about when and how to use administrative and screening tool data**. Several factors informed these decisions, including data quality and availability, resources available to implement screening, and the feasibility of successfully screening all of their attributed beneficiaries.

Exhibit 2.5 summarizes each award recipient's approach to SIL stratification based on their SOPs as of the end of 2022. Exhibit 2.5 also reports the implementation status of each award recipient's documented approach as of June 30, 2022. Award recipients' implementation status is determined by Q1 and Q2 2022 needs assessment data submitted to CMS.

Exhibit 2.5. Award Recipients' Documented Approaches to SIL Stratification Varied Significantly, as Did the Status of Their Implementation at the End of Q2, 2022.[a]

Award Recipient	Documented Approach to SIL Stratification	Status as of End of Q2 2022[b]
AHHN	Sequential[1,c]: 1) Initial SIL assignment determined by administrative data 2) Screening tool used to verify SIL assignment	Fully implemented.
BE-InCK NY	Sequential[2]: 1) Initial SIL assignment determined by administrative data 2) Screening tool used to verify SIL assignment	Not fully implemented. Using administrative data only.
CT InCK Embrace New Haven	Concurrent[3]: SIL assignment determined by administrative and screening data	Not implemented.
NJ InCK	Concurrent[4,d]: SIL assignment determined by administrative and screening data	Fully implemented.
NC InCK	Concurrent[5]: SIL assignment determined by administrative and screening data	Not fully implemented. Using administrative data only.
OH InCK	Sequential[6]: 1) Initial SIL assignment determined by administrative data 2) Screening tool used to verify SIL assignment	Fully implemented. Using administrative data and screening, when available.
Village InCK	Sequential[7]: 1) Administrative data used to assess physical and behavioral health needs to prioritize beneficiaries for screening 2) For prioritized beneficiaries, initial SIL assignment determined by screening data 3) SIL assignment verified by administrative data	Not fully implemented. Using screening data only.

Sources:
1. All Hands Health Network. AHHN Administrative Policy and Procedure. Needs Assessment and Service Integration Level Stratification for AHHN. October 17, 2022.
2. Bronx Equity Integrated Care for Kids New York. Service Integration SOP. August 24, 2022.
3. Connecticut InCK Embrace New Haven. Needs Assessment & Stratification SOP. September 29, 2022.
4. New Jersey InCK. Needs Assessment Process and Stratification SOP. October 1, 2022.
5. North Carolina InCK. NC InCK Needs Assessment Standard Operating Procedure. September 29, 2022.
6. Ohio InCK. Ohio InCK Model: Needs Assessment Process & Stratification SOP. September 1, 2022.
7. Village InCK. Village InCK Integrated Needs Assessment Process. September 30, 2022.

Notes:
a. SIL=Service Integration Level. Q=Quarter.
b. The table reflects InCK award recipients' SIL stratification processes as documented in their Needs Assessment and Stratification SOPs, revised through October 2022.

    c.   The status of implementation reflects needs assessment data reported in award recipient's Q1 and Q2 2022 SIL submissions.

    d.   Award recipients with a sequential approach use administrative data to make initial SIL assignments and screen beneficiaries that have initial assignments to either SIL 2 or SIL 3 to confirm needs and/or identify needs in additional CCS domains.

    e.   Award recipients with a concurrent approach use data collected via screening and administrative data to make SIL assignments.

AHHN, BE-InCK NY, OH InCK, and Village InCK use a sequential approach to SIL assignment. Of these award recipients, three (AHHN, BE-InCK NY, and OH InCK) use administrative data to make the initial SIL assignment (stage 1), and then conduct a screening tool assessment either in person or telephonically with beneficiaries whose preliminarily SIL assignment is either SIL 2 or SIL 3 (stage 2). The screening tool covers CCS domains not assessed from administrative data (stage 1) and may include additional questions for a previously assessed domain. AHHN employs a marketing and outreach process that engages beneficiaries to complete a screening tool assessment irrespective of their SIL assignment in stage 1 to increase participation of potentially marginalized communities in the screening process.

The fourth award recipient, Village InCK, uses a three-stage sequential process: 1) administrative data to identify beneficiaries with the greatest physical health needs, 2) a comprehensive screening on beneficiaries identified as high risk, and then 3) additional review of administrative data to confirm and verify identified needs before making SIL assignments.

By the end of Q2 2022, only OH InCK had successfully implemented their planned approach. AHHN had only screened small numbers of beneficiaries and BE-InCK NY had yet to start screening beneficiaries. Both were still primarily relying on administrative data. Village InCK was only reporting data SICs had collected via in-person or telephonic screens and had yet to incorporate administrative data.

The other three award recipients (CT InCK Embrace New Haven, NC InCK, and NJ InCK) concurrently use both administrative data and data collected via screening to determine SIL assignments.

As of the end of 2022, CT InCK Embrace New Haven had yet to fully implement this concurrent approach. They did not report any assessment data for Q1 or Q2 in 2022. In June 2022, CT InCK Embrace New Haven staff began screening beneficiaries and prioritized beneficiaries without Medicaid claims data for initial screenings. As of Q2 2022, NJ InCK had implemented assessments based on administrative and screening data but had not yet incorporated all screening tools listed in their SOP. NC InCK reported assessments using administrative data only as of Q2 2022, though they ultimately plan to use screening tool data to assess food insecurity and housing instability.

The following sections report findings of the needs assessments conducted and SIL assignments made for these two time periods (Q1 and Q2 2022).

Data sources and status of implementation strongly influenced the proportion of attributed beneficiaries assigned to a SIL. Award recipients that relied on administrative data assigned at least 80 percent of their attributed population to a SIL in the first two quarters of 2022, while award recipients relying on screening data achieved assignment for less than 4 percent of their population.

Award recipients that relied on administrative data for initial SIL assignment (AHHN, BE-InCK NY, NC InCK, and OH InCK) assigned greater proportions of attributed beneficiaries to a SIL in Q1 and Q2 2022 than those relying primarily on data collected via in-person or telephonic screen (Exhibit 1.4). In contrast, NJ InCK had fully implemented their approach but had only reported verified SIL assignments for 84 (out of 154,176 total) beneficiaries with both screening data and Medicaid claims data. As more award recipients progress toward full implementation of their documented approaches, the proportion of attributed beneficiaries with an assigned SIL will likely increase for CT InCK Embrace New Haven, NJ InCK, and Village InCK.

Award Recipients' Criteria for SIL 2 and SIL 3

As described above, CMS outlined eligibility criteria for SIL assignment in the [InCK Model NOFO](). Beyond this initial guidance, CMS granted award recipients flexibility to design an approach that aligned with local needs and the aims of their model. As with the iterative process used to refine their needs assessment approach, award recipients revised their eligibility criteria for SIL 2 and SIL 3 in response to available data, the feasibility of the proposed approaches, and their model goals. Thus, by the end of 2022, each award recipient developed unique eligibility criteria for their specific SIL stratification.

> For more information on the iterative process that award recipients used to establish their approaches to needs assessment and SIL stratification, see **Exhibit 2.4**.

Award recipients adhered to the CMS recommendation that SIL 2 eligibility be based on identified need in two or more CCS domains. Some award recipients included additional criteria or further specifications about specific needs (Exhibit 2.6). For example, OH InCK required beneficiaries to have a behavioral health need along with a need in at least one other domain, and AHHN developed two sets or paths to SIL 2 eligibility, one based solely on administrative data and the other on screening data.

The InCK Model NOFO described SIL 3 eligibility as meeting SIL 2 eligibility AND having either imminent risk of out-of-home placement (OOHP) or prolonged or multiple inpatient admissions. However, all award recipients deviated from the original SIL 3 guidance outlined in the NOFO. Five award recipients (AHHN, BE-InCK NY, NC InCK, NJ InCK, and Village InCK) expanded SIL 3 eligibility to include needs in additional CCS domains. NC InCK and NJ InCK each developed a scoring system where SIL 2 and SIL 3 assignment is based on need in multiple CCS domains with SIL 3 assignment being based on the severity of need. NC InCK allowed two paths to assign a beneficiary to SIL 3.

**Exhibit 2.6. Documented SIL 2 and 3 Eligibility Criteria Vary Across Award
Recipients.**

Award Recipient	Documented SIL 2 Eligibility	Documented SIL 3 Eligibility
AHHN[1]	**Path 1:** Claims data indicate a functional symptom or early intervention need **Path 2:** Screening indicates needs across multiple CCS domains	Need in at least one of the following CCS domains: child welfare engagement, OOHP, or prolonged inpatient admissions
BE-InCK NY[2]	Needs in a minimum of three CCS domains, including functional symptoms or functional impairment	SIL 2 eligibility and need in at least one of the following CCS domains: OOHP, child welfare engagement, or prolonged or multiple inpatient admissions
CT InCK Embrace New Haven[3]	Needs in a minimum of three CCS domains, including functional symptoms or functional impairment	SIL 2 eligibility and need in at least one of the following CCS domains: OOHP or inpatient admissions
NJ InCK[4]	Needs in a minimum of one CCS domain	Needs in two or more CCS domains
NC InCK[5]	Needs in three or more CCS domains	**Path 1:** At risk for or experiencing OOHP **Path 2:** Needs in four or more CCS domains
OH InCK[6]	Needs in two or more CCS domains, including a behavioral health need	SIL 2 eligibility and OOHP need
Village InCK[7]	Needs in two or more CCS domains, including functional symptoms or functional impairment	SIL 2 eligibility and need in at least one of the following CCS domains: housing instability, child welfare involvement, OOHP, or inpatient admissions

Sources:
1. All Hands Health Network. AHHN Administrative Policy and Procedure. Needs Assessment and Stratification for AHHN. October 17, 2022.
2. Bronx Equity Integrated Care for Kids New York. Service Integration SOP. August 24, 2022.
3. Connecticut InCK Embrace New Haven. Needs Assessment and Stratification SOP. September 29, 2022.
4. New Jersey InCK. Needs Assessment Process and Stratification SOP. October 1, 2022.
5. North Carolina InCK. NC InCK Needs Assessment and Stratification SOP. September 29, 2022.
6. Ohio InCK. Ohio InCK Model: Needs Assessment Process and Stratification SOP. September 1, 2022.
7. Village InCK. Village InCK Integrated Needs Assessment Process. September 30, 2022.

Notes:

SIL=Service Integration Level. CCS=Core Child services. OOHP=Out of Home Placement

Comparison of Award Recipients' Expected and Actual SIL Assignments

CMS asked InCK Model Award Recipients to provide the expected number of beneficiaries that would be assigned to SIL 2 and SIL 3 in their model applications. As noted in Section 2.1.1, award recipients revised their approaches to needs assessment and SIL stratification

throughout the pre-implementation and early implementation periods. This section compares award recipients' expected SIL assignment to their actual SIL assignments.

Exhibit 2.7 summarizes SIL assignments for Q1 and Q2 2022 for the four award recipients that assigned most of their beneficiaries. AHHN and OH InCK use a sequential approach to needs assessment and SIL stratification, while BE-InCK NY and NC InCK reported SIL assignments based on administrative data only. The number of beneficiaries assigned to a SIL includes those with an initial or confirmed SIL. When award recipients reported SIL assignments as initial, it meant that they had used only administrative data to make SIL assignments.

> Future analyses will examine trends in SIL 2 and SIL 3 assignments. We anticipate that SIL assignments may change as award recipients fully implement their documented approaches and conduct additional screenings.

Exhibit 2.7. The Distribution of Service Integration Level (SIL) Assignment Based on Needs Assessment Findings Was Consistent with Award Recipients' Expectations.[a]
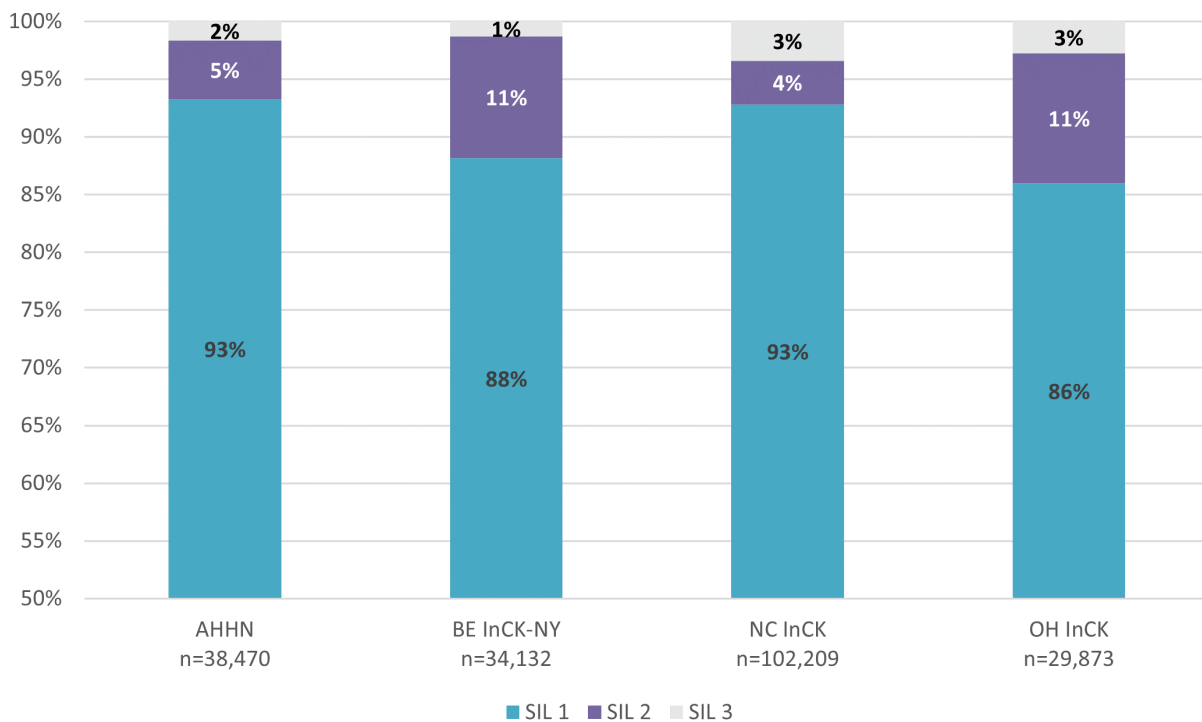
Source: InCK Model Award Recipients' Q1 and Q2 2022 SIL data submissions

Notes:
   a. We reported the total number of beneficiaries assigned to a SIL during Q1 and Q2 2022 for InCK Model Award Recipients below the bars. Among the total number of beneficiaries assigned to a SIL, the exhibit reports the percentage assigned to SIL 1 (blue), SIL 2 (purple), and SIL 3 (grey). We excluded beneficiaries with assessment

data that were not assigned to a SIL. If a beneficiary was assigned to different SILs in the Q1 and Q2 data submissions, we used the highest SIL assigned.

Expected SIL Assignments: In their InCK Model applications, all award recipients expected over 80 percent of their attributed population would be assigned to SIL 1.[c] With the exception of OH InCK, award recipients expected that less than 5 percent of the attributed population would be assigned to SIL 3.

Actual SIL Assignments: For award recipients with SIL assignments for most of their attributed population (AHHN, BE-InCK NY, NC InCK, and OH InCK), the reported SIL assignments were largely consistent with estimates in their applications.[d] OH InCK expected approximately 3 percent and 7 percent of attributed individuals would be in SIL 2 and SIL 3, respectively. As of June 30, 2022, 11 percent and 3 percent are assigned to SIL 2 and SIL 3, respectively. However, the data submitted by OH InCK only included verified SIL assignments for a subset of their attributed population.

2.1.2 Award Recipients' Approaches to Needs Assessment

Award recipients must assess beneficiary health and related needs in the 10 CCS domains that CMS specified, including physical and behavioral health needs and health-related social needs (early childhood care, education, housing, food, Title V services, and child welfare) (Exhibit 2.1). Award recipients must also assess beneficiaries for functional symptoms, functional impairments, and risk of OOHP.

As described earlier, by the end of 2022, award recipients had developed individualized approaches for needs assessment in each domain using administrative data, screening data, or both. A detailed discussion of award recipients' approaches to assess need in each domain follows.

---

[c] The Evaluation Report 1 includes a description of each award recipient's estimates of how many beneficiaries would be attributed to each SIL as reported in their initial applications. This information is available at: https://innovation.cms.gov/data-and-reports/2022/inck-model-pre-imp-first-eval-rpt

[d] For AHHN, CT InCK Embrace New Haven, NC InCK, and NJ InCK, the number of beneficiaries included in an award recipients' attributed population was calculated using the Retrospective Attribution File (RAF) for calendar year 2022 that was submitted by the award recipients in January 2023. We excluded beneficiaries that opted out of data sharing. For BE-InCK NY, OH InCK, and Village InCK, the number of beneficiaries in each award recipients' attributed population reflects the number of Medicaid enrolled individuals under age 21 (and, for BE-InCK NY, persons 21 years or older if they are pregnant or postpartum), who reside in the attributed regions according to the 2022 Interim T-MSIS Analytic Files (RAFs for BE-InCK NY, OH InCK, and Village InCK were not final by the time this report was written). See Section 5.2 for additional details.

Use of Administrative Data for Needs Assessment Domains

Award recipients developed unique approaches for assessing health and related needs with administrative data.[e] Exhibit 2.8 presents the methods award recipients used for needs assessments using administrative data as of the end of Q2 2022. CT InCK Embrace New Haven and Village InCK had yet to fully implement their approach to incorporating administrative data in their needs assessment process as of the end of Q2 2022. Village InCK had partially implemented their process, while CT InCK Embrace New Haven had yet to implement any needs assessment or SIL stratification. Expanded detail on each award recipient's approach for needs assessment using administrative data is included in Appendix H.

Leveraging Administrative Data for Needs Assessment

Award recipients relied on Medicaid claims and eligibility data to identify beneficiary needs. However, significant variation existed in how award recipients used that data for needs assessment.

Award recipients also used data from a) electronic medical records; b) health information exchanges; c) publicly available geospatial data; and d) state agency data, including education, juvenile justice, and child welfare. However, not all award recipients were able to establish data sharing agreements with state agencies.

With a few exceptions noted below, administrative data enabled award recipients to estimate needs by reviewing historical utilization related to a specific CCS domain. Award recipients using administrative data identified needs for all, or close to all, attributed beneficiaries (as of Q2 2022 – see Appendix G). However, the degree to which administrative data were measuring the same construct of need defined in a screening tool is not clear.[7] To address this gap in knowledge, award recipients will validate their needs assessment and stratification process to test for concordance of assignment among beneficiaries assigned to SIL 1 using administrative data versus screening tools. This will be done in year 2 of the implementation period (2023).

All award recipients have access to Medicaid data through their partnership with SMAs. State Medicaid data contains information for all award recipients' attributed populations and serves as the primary administrative data source for needs assessment for needs assessment many CCS domains. Award recipients use diagnosis, procedure, and service codes found in claims and encounter data to assess needs across CCS domains. All award recipients, except BE-InCK NY, developed or used validated risk adjustment algorithms to identify beneficiaries with medical complexity. These award recipients selected the 3M

---

[e] While we report their process for assessing need in each domain, CT InCK Embrace New Haven did not submit need assessment and SIL stratification data for Q1 2022 and Q2 2022.

Clinical Risk Group (CRG) algorithm[f,8] or the Pediatric Medical Complexity Algorithm (PMCA)[g,9] to assess need for at least one of the physical health, behavioral health, or functional symptom domains. CT InCK Embrace New Haven intends to assess physical and behavioral health needs and functional symptoms through a tool specifically designed for pregnant and postpartum individuals, the CareAnalyzer® assessment.[h,10]

Award recipients also use Medicaid enrollment and eligibility files to determine need in other CCS domains. For example, AHHN, BE-InCK NY, NC InCK, and OH InCK identify child welfare involvement through Medicaid enrollment files using eligibility codes or enrollment in special case management programs.

In addition to using Medicaid data, BE-InCK NY also has access to clinical encounter data, including data from school health clinics through their Lead Organization's electronic health record and their partnership with local health information exchanges.

Award recipients developed data sharing agreements with other state agencies to obtain their respective administrative data for InCK Model needs assessment purposes. CT InCK Embrace New Haven, OH InCK, and Village InCK successfully established data sharing agreements with state child welfare agencies for the purposes of identifying child welfare involvement and OOHP. NC InCK obtained administrative child welfare and juvenile justice data for the purposes of CCS domain assessment only. Through their data use agreements (DUAs), CCS agencies can share data with a third-party vendor that conducts SIL stratification. The DUAs limit sharing to NC InCK and prohibit sharing data with CMS. NC InCK is working to amend the DUA to meet model participation requirements outlined in the NOFO, which indicates that award recipients are to provide data on CCS utilization for the purposes of model evaluation.

---

[f] The CRG algorithm uses administrative data to stratify children in nine health status groups: healthy, significant acute, and seven chronic condition categories which are then further classified by severity. The CRG system is used to classify children aged 0 – 18 into nine hierarchical categories and has been tested in adults and children enrolled in Medicare, Medicaid, and private insurance.

[g] Washington Medicaid developed the PCMA to identify individuals with complex health conditions, specifically children, and identify those who would benefit most from care coordination and other services. The PMCA uses diagnosis codes mapped to specific body systems to identify individuals with complex health conditions. It has been validated in a variety of similar settings on populations similar to those served by the InCK Model.

[h] CareAnalyzer® provides a risk score for pregnant and postpartum beneficiaries. Using the Johns Hopkins ACG® (Adjusted Clinical Group) Logic, CareAnalyzer® is an analytic approach to predictive modeling that uses ICD-10 codes from a one-year period of claims data and groups claims into five clinical categories: duration of the condition, severity of the condition, diagnostic certainty, etiology, and expected need for specialty care. CareAnalyzer uses diagnostic codes to identify pregnant individuals and then identify those pregnant and postpartum individuals with higher levels of morbidity.

Other Data Sources

NC InCK and OH InCK supplement needs assessment data with publicly available geospatial data. To identify food insecurity and housing instability, NC InCK intends to use screening data that beneficiaries' health plans already collect. Data on these screens are expected to be available in 2023. Until then, NC InCK is using the social deprivation index as a proxy indicator of food insecurity and housing instability. They will continue to use the social deprivation index in the future for those beneficiaries who do not complete the screening tool. OH InCK uses the Ohio Opportunity Index[i] to assess food insecurity and maternal and child health needs. In addition, OH InCK intends to use publicly available geospatial data[j] on food access to identify food insecurity.

Award recipients used administrative data to quickly assess needs for a high number of beneficiaries, regardless of whether the award recipient implemented a sequential or concurrent needs assessment approach. In some cases, award recipients used more than one source of data, supplementing claims data with beneficiary-level data from other state agencies or publicly available geospatial data.

While administrative data afforded award recipients the opportunity to conduct needs assessments for most attributed beneficiaries, there were challenges associated with using this data for needs assessment and SIL stratification. We have summarized their experiences in the callout box below. Most award recipients use administrative data in six of the ten CCS domains. However, only a few award recipients use administrative data in the domains of maternal and child health, housing instability, food insecurity, or functional impairments; most award recipients rely primarily on screening data to assess need in those domains. We discuss the use of screening data in needs assessment in the following section.

See Appendix I for the number of beneficiaries with at least one need assessment in each domain at the end of Q2 2022.

---

[i] The Ohio Opportunity Index synthesizes over 34 variables measuring neighborhood conditions known to be associated with health and well-being across domains such as healthcare access, children's health, criminal justice, education, environment, family stability, housing, and infant health into a single index score. More information is available at: https://grc.osu.edu/Projects/OhioOpportunityIndex.

[j] The United States Department of Agriculture Economic Research Service develops food access indicators at the census-tract-level. More information is available at: https://www.ers.usda.gov/data/fooddesert.

Exhibit 2.8. InCK Award Recipients Used Different Methods to Incorporate Administrative Data in Needs Assessment for Health and Related Domains.

Award Recipient	CCS Domain							
	Medicaid: Diagnosis, Procedure, and Service Codes	Medicaid: CRG Algorithm	Medicaid: PMCA Algorithm	Medicaid: CareAnalyzer®	Medicaid: Enrollment and Eligibility Codes	State Administrative Data	Publicly Available Data	CCS Domains not Captured by Administrative Data
AHHN[1]	Behavioral health Physical health Functional symptoms Education	Functional symptoms Physical health			Child welfare Out of home placement			Food insecurity Functional impairment Housing instability Maternal and child health
BE-InCK NY[2]	Behavioral health Physical health Child welfare Functional impairment Functional symptoms Food insecurity Housing instability Maternal and child health Out of home placement Education				Child welfare Out of home placement			
CT InCK Embrace New Haven[3]			Behavioral health Physical health Functional symptoms	Behavioral health Physical health Functional symptoms		Child welfare Out of home placement		

Award Recipient	CCS Domain							
	Medicaid: Diagnosis, Procedure, and Service Codes	Medicaid: CRG Algorithm	Medicaid: PMCA Algorithm	Medicaid: CareAnalyzer®	Medicaid: Enrollment and Eligibility Codes	State Administrative Data	Publicly Available Data	CCS Domains not Captured by Administrative Data
NC InCK[4]	Behavioral health Physical health Functional impairment Functional symptoms Maternal and child health Out of home placement		Physical health		Behavioral health Child welfare Maternal and child health Out of home placement Education	Functional impairment Out of home placement		Food insecurity Housing instability
NJ InCK[5]			Behavioral health Physical health Education					Child welfare Food insecurity Functional impairments Functional symptoms Housing instability Maternal and child health Out of home placement
OH InCK[6]	Behavioral health Functional symptoms Maternal and child health Out of home placement Education	Physical health	Physical health		Housing instability Out of home placement	Child welfare Out of home placement	Food insecurity Maternal and child health	Functional impairments

Award Recipient	CCS Domain							
	Medicaid: Diagnosis, Procedure, and Service Codes	**Medicaid: CRG Algorithm**	**Medicaid: PMCA Algorithm**	**Medicaid: CareAnalyzer®**	**Medicaid: Enrollment and Eligibility Codes**	**State Administrative Data**	**Publicly Available Data**	**CCS Domains not Captured by Administrative Data**
Village InCK[7]								Behavioral health Child welfare Food insecurity Functional impairment Housing instability Maternal and child health Out of home placement Education

Sources:

1. All Hands Health Network. AHHN Administrative Policy and Procedure. Needs Assessment and Service Integration Level Stratification for AHHN. October 17, 2022.
2. Bronx Equity Integrated Care for Kids New York. Service Integration SOP. August 24, 2022.
3. CT InCK Embrace New Haven. Needs Assessment & Stratification SOP. September 29, 2022.
4. North Carolina InCK. NC InCK Needs Assessment Standard Operating Procedure. September 29, 2022.
5. New Jersey InCK. Needs Assessment Process and Stratification SOP. October 1, 2022.
6. Ohio InCK. Ohio InCK Model: Needs Assessment Process & Stratification SOP. September 1, 2022.
7. Village InCK. Village InCK Integrated Needs Assessment Process. September 30, 2022.

Notes:

CRG= Clinical Risk Group. PMCA=Patient Medical Complexity Algorithm. CCS=Core Child Services.

**Using Administrative Data for Needs Assessment
Provides Opportunities and Poses Challenges**

Opportunities:

✓ **Lower burden and reduced stigma for beneficiaries and caregivers.** Repeated screenings for medical and social needs in a variety of settings is a potential source of stigma and can be a barrier for children and families accessing the services they need. Using administrative data to assess needs potentially reduces burden and stigma by avoiding asking families to "re-tell" their story. Some award recipients cited this concern as part of their rationale for relying heavily on data rather than individually administered screening tools.

✓ **Lower burden for providers.** Administrative data may also reduce the burden on providers, as incorporating additional screening requirements adds to provider burden and takes up time during already short appointments. As demonstrated in Appendix G, award recipients initially screened 95 to 100 percent of beneficiaries in their attributed population using administrative data, as opposed to much smaller percentages among those relying on screening data alone.

✓ **Outreach targeted to those most likely to have greatest needs.** Administrative data allow award recipients to make initial SIL assignments for most of their attributed beneficiaries, allowing award recipients to target outreach to beneficiaries meeting SIL 2 or SIL 3 criteria in the administrative data.

Challenges:

✓ **Failure to fully capture actual need.** Administrative data measure utilization or enrollment, and capture service engagement that may or may not reflect a still-unmet need. Administrative data are usually not sufficient to identify needs among beneficiaries and families who are not engaged in services or have yet to receive a diagnosis or other assessment, thus hampering prevention efforts. CMS' original guidance was that the need for a service cannot be identified through the receipt of a service, as that service may already be meeting the need. Later in the pre-implementation period, CMS introduced model flexibilities to allow for data-driven approaches.

✓ **Coordination of data sharing across state agencies.** The InCK Model aspired to include beneficiary-level data from state agencies in domains such as education, child welfare, housing, and food assistance. These data would allow award recipients to identify those in their attributed population currently receiving social services and determine who was not receiving services for which they might be eligible. However, as described in Evaluation Report 1, award recipients faced barriers in their attempts to access these data, such as the inability to develop data use agreements with other agencies or obtain individual-level rather than aggregated data.

Use of Screening Data for Needs Assessment Domains

Award recipients also use in-person or telephonic screenings to identify needs in CCS domains. The extent to which they rely on these screenings and how they use them varies by award recipient. CMS granted award recipients the flexibility to identify need assessment tools appropriate for their local context, beneficiary needs, and existing screening practices. For example, as part of a state-wide transition to managed care, all providers in NC will be required to screen Medicaid beneficiaries for food insecurity and housing instability. NC InCK plans to use those data as part of their needs assessment process. Award recipients used a variety of screening tools for needs assessment. Some used pre-existing validated tools to assess needs in various CCS domains. Others adapted validated tools to create tailored screening tools, though these adapted tools have not been externally validated.

Screening Tools Leveraged by Award Recipients

The Center for Medicare and Medicaid Innovation developed the Accountable Health Communities **Health-Related Social Needs Screening Tool** (HRSN) for the Accountable Health Communities (AHC) Model. The 10-item screening tool covers five domains, including housing instability, food insecurity, transportation problems, utility help, and interpersonal violence. It also includes eight supplemental domains: financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities.[1]

The **Adverse Childhood Experience-Questionnaire** (ACE-Q) is a 10-item scale that assesses maltreatment and adverse events experienced during childhood, which research has consistently shown to be associated with poor health outcomes later in life.[2]

The **National Survey of Children's Health** examines the physical and emotional health of children aged 0 – 17. It includes measures related to the well-being of children including access to and the quality of healthcare, family interactions, parental health, neighborhood characteristics, and school and afterschool experiences.[3]

The **Pediatric ACEs and Related Life-events Screener** (PEARLS) screens children and adolescents 0 – 19 for ACEs.[4]

The **Pediatric Symptom Checklist** (PSC) is a 35-item screening questionnaire used to identify psychosocial problems in children.[5]

The **Survey of Well-being of Young Children** (SWYC) is a comprehensive screening instrument for children under five and includes domains related to developmental milestones, emotional/behavioral health, and family environment.[6]

Sources:

1. Centers for Medicare & Medicaid Services. (n.d.). *The Accountable Health Communities Health-Related Social Needs Screening Tool*. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
2. Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, 6(1), 1581447. https://doi.org/10.1080/2331205X.2019.1581447

3. Health Resources and Services Administration. (2023, March 31). *National Survey of Children's Health (NSCH)*. U.S. Census Bureau. https://www.census.gov/programs-surveys/nsch.html

4. Center for Youth Wellness, and UCSF Benioff Children's Hospital. (n.d.). *Pediatric ACEs and Related Life Events Screener (PEARLS)*. ACEs Aware. https://www.acesaware.org/pdf_wrapper/pearls-tool-child-parent-caregiver-report-de-identified-english/

5. Jellinek, M., & Murphy, M. (2023). *Pediatric Symptom Checklist (PSC)*. Massachusetts General Hospital Child Psychiatry Service. https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist

6. Tufts Medical Center. (c. 2010a). *The Survey of Well-being of Young Children*. https://pediatrics.tuftsmedicalcenter.org/The-Survey-of-Wellbeing-of-Young-Children/Overview.aspx

As with administrative data, award recipients faced challenges using screening tools for needs assessment because screenings require beneficiary engagement. For all award recipients, the number of screenings conducted at the end of Q2 2022 was significantly lower than the number of assessments using administrative data (Appendix G). In particular, the challenges associated with determining functional impairments via a screening tool are apparent given the low number of assessments conducted for this domain during Q1 and Q2 2022 for all award recipients, except BE-InCK NY. Award recipients will likely increase the proportion of beneficiaries engaged in the model and screened as they engage in quality improvement efforts, apply lessons learned, and fully implement their documented approaches.

**Conducting Screening to Identify Needs
Provides Opportunities and Poses Challenges**

Opportunities:

✓ **Capture current and emerging needs.** Screening captures needs in CCS domains for which a family has not yet been able to access services. Administrative data may be limited or unable to accurately reflect emergent needs in domains such as food insecurity, housing instability, and special education.[1]

✓ **Capture information about sensitive needs.** Screening captures information about behaviors that pose high risks to immediate and long-term health, such as substance misuse or adverse childhood events. Such high-risk behaviors are expected to be captured in award recipients' behavioral health, functional symptoms, and functional impairment assessments. However, needs in these CCS domains may not be observable in administrative data if beneficiaries are reluctant to share these needs with providers or seek services.[1]

Challenges:

✓ **Significant investment in labor and infrastructure needed.** Using screening tools to assess needs requires significant staff time, clinical expertise, and technological infrastructure to track individual-level contact attempts, survey item responses, and completed screenings.[2]

✓ **Limited engagement of beneficiaries.** Successfully conducting screenings at the population level requires innovative beneficiary engagement strategies, particularly for beneficiaries less connected to health and/or social services. Screening results may underestimate the distribution and magnitude of need within the attributed population because individuals with the greatest need are less likely to participate in screening.[3]

✓ **Inconsistent measurement.** Award recipients have adapted questions from multiple validated measures to create their own, tailored screening tools. To reduce beneficiary burden, some award recipients modified existing measures or used a subset of the questions within the validated tool. Modifications implemented by the award recipients may not appropriately or adequately measure the original intended need(s).[3]

Sources:

1. Eder, M., Henninger, M., Durbin, S., Iacocca, M. O., Martin, A., Gottlieb, L. M., & Lin, J. S. (2021). Screening and interventions for social risk factors: technical brief to support the US Preventive Services Task Force. *JAMA, 326*(14), 1416-1428.
2. Greenwood-Ericksen, M., DeJonckheere, M., Syed, F., Choudhury, N., Cohen, A. J., & Tipirneni, R. (2021). Implementation of health-related social needs screening at Michigan health centers: a qualitative study. *The Annals of Family Medicine, 19*(4), 310-317.
3. Eder, M., Henninger, M., Durbin, S., Iacocca, M. O., Martin, A., Gottlieb, L. M., & Lin, J. S. (2021). Screening and interventions for social risk factors: technical brief to support the US Preventive Services Task Force. *JAMA, 326*(14), 1416-1428.

Exhibit 2.9 lists the instruments award recipients used to assess need in each domain as of the end of Q2 2022. We discuss these approaches in detail in [Appendix I.](#) CT InCK Embrace New Haven had not yet started conducting needs assessments at that time. BE-InCK NY and NC InCK were relying on administrative data only and had yet to implement screening tools as they planned. All three of these award recipients plan to use a combination of administrative and screening data for SIL stratification. Multiple award recipients used the same tool for some CCS domains. For example, to assess housing instability and food insecurity,

Tools Leveraged for Functional Impairment Need Identification

- ACE-Q (Village InCK)
- HRSN (BE-InCK NY, Village InCK)
- NSCH Health (AHHN)
- Ohio Mental Health Consumer Outcomes System's functioning scale (CT InCK Embrace New Haven)
- PEARLS (Village InCK)
- Pediatric Symptom Checklist-17 (PSC-17) (NJ InCK)
- Pediatric Quality of Life Inventory™ (OH InCK)
- 12-item short form survey (OH InCK)
- SWYC (OH InCK)
- State tools (OH InCK)

five out of seven award recipients used the Children's HealthWatch VitalSign tools. Similarly, to assess the need for special education and early intervention, three award recipients used the SWYC. In contrast, award recipients elected to use a broad set of screening instruments to assess functional impairments (highlighted in the text box).

Exhibit 2.9. InCK Award Recipients Used a Variety of Validated Instruments to Determine Health and Related Needs.

Award Recipient	CCS Domains								CCS Domains Not Captured by Screening Tools
	AHC HRSN Tool	ACE-Q	Children's HealthWatch	National Survey of Children's Health	PEARLS	Pediatric Symptoms Checklist	SWYC	Other Tools	
AHHN[1]			Food insecurity Housing instability	Behavioral health Functional impairment Functional symptoms Maternal and child health Physical health				Behavioral health Functional symptoms Education	Child welfare Out of home placement
BE-InCK NY[2]									Functional symptoms Out of home placement Education
CT InCK Embrace New Haven[3,a]			Food insecurity Housing instability				Maternal and child health	Maternal and child health Functional symptoms Functional impairments	Physical health Behavioral health Child welfare Out of home placement Education

Award Recipient	CCS Domains								
	AHC HRSN Tool	**ACE-Q**	**Children's HealthWatch**	**National Survey of Children's Health**	**PEARLS**	**Pediatric Symptoms Checklist**	**SWYC**	**Other Tools**	**CCS Domains Not Captured by Screening Tools**
NC InCK[4]									Behavioral health Child welfare Functional impairment Functional symptoms Maternal and child health
NJ InCK[5]			Food insecurity Housing instability		Out of home placement	Behavioral health Child welfare Functional impairment Functional symptoms Maternal and child health	Behavioral health Child welfare Maternal and child health Education	Behavioral health	Physical health
OH InCK[6]	Food insecurity Housing instability						Functional impairment Education	Functional impairment Maternal and child health	Behavioral health Physical health Child welfare Functional symptoms Out of home placement

Award Recipient	CCS Domains								
	AHC HRSN Tool	ACE-Q	Children's HealthWatch	National Survey of Children's Health	PEARLS	Pediatric Symptoms Checklist	SWYC	Other Tools	CCS Domains Not Captured by Screening Tools
Village InCK[7,b]	Behavioral health Functional impairment Functional symptoms Maternal and child health Physical health	Behavioral health Functional impairment Functional symptoms Maternal and child health Out of home placement Physical health	Food insecurity Housing instability Out of home placement		Maternal and child heath Out of home placement Physical health Education			Behavioral heath Child welfare Functional impairment Functional symptoms	

Sources:
1. All Hands Health Network. AHHN Administrative Policy and Procedure. Needs Assessment and Service Integration Level Stratification for AHHN. October 17, 2022.
2. Bronx Equity Integrated Care for Kids New York. Service Integration SOP. August 24, 2022.
3. CT InCK Embrace New Haven. Needs Assessment & Stratification SOP. September 29, 2022.
4. North Carolina InCK. NC InCK Needs Assessment Standard Operating Procedure. September 29, 2022.
5. New Jersey InCK. Needs Assessment Process and Stratification SOP. October 1, 2022.
6. Ohio InCK. Ohio InCK Model: Needs Assessment Process & Stratification SOP. September 1, 2022.
7. Village InCK. Village InCK Integrated Needs Assessment Process. September 30, 2022.

Notes:
a. CT InCK Embrace New Haven had yet to implement their planned approach to needs assessment and SIL stratification as of June 30, 2022. When fully implemented, they plan to use validated instruments to assess needs but did not specify which tools they would use to assess which domains. The tools include: the ACES-Q, ASQ, the Social, Emotional, Child and Adolescent Needs and Strengths, Healthy Opportunities Screening Tool, the PHQ-Adolescent, PEARLs, the Pediatric Quality of Life Inventory, the Short-form health survey and the SWYC.
b. Village InCK created their own screening tool, the Village InCK screening (VIS). The VIS is derived from the Accountable Health Communities HRSN tool.

c. AHC=Accountable Health Communities. HRSN=Health Related Social Needs. ACE-Q= Adverse Childhood Experiences -Questionnaire. PEARLS=Pediatric ACES and Related Life Events Screener. SWYC=Survey of Wellbeing of Young Children. CCS=Core Child Services.

2.1.3 Conclusion

Award recipients' needs assessment and SIL stratification approaches evolved over time. Data in this report reflect award recipients' processes as implemented through the end of Q2 2022. Award recipients will likely continue to evolve their approaches to needs assessment and SIL stratification over the course of the implementation period.

All award recipients ultimately plan to use a combination of administrative data and data collected directly from beneficiaries via screening for needs assessment and SIL stratification. As of the end of Q2 2022, some award recipients relied entirely on administrative data, others relied entirely on data collected via screening, and some were using both. Despite differences in methods, all award recipients (except CT InCK Embrace New Haven) were able to screen at least a small proportion of their attributed beneficiaries. The award recipients' progress toward implementing their approaches is reflected in the number of beneficiaries with SIL assignments, the SILs to which they have been assigned, and the CCS domains in which their needs have been identified. Award recipients using primarily administrative data had assigned at least a preliminary SIL for a high proportion of their attributed beneficiaries (ranging from 83% - 93%), whereas award recipients focusing on screening data had assigned a very small proportion of attributed beneficiaries to a SIL (ranging from 0.1% - 3%). As award recipients validate their data-driven approaches, the evaluation team will assess the reliability of SIL assignments derived solely from administrative data. The evaluation team anticipates that the number of beneficiaries assigned to each SIL and the CCS domains informing that assignment will change over time as award recipients move toward full implementation of their planned approaches and refine their approaches based on lessons learned. Future reports will include analyses summarizing how SIL assignments evolve over the course of model implementation.

Despite award recipients' assessing need for the same CCS domains, each employed unique approaches with different data sources for determining unmet need. As a result, the specific needs identified within a given domain vary across award recipients. For example, OH InCK uses Medicaid enrollment files to identify enrollees who experienced two or more address changes in the past 12 months to assess housing instability, while Village InCK uses its own screening tool, which incorporates components of the Children's HealthWatch housing vital sign measure. Award recipients similarly developed unique SIL 3 eligibility criteria. Given this variability, it is not possible to compare rates of need across award recipients. Further, InCK award recipients' referrals to care coordination and case management programs will be unique, reflecting the specific needs identified by their respective approaches. Future reports will examine award recipients' approaches to provide care coordination and referrals for beneficiaries in SILs 2 and 3, as well as SIL 1 beneficiaries with unmet needs.

Chapter 3.
Alternative Payment Models Design and Implementation

Key Findings

- Most InCK Model Alternative Payment Models (APMs) include per-member per-month payments (PMPM) in which eligible providers receive a small incentive payment for each InCK beneficiary.

- Most InCK Model Award Recipients are leveraging existing provider organizations and incorporating the APM into existing managed care entity (MCE) contracts.

- Each InCK Model Award Recipient is using a unique set of quality measures in their APM design to incentivize providers to increase use of preventive care, improve care coordination, decrease unnecessary utilization, and screen beneficiaries for health-related social needs. Some award recipients are also providing incentives to stabilize the total cost of care.

- Most InCK Model APMs allow providers to earn partial incentives and offer higher PMPM amounts for beneficiaries assigned to SIL 2 or SIL 3.

- Five award recipients plan to implement their APMs with the SMA using federal authorities (i.e., state-directed payments or state plan amendments). Two award recipients are implementing their APMs solely through negotiations between MCEs and providers.

- Award recipients are on different timelines to collect data and begin allocating payment.

- Award recipients have leveraged relationships with key stakeholders, through the Partnership Councils and workgroups, to design and implement their APMs.

- Award recipients have encountered challenges engaging with MCEs due to insufficient interest in pediatric APMs or competing priorities.

3.1   INTRODUCTION AND INCK MODEL APM REQUIREMENTS

An APM is an approach that provides added incentive payments for providing high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.[5] APMs reimburse providers through a variety of mechanisms, such as care management payments, episode-based payments, shared savings payments, or population-based payments. Each incentivizes providers to provide higher-value, patient-centered care to yield improved outcomes.

Per-member per-month payments: Providers receive a per-beneficiary per-month payment for activities such as care management, coordination, or other non-clinical functions, generally layered on top of another form of payment, which has typically been fee-for-service. The goal of this type of payment structure is to provide resources for care coordination and management.

Episode-based payments: Providers or health care facilities receive a single payment for services used to treat a specific medical event or condition and incorporate measures to monitor the quality of care received. If the actual costs are less than the payment, the provider retains the savings. If the actual costs are more than that amount, providers incur losses.

Shared savings payments: Providers that deliver care that meets pre-specified quality benchmarks and reduce spending compared to a financial target share in a portion of the savings they generate. Some shared savings models include downside risk. In downside risk models, providers receive a larger portion of the shared savings in exchange for repaying a portion of spending that exceeds a financial target.

Population-based payments: Providers receive a predetermined payment for delivering high-quality care to a defined group of patients. Capitation models are specific types of population-based payments that include downside risk. In these models, the provider receives a certain payment amount per patient, typically to cover an entire year, and either retains the savings for patients whose care costs less than that amount or incurs the losses for patients whose care costs more than that amount.

Source: Department of Health and Human Services' Office of Health Policy of the Assistant Secretary for Planning and Evaluation (ASPE) (2021). *Common Alternative Payment Model (APM) Approaches.* https://aspe.hhs.gov/sites/default/files/private/aspe-files/207901/common-apms-reference-guide-2021.pdf

The Centers for Medicare & Medicaid Services (CMS) require each InCK Model Award Recipient to implement one or more APMs to sustain their InCK interventions after model funding ceases at the end of 2026. The notice of funding opportunity (NOFO) soliciting model applications stated that InCK Model APMs must support care coordination, case management, and mobile crisis response and stabilization[k] while promoting accountability for improved outcomes, such as decreased rates of avoidable out-of-home placement (OOHP). Private payers and Medicare have made significant investment in APMs for the adult population, but limited evidence exists for APMs for pediatric populations, either among private payers or in Medicaid.[11] CMS recognized that innovations in pediatric-focused APMs are still in early stages and thus did not require InCK Model APMs to have downside risk—meaning providers were not required to incur any financial losses. CMS originally required award recipients to launch their APMs by the beginning of Model Year 4 (January 1,

---

[k] In 2021, CMS removed the requirement that the APM include mobile crisis response services. This was in due in part to the fact that most award recipients were engaging existing mobile crisis response providers which had existing funding sources rather than supporting novel services with their InCK APM.

2023). At the end of 2022, award recipients had reached varying levels of APM implementation readiness. Only one, NJ InCK, had fully launched its APM by that date.

Award recipients designed unique APMs based on their local contexts; state and institutional policy priorities; and relationships with SMAs, MCEs, and provider organizations. This chapter describes the APMs that each award recipient designed, implementation status, and facilitators and barriers to APM design and implementation as of the end of 2022. Award recipients continued to work on APM design and implementation in 2023. Findings in this chapter draw on draft or approved Medicaid authority submissions (state plan amendments, waivers, or pre-prints); award recipients' Model Year 3 progress reports and Model Year 4 operational plans; and interviews with Lead Organizations and SMA officials (conducted in fall 2022).

3.2 APM DESIGN

3.2.1 APM Design Process

SMAs oversee Medicaid benefits and reimbursement. As such, SMAs are critical partners for Lead Organizations in both APM development and implementation. SMAs must receive approval from the CMS Center for Medicaid and CHIP Services (CMCS) to ensure any payment model or benefit changes comply with federal Medicaid program requirements.

Most InCK Model states rely on MCEs to contract with and reimburse providers for Medicaid-covered services, which creates an additional step in the design and implementation of Medicaid APMs. Exhibit 3.1 describes the generic process to implement APMs in Medicaid managed care.

Exhibit 3.1. **Implementing Alternative Payment Models (APMs) within Medicaid Managed Care Often Requires Negotiation with Managed Care Entities (MCEs).**

> SMAs renegotiate their contracts with Medicaid MCEs to specify use of, or payment for, the InCK Model APM

> →

> MCEs contract with provider organizations to implement the InCK Model APM
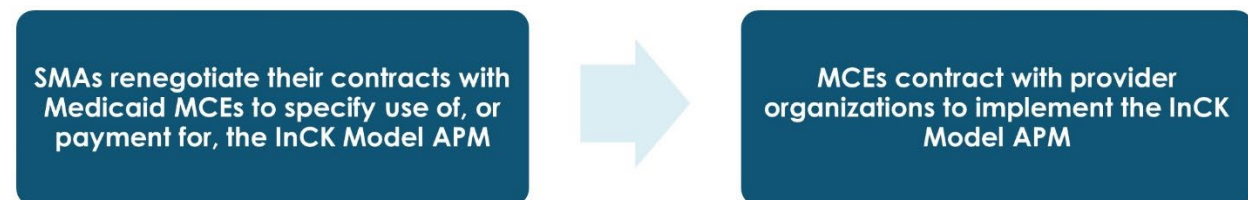
Connecticut (CT) is the only InCK Model state that administers their Medicaid program directly rather than contracting through a MCE. NJ InCK is implementing part of their

SMAs, MCEs, and providers must mutually agree on the design of each APM, including which beneficiaries and providers will be eligible for these alternative payments (patient assignment), what outcomes will be assessed (measurement), and how improvement in those outcomes will be determined (benchmarking).

APMs through their fee-for-service structure, so the SMAs for NJ and CT work directly with providers to implement one part of their APM.

During Model Year 3 (2022), award recipients sought required state and federal authorities and approval for their APM designs, negotiated contracts with MCEs, and refined their APM approaches as needed. Award recipients may continue to revise details of their APMs throughout the model.

3.2.2 Award Recipients' APM Designs in Brief

In this section, we provide a brief overview of each award recipients' APM design, a summary of the provider behaviors they are incentivizing via quality measures, and design considerations for each approach. Exhibits 3.2 – 3.8 also include award recipients' APM assignment, quality, and payment details.

AHHN

AHHN's APM is a pay-for-performance model in which providers receive a higher PMPM payment if they meet certain quality benchmarks, such as the proportion of children who attend well-care visits or receive recommended immunizations. Providers also receive an incentive and payment for keeping costs stable. The APM intends to increase preventive care uptake without raising costs.

Design considerations: In 2022, the Illinois SMA assumed additional financial risk for the APM, meaning MCEs were not at risk. In late 2022 they submitted a revised state plan amendment (SPA), which will increase the PMPM amounts in 2023 to further incentivize provider participation. The AHHN APM is layered on top of MCEs' existing APMs, rather than asking providers to choose between them. The AHHN APM measures are not duplicative of those used in the MCEs' other APMs.

Exhibit 3.2. AHHN's Alternative Payment Model (APM) is a Per Member Per Month (PMPM) with Quality Incentives

AHHN APM Details			
Assignment	Eligible providers: All Hands Health Network[a] Eligible beneficiaries: All InCK Model Beneficiaries		
Measure Type	**Preventive Care**		**Cost**
Measure Details	Child and Adolescent Well-Care Visits (National Quality Forum (NQF) #1516)	Childhood Immunization Status (#0038)	Well-Child Visits in the First 30 Months of Life (NQF #1392)[b, c]	Total cost of care
Performance Benchmark	**To earn 70% of the incentive:** achieve 75th Healthcare Effectiveness Data and Information Set (HEDIS) percentile or 4-7 percent improvement over previous year. **To earn full incentive:** achieve 90th HEDIS percentile or 7+ percent improvement over previous year.			**To earn 50% of the incentive**: within 102% of the prior year. **To earn full incentive**: within 100% of the prior year.

AHHN APM Details	
Payment	Up to $1.50 per beneficiary per month[c] • $0.50 for efficiency measures • $1.00 for quality measures

Notes:

    a.   AHHN has established a network of providers including those affiliated with local federally qualified health centers (FQHCs), those affiliated with Lurie Children's Hospital, and other community-based providers. If a beneficiary's provider is not part of AHHN, the MCE still assigns the beneficiary to AHHN for purposes of the InCK Model APM. AHHN further assigns beneficiaries to individual providers.

    b.   Indicates the measure was part of the Medicaid 2022 – 2023 Core Child Service Set. The complete list of measures in the Core Child Service set in 2022 is available here: https://www.medicaid.gov/media/3996.

    c.   The Medicaid Core Set previously included a measure of Well-Child Visits in the First 15 Months of Life. Starting in 2021, they changed the measure to Well-Child Visits in the First 30 Months of Life.

    d.   AHHN's 2022 APM included a total PMPM of up to $1.50. In late 2022, AHHN submitted a revised SPA for 2023 that will increase the PMPM to $4.50.

BE-InCK NY

BE-InCK NY's APM is a shared savings model. The MCE and the BE-InCK NY Lead Organization, Montefiore Medical Center, will share savings if providers are able to maintain total cost of care and achieve pre-established quality metrics related to preventive care, healthcare utilization, behavioral health, and food insecurity and housing instability screening. Montefiore based their InCK APM on their Medicaid ACO, which predates the InCK Model. Total cost of care will include all MCE-covered services, including InCK services (integrated care coordination, case management, and mobile crisis response).

Design considerations: BE-InCK NY's APM is the only InCK Model APM in which providers are sharing savings based on total cost of care. While they were still finalizing details as of the end of 2022, BE-InCK NY plans to weight quality measures based on beneficiaries' assigned SILs. For example, preventive care measures are weighted more heavily for beneficiaries in SIL 1, while measures of healthcare utilization are weighted more heavily for beneficiaries in SIL 2 and SIL 3. Some stakeholders have raised concerns about the total cost of care measure for a low-risk pediatric population (SIL 1) since utilization (such as well-child visits) may actually increase if needs assessments reveal unmet medical or behavioral health needs. As of the end of 2022, the BE-InCK NY APM was limited to Montefiore providers and beneficiaries associated with a single MCE, Healthfirst, which represents 22 percent of the attributed population. BE-InCK NY leadership anticipates that approximately 13 percent of eligible beneficiaries will not be assigned to the InCK APM because they lack claims data — either because they opted out of data sharing or have not received services in the preceding 12 months.

Exhibit 3.3. BE-InCK NY Alternative Payment Model (APM) is a Shared Savings Model

BE-InCK NY APM Details	
Assignment	Eligible providers: Montefiore Medical Center Eligible beneficiaries: InCK Model Beneficiaries enrolled in MCE for at least nine months
Measure Type	Not yet finalized
Measure Details	Not yet finalized

BE-InCK NY APM Details	
Performance Benchmark	Not yet finalized
Payment	Not yet finalized

Note: MCE=Managed Care Entity.

CT InCK Embrace New Haven

CT InCK Embrace New Haven designed a PMPM APM that intends to incentivize community-based organizations (CBOs) to provide targeted case management services for beneficiaries in SIL 2 and SIL 3. PMPM payments are tied to three quality metrics: completion of the InCK needs assessment; collection of race, ethnicity, and preferred language data via needs assessments; and successful closing of referral loops. Providers who meet specified performance measures are eligible for additional performance-based payments, but details regarding those payments were not finalized at the end of 2022.

Design considerations: The CT SMA will use claims data to assign beneficiaries to the CBOs providing targeted case management. Claims data may be limited early in the APM, so CT InCK Embrace New Haven has identified mitigation strategies, including having their local equivalents of Service Integration Coordinators (SICs) directly contact beneficiaries with no claims to identify needs and historical service utilization. CT InCK Embrace New Haven elected to make local CBOs from their Partnership Council eligible providers in their InCK APM. This approach holds promise to increase resources and staff capacity at the CBOs. However, CBO providers have had little to no previous experience billing Medicaid and may have limited infrastructure to process such payments.

Exhibit 3.4. CT InCK Embrace New Haven Alternative Payment Model (APM) is a Per Member Per Month (PMPM) with Quality Incentives

CT InCK Embrace New Haven APM Details		
Assignment	Eligible providers: InCK Model Targeted Case Management Providers[a] Eligible beneficiaries: Beneficiaries in SIL 2 and SIL 3	
Measure Type	**Care Coordination**	**Health Related Social Needs**
Measure Details	Referral Efficacy[b]	Successful completion of the needs assessment	Comprehensive collection of race, ethnicity, and language data
Performance Benchmark	50% performance or greater	Successful completion of needs assessment for 60% of attributed beneficiaries	75% performance or greater
Payment	SIL 2: $201 PMPM SIL 3: $443 PMPM		

Notes:
    a.   As of this report, CT InCK Embrace New Haven has seven providers that offer targeted case management. These providers are behavioral health providers or CBOs.

b. Referral efficacy reflects the proportion of referrals by InCK providers for InCK beneficiaries that are "closed" (i.e., the number of closed referrals / the total number of referrals), which indicates that the provider to whom a referral was made begins working with the referred individual. CT InCK Embrace New Haven did not provide additional documentation about how they are defining closed referrals, as of the end of 2022.

NJ InCK

NJ InCK's APM includes two components: 1) a payment to primary care providers to review and discuss a beneficiary's InCK needs assessment (called the HealthStory); and 2) a supplemental PMPM care management payment to Advanced Care Management Teams based on services provided to individuals in SIL 2 and SIL 3. The SMA expects Advanced Care Management Teams to provide at least one billable service to each of their assigned beneficiaries each month, which should, at a minimum, include review of the care plan. NJ InCK's APM is a fee-for-service model that does not currently include any quality performance incentives. Performance incentives may be introduced in 2025.

Design considerations: NJ InCK's APM did not include any performance incentives as of the end of 2022, which may ultimately limit its impact on provider behavior. In addition, federal payment rules render Federally Qualified Health Centers (FQHCs) ineligible for additional Medicaid funds beyond the existing prospective payment system; as a result, providers in FQHCs may choose not to bill for review and discussion of the HealthStory.

Exhibit 3.5. NJ InCK Alternative Payment Model (APM) is a Per Member Per Month (PMPM) with Incentives to Improve Care Coordination.

NJ InCK APM Details		
Assignment	Eligible providers: Primary care providers (for HealthStory interpretation), InCK Advanced Care Teams[a] (for care management) Eligible beneficiaries: All InCK Model Beneficiaries (for HealthStory interpretation); Beneficiaries in SIL 2 and SIL 3 (for care management)	
Measure Type	Care Coordination	
Measure Details	HealthStory Interpretation	Care Management Services to beneficiaries in SIL 2 and SIL 3
Performance Benchmark	As of the end of 2022, NJ InCK did not tie payment to quality. They hope to implement this in the future.	
Payment	HealthStory Interpretation: $29 SIL 2 Care Management: $64 SIL 3 Care Management: $110	

NC InCK

NC InCK designed an APM that provides incentive payments to providers for reaching quality benchmarks related to care coordination, Well-Child Visits for children aged 0-15 months, behavioral health, healthcare utilization, and screening for health-related social needs. NC InCK refers to this APM as NC InCK Foundation. They plan to work towards a second APM, a shared savings and shared risk model, referred to as NC InCK Advanced, in the future. (Unless otherwise indicated, we discuss NC InCK Foundation throughout this report.) NC InCK will also collect data for an additional five measures that will be shared

with providers but not tied to payment: Kindergarten Readiness Rate, Food Insecurity Screening Rate, Housing Instability Screening Rate, Well-Child Visits for children up to 30 months, and total cost of care. NC InCK provided additional education and support for providers to prepare for the novel Kindergarten Readiness measure, which does not have analogs in the current billing landscape.

Design considerations: NC InCK is implementing its APM with three participating clinically integrated networks (Duke University Health System, UNC Health, and Community Care Physician Network), which have different resources, caseloads, and levels of experience with APMs. The Community Care Physician Network is comprised of smaller, independent practices. These practices have fewer InCK beneficiaries and limited IT resources to adapt their electronic health records for APM documentation and billing. Both of these characteristics may limit the number and size of their incentive payments. All five MCEs that serve the NC InCK attributed population are offering APM contracts to the three clinically integrated networks. The five MCEs agreed on the same quality measures and that they will assess provider performance across all five rather than separately. However, each MCE uses different incentive amounts. NC InCK leaders and the SMA view the pooled benchmarks as a significant success for multi-payer alignment. The pooled measures have the potential to increase provider engagement in the APM, as a larger proportion of providers' caseloads will be eligible for inclusion in the quality measures. The NC InCK APM includes quality measures related to reducing racial disparities in attendance at well-child visits and assessing kindergarten readiness as part of primary care visits, both of which are novel within the InCK Model APMs.

Exhibit 3.6. NC InCK Alternative Payment Model (APM) is a Per Member Per Month (PMPM) with Quality Incentives.

NC InCK APM Details					
Assignment	Eligible providers: Advanced Medical Homes within participating Clinically Integrated Networks Eligible beneficiaries: All InCK Model Beneficiaries in Standard Medicaid Managed Care Plans				
Measure Type[f]	**Care Coordination**	**Preventive Care**	**Behavioral Health**	**Utilization**	**Health Related Social Needs**
Measure Details	Shared Action Plan for Beneficiaries in SIL 2 and SIL 3	Well-Child Visits in the First 15 Months of Life (NQF #1392)[a,b] Well-Child Visits in the First 30 Months (NQF #761)[d]	Screening for Clinical Depression and Follow-up Plan: Ages 12 – 17 (NQF #0418)[a]	Ambulatory Care Emergency Department Visits (NQF #49)[a,c]	Kindergarten Readiness Bundle[d] Food Insecurity and Housing Instability Screening[d,e]

NC InCK APM Details					
Performance Benchmark	To earn 50% of the incentive: 5% of SIL 2 and 10% of SIL 3 To earn 75% of the incentive: 10% of SIL 2 and 20% of SIL 3 To earn full incentive: 10% of SIL 2 and 30% or more of SIL 3	To earn 50% of the incentive: 5% increase from baseline performance rate for Black/African Americans and overall rate is stable or improving. To earn 75% of the incentives: 10% increase from baseline performance rate for Black/African Americans and overall rate is stable or improving. To earn full incentive: 15% increase from baseline performance rate or greater for Black/African Americans and overall rate is stable or improving	To earn 50% of the incentive: 20% performance rate To earn 75% of the incentive: 40% performance rate To earn full incentive: 60% performance rate	To earn 50% of the incentive: Stable relative to two-year baseline To earn 75% of the incentive: 2.5% decrease from two-year baseline To earn full incentive: 5% decrease from two-year baseline	To earn 50% of the incentive: 20% performance rate To earn 75% of the incentive: 40% performance rate To earn full incentive: 60% performance rate
Payment	PMPM payment amount determined by MCEs PMPM based on Advanced Medical Home performance relative to a cross-plan benchmark				

Notes

a. Indicates the measure is part of the Medicaid 2023 – 2024 Core Child Service Set. The complete list of the measures in the Core Child Service set is available here: https://www.medicaid.gov/media/3996

b. The National Committee for Quality Assurance (NCQA) replaced the original measures Well-Child Visits in the First 15 months of Life (NQF #1392) with this measure in 2021. NC InCK is continuing to use both measures.

c. NA indicates that NQF has not endorsed this measure.

d. NC InCK is collecting data on these measures and sharing it with providers. These measures are not tied to payment.

e. NC InCK is using a single combined Food Insecurity and Housing Instability Bundle. NC InCK includes screening for these measures in their incentive PMPM. They are collecting data on the Food Insecurity and Housing Instability Bundle but have not yet linking it to payment.

f.   In addition to these measures, NC InCK is also collecting data on total cost of care and providing that data providers. They have yet to link payment to total cost of care measures.

OH InCK

Partners for Kids (PFK), the ACO affiliated with Nationwide Children's Hospital (the OH InCK Lead Organization), has full financial risk for children in several Ohio counties, including those participating in InCK. PFK will administer OH's InCK APM as part of its existing primary care and behavioral health provider incentive programs by offering performance-based incentive payments to participating providers. OH InCK was still finalizing the details of their InCK Model APM at the end of 2022, but they expect the APM will include a total cost of care measure and performance linked to quality measures. These measures will include the completion of the health needs assessment and quality metrics related to care for attention-deficit/hyperactivity disorder (ADHD). OH InCK's planned ADHD measures include two HEDIS measures: ADHD Treatment Initiation and Follow-Up Within 30 Days, and Follow-Up Within Nine Months for 6–12-year-olds. It also includes a novel measure for preferred first line ADHD medication.

Design considerations: The InCK APM design process can be complex for award recipients designing APMs around existing value-based care arrangements, which may already be advanced. Instead of duplicating existing quality measures, OH InCK is striving to identify quality measures insufficiently covered or incentivized by other programs, including the existing Medicaid ACO. Further, the OH InCK team is designing their APM around OhioRISE, a specialized statewide MCE for youth with complex needs. OH InCK SICs assess beneficiaries who do not qualify for OhioRISE to determine if they are eligible for OH InCK, as the programs have similar goals and services. OH InCK leadership originally planned to include shared savings in their APM but were unsure how to move forward with a shared savings model given the overlap with OhioRISE. They anticipate that the beneficiaries with the highest needs will be eligible for OhioRISE, so they will not receive care coordination services from OH InCK. This makes attribution more complicated for the purposes of sharing savings. OH InCK was still finalizing many details of their APM as of the end of 2022.

Exhibit 3.7.   OH InCK Alternative Payment Model (APM) is an Incentive Payment for Completing Health Risk Assessments.

OH InCK APM Details	
Assignment	Eligible Providers: PFK Pediatric ACO Eligible Beneficiaries: All InCK Model beneficiaries
Measure Type	Care Coordination
Measure Details	Provider incentive payment for Health Risk Assessment
Performance Benchmark	Not yet finalized
Payment	Not yet finalized

Note: PFK=Partners for Kids. ACO=Accountable Care Organization

Village InCK

Village InCK's APM is a pay-for-performance model with PMPM incentive payments for primary care and behavioral providers who meet annual performance targets related to preventive care and behavioral health and establish the shared care plan for beneficiaries in SIL 2 and SIL 3. Providers can earn PMPM payments if they are able to make improvements on these measures.

Design considerations: The Village InCK APM relies on existing provider and beneficiary relationships, which will likely support implementation. Village InCK has aligned quality measures with existing priorities and InCK Model goals.

Exhibit 3.8. Village InCK Alternative Payment Model (APM) is a Per Member Per Month (PMPM) with Quality Incentives.

Village InCK APM Details			
Assignment	Eligible providers: Egyptian Health Department[a] Eligible beneficiaries: All InCK Model Beneficiaries		
Measure Type	**Care Coordination**	**Preventive Care**	**Behavioral Health**
Measure Details	Universal Plan of Care	Well-Child Visits in the First 15 Months of Life (NQF#1361)[b] Well-Child Visit in the First 30 Months of Life (NQF#1392)[b] Adolescent Well-Care Visits (NQF#24)	Follow-Up After Hospitalization for Mental Illness: Ages 6 – 17 (NQF# 0576)
Performance Benchmark	Plan created for 60% or more of SIL 2 and SIL 3 population	1% improvement from 2022 performance	1% improvement from 2022 baseline
Payment	Up to $4.50 per beneficiary per month $3.00 for quality measures[c] $1.50 for shared care plan		

Notes:

a. Egyptian Health Department, the InCK Model Lead Organization, is a partnering member-owner of Illinois Health Provider Alliance, a statewide network of independent behavioral health providers. Whether the MCEs will contract with Egyptian Health Department or Illinois Health Provider Alliance, and whether primary care physicians are considered part of either network, is unknown at the time of the report.

b. In Village InCK's original pre-print included Well-Child Visits in the First 15 Months of Life (NQF #1392). NCQA replaced this measure with Well-Child Visits in the First 30 Months of Life (NQF #761).

c. Indicates the measure was part of the Medicaid 2022 – 2023 Core Child Service Set. The complete list of measures in the Core Child Service set in 2022 is available here: https://www.medicaid.gov/media/3996

d. The incentive structure varies by provider type. Primary Care Providers are assessed on the three preventive care measures and eligible to receive $1.00 per beneficiary per member. Behavioral health providers are assessed on the Follow-Up After Hospitalization Measure.

3.2.3 APM Quality and Cost Measures and Payment Details

Five InCK Model Award Recipients (AHHN, CT InCK Embrace New Haven, NC InCK, NJ InCK, and Village InCK) designed PMPM APMs that will make providers eligible for a fixed amount of money for each eligible patient whom they engage in certain activities. Activities are both pay-for-reporting, such as conducting needs assessments or screening for health-related social needs, and pay-for-performance, such as meeting quality standards for well-child visits or appropriate follow-up after hospitalizations. See the APM Quality and Cost Measures and Payment sections below for further details.

- All eligible providers in CT InCK Embrace New Haven will receive the PMPM payment for beneficiaries in SIL 2 and SIL 3. Eligible providers also have the potential to earn an additional quality incentives, but as of the end of 2022 CT InCK Embrace New Haven had not yet finalized which quality measures they were going to use. CT InCK Embrace New Haven's approach ensures that providers will receive a PMPM payment for care coordination they provide to SIL 2 and SIL 3 beneficiaries even if they are unable to meet quality benchmarks.

- NJ InCK's approach applies a mix of fee-for-service payments and PMPM payments for care management. Neither of these payment types are tied to performance, though NJ InCK may modify its approach in the future.

- BE-InCK NY and OH InCK are building on previous experience with payment models. BE-InCK NY has designed a shared savings model, while OH InCK is adding InCK-specific quality measures to existing ACO contracts. NC InCK plans to work toward a shared savings model (InCK Advanced) over the next two years. Shared savings models give providers the opportunity to earn higher incentives the more they reduce total cost of care.

> The Health Care Payment Learning & Action Network developed a framework categorizing APMs to reflect providers' increasing risk of financial losses and decreasing reliance on fee-for-service payments or architecture.
>
> The InCK Model's PMPM-based models are AHHN, CT InCK Embrace New Haven, NC InCK, NJ InCK, OH InCK, and Village InCK. These are **Category 2 APMs**, which link fee-for-service payments to quality and value. Providers have no financial risk in these models.
>
> BE-InCK NY's shared savings-based model is a **Category 3 APM**. This type of APM is built on a fee-for-service architecture. Providers may or may not have financial risk in these models. BE-InCK NY providers will not have financial risk in their APM.

Exhibit 3.9. The InCK Model Alternative Payment Models (APMs)All Fit Within the Health Care Payment Learning & Action Network APM Framework.

Category 1: Fee-for-Service with No Link to Quality or Value	Category 2: Fee-for-Service Linked to Quality or Value	Category 3: APMs Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
	2A: Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments) **NJ InCK**	**3A: APMs with Shared Savings** (e.g., shared savings with upside risk only) **BE-InCK NY**	**4A: Condition-Specific Population-Based Payment** (e.g., per member per month payments for specialty services, such as oncology or mental health)
	2B: Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**3B: APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**4B: Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	2C: Pay-for-Performance (e.g., bonuses for quality performance) **AHHN** **CT InCK Embrace** **New Haven** **NC InCK** **OH InCK** **Village InCK**		**4C: Integrated Finance and Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N: Risk Based Payments Not Linked to Quality	**4N: Capitated Payments Not Linked to Quality**

Note: HIT=Health Information Technology

Assignment

APM assignment is the process by which a payer determines which provider receives payment for which beneficiaries. Managed care and fee-for-service plans often approach assignment differently.

When an MCE administrates Medicaid, the typical process for assignment is as follows:

1. The beneficiary is aligned to an MCE.
2. The MCE assigns the beneficiary to a primary care provider.

3. The beneficiary is aligned to a provider for the purposes of the APM distribution.

When Medicaid is administered as a fee-for-service program, the typical process for assignment is as follows:

> Payers use historical healthcare utilization to assign beneficiaries to providers. Typically, beneficiaries are assigned to the provider with whom they had the most visits in the previous year.

AHHN, BE-InCK NY, NC InCK, NJ InCK, OH InCK, and Village InCK are all implementing at least part of their APMs within the context of managed care and will incorporate the InCK Model APM into the contracts between MCEs and provider organizations. Each of these award recipients is establishing these contracts a bit differently. For example:

- Both AHHN and Village InCK contract as unique provider entities with Illinois' MCEs. AHHN acknowledges that not all InCK Model Attributed Beneficiaries will have an AHHN provider. The MCEs will still assign those beneficiaries to AHHN for the purposes of the InCK Model APM to indicate the beneficiary receives services from AHHN, such as access to the AHHN resource coordinators and helpline.

- Three provider organizations serve the NC InCK attributed population, each with its own contracts with the MCEs serving the attributed population. All contracts have been updated to include the InCK Model APMs.

- NJ InCK is implementing one component of their APM, the HealthStory Implementation, through their managed care contracts.

CT InCK Embrace New Haven is implementing their APM outside of managed care and is using a different system to assign beneficiaries to providers. Providers will receive a PMPM payment for InCK Model Beneficiaries for whom they have submitted claims. CT InCK Embrace New Haven includes CBOs as providers who can receive reimbursement for case management services provided as part of the InCK Model.

Beyond assignment, award recipients must also determine whether providers are accountable for all InCK Model Beneficiaries or only a subset. AHHN, NC InCK, and Village InCK will include their full InCK Model Attributed Populations in their APMs. CT InCK Embrace New Haven and NJ InCK will focus all or part of the APM on beneficiaries in SIL 2 and SIL 3.[l]

Finally, InCK Model APMs may exclude otherwise eligible beneficiaries who lack a claims history or are attributed to another value-based care model.

---

[l]   The care management component of NJ InCK's APM only includes SIL 2 and SIL 3 beneficiaries. The universal screening component can be reimbursed for all InCK Model Beneficiaries.

- BE-InCK NY estimates about 13 percent of attributed beneficiaries will not be included in the APM because they have opted not to share data or have not had a Medicaid claim in the past year.

- OH InCK is excluding beneficiaries from its InCK APM who are attributed to the OhioRISE program.

APM Quality and Cost Measures

APMs improve quality and patient outcomes by tying payment to the reporting or performance on quality or cost measures. BE-InCK NY and OH InCK had yet to finalize the quality measures they will use in their APMs at the end of 2022. NJ InCK is not yet including quality measures as of the end of 2022 but plans to in the future.

Across award recipients, InCK Model APM quality and cost measures fall into six domains, for which there are disparate benchmarks and corresponding payments. The six domains include measures for care coordination, preventive care, behavioral health, utilization, cost, and screening for health-related social needs. Care coordination and preventive care are the most common measures included in the InCK Model APMs.

- Care coordination: CT InCK Embrace New Haven, NC InCK, NJ InCK, and Village InCK include measures related to establishing care plans and successful referrals.

- Preventive care: AHHN, BE-InCK NY, NC InCK, OH InCK, and Village InCK include measures such as well-care visits and childhood immunization status. Notably, only NC InCK's preventive care quality measure is targeted toward reducing racial disparities in receipt of preventive care.

- Behavioral Health: BE-InCK NY, NC InCK, and Village InCK include measures such as depression screening or follow-up appointments after a behavioral health hospitalization.

- Utilization: NC InCK includes measures related to emergency department visits and avoidable inpatient admissions.

- Cost: Only AHHN includes a measure to stabilize total cost of care as of the end of 2022. BE-InCK NY will include a total cost of care measure in the future.

- Screening for health-related social needs: CT InCK Embrace New Haven and NC InCK incentivize providers to conduct screening for health-related social needs such as food insecurity or housing instability. NC InCK also includes screening for kindergarten readiness.

APMs may include payments tied to reporting, in which providers receive incentive payments for collecting or submitting data, and performance, in which they receive incentive payments for achieving or improving upon certain performance benchmarks. Most award recipients include both types of measures in their InCK APM. CT InCK Embrace New Haven only required pay-for-reporting at the end of 2022. They plan to incorporate a pay for performance component in the future. BE-InCK NY and OH InCK had yet to finalize their

performance measures as of late 2022, and NJ InCK is not including performance measures in their APM.

NC InCK's APM includes a number of reporting measures in addition to performance measures. They hope to shift some of their reporting measures to performance measures in the future, as providers become more comfortable with how to achieve performance goals for these measures. In preparation for inclusion of new performance measures, NC's SMA implemented new, non-reimbursable billing codes to allow providers to document when they have successfully conducted Food Security, Housing Stability, and kindergarten readiness screens. Kindergarten readiness is a novel measure for providers in NC, and providers had early hesitation about being assessed on their performance on it. At this point, NC InCK is offering providers data on their performance on the kindergarten readiness measure, but they are not including the measure in APM bonus payments.

AHHN, NC InCK, and Village InCK are incentivizing improvement on performance measures over the course of the model by making providers eligible for higher payments if they improve their performance over time. For example, AHHN and Village InCK have both designed their APM performance measures so that providers need to improve over time to continue to earn incentive payments.

AHHN's APM includes both a quality component and cost component, providing a bonus payment to providers who reduce the total cost of care, but cost of care measure is only 20 percent of the total available PMPM payment. Providers earn the remaining 80 percent by meeting quality metrics.

Payment

APM payment refers to what the payer, typically an MCE, pays to the provider organizations. Participating provider organizations can then choose whether to distribute bonus payments to individual providers within their organization. The dollar amount and structure of incentive payments varies across the InCK Model APMs.

AHHN, CT InCK Embrace New Haven, NC InCK, and Village InCK have established mechanisms for participating provider organizations to receive partial incentives in their InCK Model APMs if they meet some but not all of the performance benchmarks. For example:

- For AHHN and Village InCK, the MCE reimburses for each measure that met the performance benchmark.

  o As of 2022, AHHN's APM specifies a PMPM of up to $1.00 for its quality measures and $0.50 for its total cost of care measure. In late 2022, AHHN submitted a revised 438 preprint which will raise the PMPM to a maximum of $4.50 in 2023. AHHN hopes that higher payments will incentivize provider engagement.

> For more information on this increase, see Facilitators and Barriers to APM Design and Implementation.

○ Village InCK implements a similar approach. Primary care providers can earn a PMPM up to $3.00 for well child measures ($1.00 per measure) and behavioral health providers can earn $3.00 for follow-up after a hospitalization for mental illness. Egyptian Health Department earns a $1.50 PMPM for establishing care plans.

NC InCK: Balancing Consistency Across MCEs with MCE Autonomy

The NC SMA determined NC InCK's APM measures and calculated performance scores across the five MCEs serving InCK Model Beneficiaries. Providers will receive information about their performance on quality measures for all InCK Model Attributed Beneficiaries in their practice. Each MCE determined the value and beneficiary inclusion criteria for the APM independently. This approach may increase provider engagement in the APM and the InCK Model overall, since providers will see performance measures on a greater proportion of their patient population. MCEs retained flexibility in their measure specifications. For example, one MCE may pay the PMPM for each beneficiary in a measure numerator (i.e., the beneficiaries who received the quality action, such as a well-child visit), while another may pay a PMPM for each beneficiary in a measure's denominator (i.e., each beneficiary who was eligible to receive the quality action).

Most InCK Model APMs include a PMPM payment directly tied to quality measure performance, with the exceptions of BE-InCK NY and NJ InCK. BE-InCK NY plans to implement a shared savings model. Both award recipients are still finalizing payments details. NJ InCK does not tie their monthly care management fees to quality measures. However, NJ InCK plans to incentivize providers to support the development of care plans through the payment to review and discuss the needs assessment (HealthStory).

CT InCK Embrace New Haven and NJ InCK are using tiered PMPM structures to provide a higher payment for care provided to beneficiaries in SILs 2 and 3.

- CT InCK Embrace New Haven's PMPM amount for SIL 3 beneficiaries is more than double the PMPM amount for SIL 2 beneficiaries ($443 and $201, respectively). CT InCK Embrace New Haven expects rates will remain in place for the APM's first 18 months, and then the SMA will adjust the rates in subsequent years based on quality measure performance and beneficiary transitions between SILs.

- NJ InCK's PMPM amount for SIL 3 is nearly double the PMPM amount for SIL 2 beneficiaries ($110 vs $64).

Conversely, OH InCK excludes many SIL 3 beneficiaries from their APM by excluding OhioRISE beneficiaries (i.e., those with the highest need). This approach will likely limit the potential cost savings available under a full risk capitation arrangement.

> **AHHN and Village InCK: Pooling APM Payments to Support Infrastructure and Reward Partners**
>
> The AHHN and the Village InCK provider organizations pool their PMPM payments across MCEs, rather than distributing them to their participating providers.
>
> AHHN may distribute the pooled MCE PMPM payments for measures or provider types that are different than those in their formal APM contract with the MCEs—for example, to better engage and incentivize providers that currently do not directly contract with MCEs, such as community service organizations.
>
> The Village InCK provider organization chose not to redistribute the $1.50 PMPM payment to providers and instead used it to fund the care coordination platform that allows information sharing across all payers and providers.

3.2.4 Implementation Details

As of late 2022, two award recipients receive direct payment through their SMAs: AHHN and Village InCK. SMAs are not typically able to specify the rates an MCE pays to its contracted providers; however, regulations allow direct payments under specific circumstances, including implementation of a value-based payment arrangement, such as an APM.[12] To obtain CMCS' approval of these directed payments, the SMA must complete and submit a 438.6 pre-print form. SMAs that pursue preprints must also receive CMCS' approval for any Medicaid benefits the APMs will support or incentivize, if applicable.

InCK Model APMs that rely solely on existing relationships between MCEs and providers do not require federal approval. MCEs simply needed to update their contracts with provider organizations to move forward with APM implementation. As of late 2022:

- BE-InCK NY and OH InCK are planning to implement their APMs within existing MCE arrangements, with the MCEs self-funding the APM incentives. Montefiore Medical Center and PFK are the APM provider organizations for BE-InCK NY and OH InCK, respectively and have long-standing MCE relationships that include risk-bearing payment arrangements. These experiences may have made the NY and OH MCEs more willing to assume the risk of funding the APM without additional financial support from the SMA.

- In contrast, the AHHN, NJ InCK, and Village InCK APMs are at least partially funded through the Medicaid program, which required the respective SMA to amend or renegotiate their agreements with the MCEs. MCEs subsequently reflected those changes in their contracts with provider organizations.

CT InCK Embrace New Haven and NJ InCK relied on state plan amendments (SPAs) to implement their APMs because they are using fee-for-service structures. CT's SMA has a pending SPA that implements targeted case management for the InCK Model Attributed Population. This SPA includes details on their APM, such as performance-based payments and a waiver of statewideness.

NJ InCK also relies on a [SPA](#). While MCEs administer NJ's Medicaid program, the SMA reimburses for the case management portion of the APM. NJ's SMA is working toward incorporating their InCK APM care management and screening services into the [New Jersey FamilyCare Comprehensive Demonstration](#). This FamilyCare demonstration is part of an existing 1115 waiver originally approved in 2012 that has been [extended through March 2023](#). The demonstration's [renewal request](#) which includes InCK Model services was pending as of the end of 2022.

> [Federal statute](#) does not allow Medicaid programs to exclude enrollees or providers based on the location of their home or workplace. SMAs may request a waiver of this requirement to, for example, test a new program or limit state expenditures—called a **waiver of statewideness.**

3.3   APM IMPLEMENTATION STATUS

Implementing APMs requires execution of several steps before the first payments can be made.

1. Receive federal authority: CMCS approves payment-related changes, particularly when the APM only affects a subset of the state's Medicaid-enrollees.
2. Negotiate contracts with MCEs and providers: If the state is a managed care state, the SMA negotiates new rates with MCEs, then MCEs secure agreements with applicable providers. If the state is a fee-for-service state, the SMA updates their arrangements with Medicaid providers or provider organizations.
3. Collect data: States collect and analyze data to tie payment to reporting or performance on specific quality or cost measures.

Over the course of the first three years of funding, InCK Model Award Recipients worked toward full implementation of the InCK Model APMs with varying levels of progress (Exhibit 3.10).

Exhibit 3.10. InCK Model APM Implementation Progress Varied Across Award Recipients as of December 2022.

Award Recipient	Step 1. Federal Authority	Step 2. MCE Contracts	Step 3. Provider Contracts	Step 4. Data Collection Begins	Step 5. Payment Begins
BE-InCK NY	N/A	In Progress	In Progress[b]	Starting in 2023	Planned for 2024
CT InCK Embrace New Haven	SPA[c]	N/A	N/A	Starting in 2023	Planned for 2023[d]
NC InCK	438 preprint[e]	Complete	Complete	Starting in 2023	Planned for 2024
NJ InCK	SPA[f]	Complete[g]	Complete	N/A	Completed in 2022
OH InCK	N/A	In Progress[h]	In Progress	TBD	TBD
Village InCK	438 preprint	In Progress	In Progress[i]	Starting in 2023	Planned for 2023
AHHN[a]	438 preprint	Complete	Complete	2022	Planned for 2024

Key: ○ N/A ● Complete ● Pending or In Progress ● To Be Determined ● Future

Notes:
a. CMCS approved AHHN's 2022 438 preprint and MCEs updated their AHHN contracts accordingly. Approval of their revised preprint for 2023 to 2024 is pending, as are updates to the AHHN MCE contracts.
b. Montefiore Medical Center and HealthFirst have an agreement in place with other MCE agreements pending.
c. CT InCK Embrace New Haven and NC InCK are confident CMCS will approve and backdate their federal authority submissions to support the InCK APM. SPA=State Plan Amendment
d. The PMPM payments will begin in 2023. The quality incentive payments, based on 2023 data, will begin in 2024.
e. Data reflects the InCK Foundation (PMPM) APM. NC InCK is considering a shared savings model in the future but has yet to finalize design or seek approval.
f. New Jersey has requested the InCK Model services be added to their existing 1115 waiver as a part of a pending renewal. SPA=State Plan Amendment.
g. NJ InCK's MCE contract changes only include updates to their fee schedule to include the universal screening fee.
h. OH's SMA reprocured all their MCE contracts in 2022 but it is not directing APM payments. OH InCK has delegated development and implementation of the InCK APM to agreements between providers and MCEs.
i. Village InCK intends to backdate provider contracts to the beginning of 2023.
j. MCE=Managed Care Entity.

As of December 2022, CMCS approved AHHN's and Village InCK's APMs. CT InCK Embrace New Haven and NC InCK anticipate approval early in 2023. BE-InCK NY and OH InCK did not submit the appropriate documentation for federal approval as of December 2022. NJ InCK is using an existing 1115 waiver to fund their APM and submitted that waiver for approval as of December 2022.

SMAs have revised their MCE agreements where needed.

- IL and NC SMAs revised their MCE contracts to include the AHHN, Village InCK, and NC InCK APMs.

- NJ SMA notified the MCEs of the updated Medicaid fee schedule, which now includes the universal screening fee. The SMA pays NJ InCK's APM care management fees directly to providers. NJ InCK's providers are mostly community-based organizations, which likely do not have existing relationships with MCEs.

- OH SMA reprocured all their MCE contracts in 2022, which do not include the OH InCK APM. OH InCK has delegated development and implementation of the InCK APM to agreements between providers and MCEs. BE-InCK NY is similarly relying on agreements between providers and MCEs to implement its APM. This means that PFK and Montefiore Medical Center, the APM providers for OH InCK and BE-InCK NY, respectively, need to negotiate the terms of the APM with each MCE individually, rather than having a state-directed framework to which the MCEs have agreed.

- CT's Medicaid program is fully FFS, but the SMA has completed the necessary arrangements with the administrative service organizations (ASOs) that administer the CT Medicaid program.

As of December 2022, AHHN, CT InCK Embrace New Haven, NC InCK, and NJ InCK had completed necessary negotiations or established required contacts with state MCEs and APM provider organizations. BE-InCK NY had completed negotiations with one MCE (HealthFirst) but not others. Village InCK was actively negotiating with all MCEs that serve InCK Model Beneficiaries. Village InCK anticipates completing these agreements in mid-2023. Village InCK's APM is state-directed and the SMA determines the measures and payment amounts, which are not substantive parts of MCE and provider negotiations. Data collection will begin in 2023 with payments anticipated in 2024.

> Future reports will explore if and how award recipients expand their APMs to include additional providers and/or MCEs, and whether the APMs become more complex or adjust incentives over time.

Most InCK Model APMs will either begin collecting data or issuing payments in 2023. A year of data collection precedes payment for InCK Model APMs that tie payment to performance. Payers need baseline data to determine whether providers achieved their benchmarks and therefore earned their incentive payments. Most InCK Model APMs plan to collect this data in 2023, with two exceptions.

> Future reports will confirm whether MCEs or SMAs have been able to collect APM data, determine performance, and pay incentives as intended.

- CT InCK Embrace New Haven's approach of offering an incentive payment in addition to a PMPM payment enabled their APM to begin

payment and data collection simultaneously. They planned to begin providing PMPM payments in 2023, while incentive payments that rely on 2023 data will be available in 2024.

- NJ InCK's APM does not include any quality or cost measures, so they began issuing payments in 2022.

OH InCK is delayed in achieving APM implementation milestones. They anticipate that, given PFK's longstanding history of full-risk payment arrangements with the MCEs, implementation will progress quickly once they finalize the design of the APM. OH InCK identified three factors contributing to their APM implementation delays:

1. In 2021, OH InCK transitioned the Lead Organization from the OH SMA to Nationwide Children's Hospital, which delayed the start of designing OH InCK's APM.
2. The OH SMA completed its MCE re-procurement process six months later than originally anticipated. Subsequently, PFK was delayed since negotiations with the MCEs could not occur until the SMA completed the re-procurement.
3. The potential overlap between the OhioRISE program and OH InCK means that it has taken additional time to finalize how the OH InCK APM will complement OhioRISE.

3.4 FACILITATORS AND BARRIERS TO APM DESIGN AND IMPLEMENTATION

3.4.1 *Role of Key Stakeholders*

Partnership Councils and APM workgroups facilitated APM design and implementation for all award recipients. Other stakeholders participating in APM design and implementation discussions included SMA officials, provider organizations, and quality improvement organizations. Award recipients engaged MCE representatives through Partnership Council workgroups to elicit input on attribution rules, quality, and cost measurement, as well as other APM design and implementation details. Through Partnership Council meetings, award recipients and MCEs discussed MCE offerings and demonstrated the intended outcomes of planned InCK APMs. Most award recipients included MCEs in the design process through the structure of the Partnership Council, except NJ InCK, who designed their APM prior to engaging the MCEs.

Some award recipients encountered challenges engaging with MCEs due to limited interest in pediatric APMs—as high-cost adults typically offer more significant savings opportunities than pediatric populations—or competing priorities. Award recipients used a variety of strategies to engage MCEs:

- There are four MCEs which are part of the BE-InCK NY Partnership Council, but not all are equally engaged. The BE-InCK NY Partnership Council's co-chairs conducted targeted outreach to a few of the less engaged MCEs. They are considering providing upfront payments to providers to increase APM engagement, but they had not yet finalized that decision and implementation details as of December 2022.

- OH InCK is contemplating how to structure incentives when the highest cost beneficiaries (those likely to be in SIL 3) will be in OhioRISE, limiting the potential cost savings that can be realized with the remaining beneficiaries. OH MCEs had limited participation in early discussions about the OH InCK APM because of the concurrent MCE re-procurement.

- Village InCK has an InCK-aligned adult-focused model, Integrated Care for Adults, which helped engage MCEs in discussions about the pediatric population. The SMA explicitly encouraged IL MCEs to engage in both efforts.

- Though IL MCEs did attend early InCK Model APM design meetings for both AHHN and Village InCK, issues such as staff turnover and the COVID-19 public health emergency prevented them from fully engaging.

AHHN and Village InCK: Overcoming MCE Engagment Challenges

AHHN and Village InCK both had significant challenges engaging their MCEs.

✓ Village InCK reported engaging MCEs later than anticipated due to MCEs repeatedly cancelling or rescheduling meetings.

✓ AHHN reported that MCEs raised objections to items AHHN believed they had already decided.

✓ AHHN initially tried to work with MCEs individually and subsequently achieve consensus across plans but found this was not possible.

Both AHHN and Village InCK relied on University of Illinois' Office of Medicaid Innovation (OMI) for assistance, with OMI engaging the Illinois Association of Medicaid Health Plans CEO to better engage MCEs and help overcome challenges.

Some MCEs had existing APMs or other initiatives to improve quality, which complicated development and implementation of InCK Model APMs and required careful delineation of responsibilities. Both MCEs and award recipients wanted to ensure their InCK Model APMs were complementary to existing efforts rather than redundant (e.g., not paying a provider to do something the MCE was already doing).

- In Village InCK's APM, participating providers administer the Universal Plan of Care. Service Integration Coordinators work with existing MCE coordinators so that the beneficiary's care plan reflects the MCE's care management goals.

- NY MCEs' had experience with adult focused APMs rather than pediatric ones. Despite the different target populations, NY MCE's care management programs informed BE-InCK NY's APM design. The MCEs also helped specify how the InCK Model APM would tie into the MCEs' existing arrangements with hospital systems serving the same population.

- Under the AHHN APM, AHHN resource coordinators provide and are reimbursed for care management to beneficiaries whom MCEs do not typically enroll in their own care management programs (i.e., beneficiaries who are currently not high-risk but may become high-risk). AHHN focuses on these lower-risk beneficiaries, so their efforts complement the MCEs' efforts. The MCEs provide a dedicated liaison to AHHN, deliver periodic data on enrollment and participation in MCE-provided care management, and educate AHHN resource coordinators on MCE care management offerings. The IL MCEs also worked with the AHHN Lead Organization to align their health risk screenings with the InCK Model needs assessment.

> Future reports will explore whether MCEs and providers are effectively avoiding duplication of care management services while still effectively managing care for those who need it.

- In OH InCK's anticipated APM, MCEs will be responsible for utilization. PFK, the APM provider organization, will be responsible for care coordination. Each organization will share claims and eligibility information with the other.

Engaging MCEs Reluctant to Take on Additional Financial Risk in Illinois

Initially, AHHN providers would have had to opt into either the InCK Model APM or an existing MCE APM. This approach would have limited additional costs for the MCE, as it would not require them to set up a new APM for the InCK Model. However, the MCE infrastructure was unable to support the APM as originally planned. The initial plan also risked limiting provider participation, as providers may have been reluctant to exchange one APM for another.

In response, AHHN and Village InCK revised their approach so that the InCK APMs would operate in addition to existing APMs, which created new costs for the MCE. AHHN originally proposed an incentive payment of $1.50, but MCEs raised concerns that such a low payment would put them at too much financial risk. In late 2022, AHHN proposed tripling their incentive payment for 2023 to $4.50 to get buy in from the MCEs.

Three award recipients relied on Medicaid claims to develop and refine their APMs.

- BE-InCK NY used Medicaid claims data and clinical data from Bronx RHIO (a regional health information exchange) to identify potential areas for cost savings and support model revisions.

- Village InCK hired a consultant who used claims data to refine their model, inform outcome measures, and incorporate MCE objectives.

- AHHN completed financial analyses using claims data to share with MCEs, though AHHN's MCE presentation was delayed because the Medicaid agency did not deliver the claims data on time.

Four award recipients needed additional external support for APM design and implementation, especially for data analysis and sharing.

- OH InCK relied on an actuarial contractor for many of their analyses, including utilization patterns, cost saving opportunities, and reducing Out of Home Placement. The actuarial analyses results informed final APM payment details, including quality and cost measure specifications.

- Village InCK staff lacked APM experience and relied on consultants and technical assistance providers for support.

- BE-InCK NY found obtaining needed data (i.e., data from providers, NY state, New York City, and the federal government) was complex and time-consuming given HIPAA and FERPA regulations. Their Partnership Council implemented a Data Sharing and Information Technology workgroup to identify and address data concerns with some success.

- CT InCK Embrace New Haven acknowledged early on that establishing DUAs with Partnership Council Members, which would help APM workgroups have access to data needed to design the APM, was dependent on legal capacity and availability. CT InCK Embrace New Haven was still struggling to establish these DUAs at the end of 2022.

3.4.2 Coordination with Federal Stakeholders

Most award recipients found the process of getting federal approval to be more time consuming than they originally anticipated. Some, however, had to negotiate their federal authorities with CMCS before final submission.

- CT InCK Embrace New Haven did not meet actuarial requirements in their first SPA proposal because the initial attributed population was too large. During the pre-implementation period, CT InCK Embrace New Haven decreased its attributed population from six to two New Haven ZIP Codes, which sufficiently adjusted the APM costs. The smaller attributed population size made the APM financially viable for the community-based organizations enrolled as InCK Providers.

- CMCS rejected AHHN's initial efficiency measure, in which providers would earn an incentive payment if they were able to reduce the total cost of care for beneficiaries to 85 percent of a beneficiary's effective premium. In response, AHHN updated their total cost of care measure in their 438 pre-prints.

- Village InCK needed to provide additional actuarial details to CMCS before receiving their approval.

3.4.3 *Provider Outreach, Enrollment, and Engagement*

During the first year of the implementation period, most award recipients focused their efforts on engaging provider organizations rather than individual providers. As of the end of 2022, only CT InCK Embrace New Haven, NC InCK, and Village InCK had taken steps to educate individual providers about the InCK Model and offered training to support successful implementation. Award recipients also developed written materials and led presentations for provider engagement teams. As of the end of 2022, provider organizations had not yet determined the details of how InCK Model APMs would affect individual providers: for example, how incentive payments would be distributed at the individual provider or practice level.

> Future reports will explore whether and how the APM provider organizations have engaged individual practices or providers.

Incentive Amounts

Award recipients found that the size of incentives and reimbursement led to additional challenges.

- For NJ InCK, few providers requested reimbursement for interpretating the care plan — a newly reimbursable service under the InCK APM — even after the SMA helped to address claims processing issues. Stakeholders expressed concern that the NJ InCK care management PMPM payment is insufficient to sustain the services.

- CT InCK Embrace New Haven increased its PMPM amount by decreasing its InCK Model Attributed Population, which addressed concerns regarding the inadequacy of the initial payment amount. However, not all challenges were addressed – CT InCK Embrace New Haven's payment system is designed to process fee-for-service encounters rather than PMPM incentives.

> Future reports will explore how and whether APMs are designed to foster sustainable practice changes.

3.5 CONCLUSION

Five of the seven InCK Model Award Recipients are implementing payment models that offer providers a PMPM tied to performance but without downside financial risk. All award recipients expect APM payments to begin by 2024. The two award recipients that are implementing more complex models, BE-InCK NY and OH InCK, have made comparatively less progress than others and have not finalized the details of their APMs.

In the first three years of the InCK Model, award recipients spent considerable time negotiating with MCEs to establish new APMs. Three award recipients turned to state-

directed payments, transferring the cost and structure of the APM incentives to the SMA, which was able to exert greater influence over the MCEs. BE-InCK NY and OH InCK are negotiating their InCK APMs directly with MCEs based on existing partnerships.

Award recipients expected to launch APMs in early 2023. As award recipients face the realities of implementation, their approach to InCK Model components and details of their APM design may change. For example, they may expand to include additional providers or payers, increase in complexity, or adjust incentives to encourage different provider behaviors. Once payments are established, APM-participating provider organizations may determine whether payments are sufficient to cover the services beneficiaries need, which additional partners they may have to engage to effectively provide those services, and how to effectively incentivize those partners. Perhaps most importantly, if InCK Model APMs show cost savings, the model may incentivize broader interest by providers and payers to develop pediatric APMs.

Chapter 4.
Core Child Service
Context

4. Core Child Service Context

Key Findings

- Availability and accessibility of Core Child Services (CCS) – including the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and public housing – vary across award recipient states. Limited availability and access to these services may diminish the model's potential to address CCS needs.

- Lead Organization characteristics and concurrent state Medicaid initiatives in InCK Model states may affect access to services for attributed populations and make it easier or more difficult for award recipients to address the common challenges beneficiaries and their families face.

- State-level policies such as those related to immigration and access to reproductive health services have the potential to limit InCK Model beneficiaries' access to CCS. Award recipients reported that families with mixed immigration status face barriers accessing and engaging in InCK Model services.

4.1   INTRODUCTION

As reported in Evaluation Report 1, caregivers, local providers, and award recipients all described significant barriers to accessing needed medical care and CCS. This chapter uses secondary data to further illustrate select service environments and contexts in which InCK Model award recipients operate and the barriers to both access and availability of services. As described in the Practical Robust Implementation and Sustainability (PRISM) framework (Exhibit 4.1), the local context and policy environment are critical components to assess since these factors influence the implementation and ultimately the impact of each InCK Model. The contextual and policy factors described below include behavioral health, cash assistance, food, housing, child welfare, foster care, and reproductive health.

> For more information on the InCK Model and early findings on local context in InCK Model Attributed Populations, see Evaluation Report 1.

Using summaries for individual InCK award recipients, this chapter provides insight into local contextual factors that may influence award recipients' model design and implementation, and ultimately the impact of the model. These summaries are designed to be "stand-alone" documents that can assist key stakeholders to identify relevant CCS domains. Each summary follows a similar structure including: 1) key findings related to CCS

access and needs from [Evaluation Report 1](); 2) CCS policy; and 3) additional information about relevant CCS domains.

Exhibit 4.1. PRISM Implementation Framework Informs the InCK Evaluation.
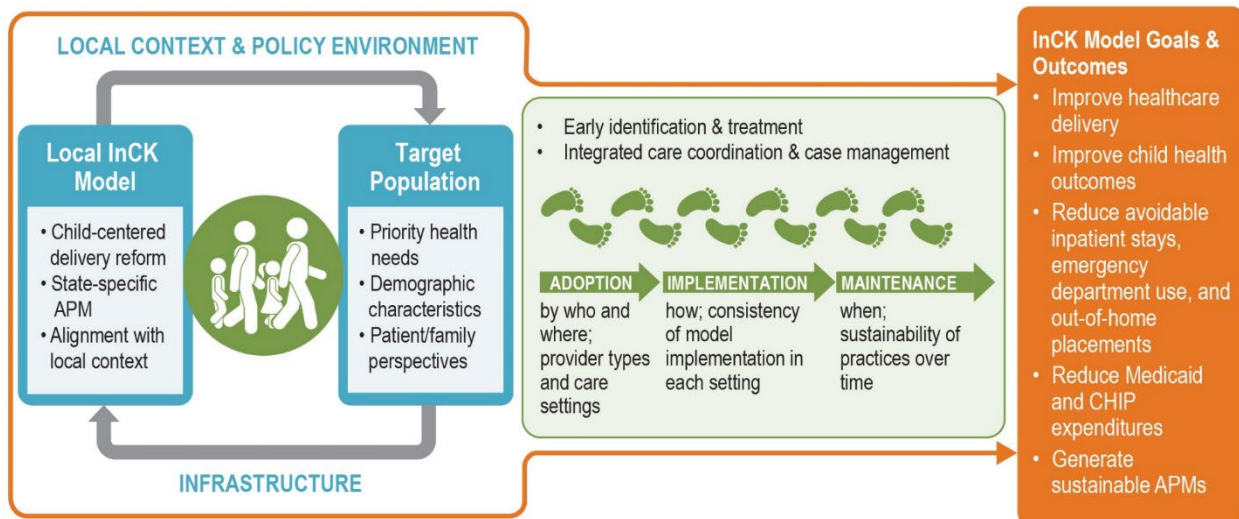
Note: PRISM=Practical Robust Implementation and Sustainability Model. APM=Alternative Payment Model. CHIP=Children's Health Insurance Program.

4.2 SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **ALL HANDS HEALTH NETWORK (AHHN)**

4.2.1 *Key Findings about CCS Needs from AHHN in Evaluation Report 1*

AHHN leadership and providers identified several challenges beneficiaries and their caregivers experienced to access behavioral health care and CCS:

1. **The supply of specialty providers who accept Medicaid is limited**. Few local behavioral health providers accept Medicaid, resulting in significant delays in receiving services. Occupational, speech, physical, and developmental therapies are difficult to access for Medicaid beneficiaries. For example, pediatricians and other providers often refer families to Chicago Public Schools to access therapy services, which can have long wait times.
2. **Most residents in the AHHN attributed region have internet access, but not all have computer literacy.** Having limited computer literacy creates barriers for scheduling appointments through online portals, accessing information to learn about available health or CCS services, or attending virtual visits.
3. **Despite ample transportation options in the area, transit to services remains difficult.** Medicaid transportation is complicated to schedule and confined to certain geographic areas. Public transportation is available but expensive, time-consuming, and inconvenient for families, particularly in bad weather. Providers noted that families often need to travel across the city to access specialty care appointments,

and using public transportation for cross-town trips can be a convoluted and cumbersome process.

4. **Distrust of the service system (including health care, government programs, childcare, and early education) is a barrier to accessing services for many families.** The AHHN attributed region has a high proportion of families who identify as Hispanic, and some of these families include members without documentation of U.S citizenship or legal residency. Families with mixed immigration status are often reluctant to seek services to avoid attracting the attention of the service system to their undocumented family members.

4.2.2   Summary of Factors Shaping AHHN Context

The evaluation team reviewed publicly available data about the CCS policy context in the state of Illinois (IL) and the AHHN attributed region, when possible, and determined AHHN has resources equivalent to national averages in most domains (Exhibit 4.2).

Exhibit 4.2.   Key Contextual Factors in the AHHN Attributed Region Which May Influence InCK Model Design and Implementation.

Contextual Factor	Status in AHHN InCK Attributed Region	AHHN Compared to National Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care. For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out-of-home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	IL = 8%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	IL = 9%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode.	IL = 23%	At or near the U.S. average (20%)[1]
Cash Assistance The Temporary Assistance for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attendance at appointments because one can pay for transportation or gas).[13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean eligible InCK beneficiaries and their families receive more generous benefits. A policy flag for low TANF utilization may indicate a cumbersome application process or other challenges accessing, enrolling in, or receiving TANF. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		

Contextual Factor	Status in AHHN InCK Attributed Region	AHHN Compared to National Benchmarks
Maximum monthly benefits.	IL = $533	Nationally the maximum monthly benefits range from $170 to $1,086.[2] IL is ranked 20th out of all 50 states and DC.
Monthly income limit at application.	IL = $889	The monthly income limit at application ranges from $268 to $2,359.[2] IL is ranked 23rd out of all 50 states and DC.
Utilization among eligible households.	IL = 16%	TANF utilization is lower in IL than it is in other states. The U.S. average is 21%.[3]
Food Assistance The Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and contributes to improved health outcomes.[14,15] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[16] For the InCK Model Attributed Population, the role of the SICs may help improve enrollment and engagement with these programs.		
Maximum monthly SNAP benefits.	IL = $939	IL's maximum monthly SNAP benefits are the same as the US average ($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	IL = 165%	IL's income eligibility for SNAP is higher than federal eligibility guidelines (130% of the Federal Poverty Limit (FPL)).[4]
Percent of eligible individuals receiving SNAP.	IL = 100%	The percent of eligible individuals who receive SNAP in IL is higher than the U.S. average (82%).[5]
Percent of eligible individuals receiving WIC.	IL = 37%	The percent of eligible individuals who receive WIC in IL is lower than the U.S. average (51%).[6]
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. The limited supply of available housing will make it difficult to address housing instability.		
Total homeless population. % unsheltered	3,875 33%	The proportion of homeless individuals who are unsheltered in Chicago is lower than the U.S. average (40%).[7]
Total homeless population under 18. % unsheltered	626 0%	The proportion of homeless individuals under 18 who are unsheltered in Chicago is lower than the U.S. average (10%).[7]
Proportion of occupied Section 8 units.	IL = 86.9%	The proportion of occupied Section 8 units in IL is at or near the U.S. average (84.8%).[8]
Proportion of occupied public housing units.	IL = 66.0%	The proportion of occupied public housing units in IL is lower than the U.S. average (87.4%).[8]

Contextual Factor	Status in AHHN InCK Attributed Region	AHHN Compared to National Benchmarks
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs associated with increased risk for child welfare involvement and OOHP. SICs play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		
Rate of reported instances of child abuse and neglect per 1,000 children[a]	IL = 14.4	IL's rate of reported instances of child abuse and neglect is higher than the U.S. rate (8.4)[9]
Maltreatment type (%): Neglect	IL = 77%	IL's percent of reported instances of maltreatment is at or near the U.S. average (76%).[10]
Maltreatment type (%): Physical abuse	IL = 17%	IL's percent of reported instances of physical abuse is at or near the U.S. average (17%).[10]

Sources:

1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions. https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen
4. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits
5. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (FY2018). Retrieved at http://www.fns.usda.gov/usamap#
6. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5
7. U.S Department of Housing and Urban Development. (2022). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
8. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about
9. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0
10. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:
  a. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a Child Protective Services (CPS) agency that are determined to require a response by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[m]
  b. IL = Illinois; AHHN = All Hands Health Network.

4.2.3 Details on Notable Factors Influencing AHHN Context

This section provides further detail about the behavioral health, cash assistance, food assistance, housing assistance, and child welfare systems within the AHHN attributed region. The section also describes characteristics of the Lead Organization and IL state policies that may enhance or alternatively moderate the impact of the InCK Model.

Behavioral Health

Early identification of behavioral health needs and referral to appropriate treatment services are core components of the InCK Model.[n] Understanding the availability of behavioral health services, prevalence of behavioral health needs, and behavioral health service utilization in InCK Model Attributed Regions helps to evaluate the progress of model implementation and the corresponding impacts of the model.

The AHHN attributed region is a Mental Health Professional Shortage Area (HPSA) for Medicaid enrollees.[18] Not surprisingly, AHHN leadership, providers, resource coordinators, and Partnership Council members reported limited provider supply in the area, which leads to significant unmet behavioral health needs.

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the Earned Income Tax Credit, which is a tax credit provided to employed parents with low household income.[19]

IL's TANF program has an annual total budget of $1.1 billion, which is the 6th highest budget in the country. Only five percent of the budget, however, goes toward providing cash benefits,[20] which is considerably lower than the 2021 national average (23 percent).[20] IL spends the largest proportion of its TANF funding on childcare (47 percent), child welfare (20 percent), and pre-k or Head Start (10 percent).[20]

IL's TANF cash assistance benefits are modest—most features of the cash assistance portion of the program are around the median for the 50 states. IL's maximum monthly benefit limit is $533 (ranked 20th of all 50 states) and the monthly income eligibility limit is $889

---

m   U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

n   InCK Model Notice of Funding Opportunity. View Opportunity | GRANTS.GOV

(ranked 23rd of all 50 states).[21] Additionally, the proportion of families with children living in poverty who receive TANF cash assistance is 16 percent, compared to the national average of 21 percent.[22] This means that 84 percent of IL households experiencing poverty do not receive TANF cash assistance.

Food Assistance

Food insecurity in the AHHN InCK attributed region (10 percent) is lower than the national average (13 percent).[23] Still, beneficiaries, caregivers, and providers in the AHHN InCK attributed region reported experiencing high levels of food insecurity, as discussed in Evaluation Report 1.

SNAP is a means-based federal entitlement program. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food. Maximum monthly benefits are determined by family size. For example, the maximum monthly benefit for a family of three is $766.[25] Some states use state funding to augment SNAP and increase the minimum income eligibility threshold and maximum benefit allotment; thus, program characteristics vary by award recipient state. The maximum monthly benefit for a family of four in IL is $939, on par with the national average.[26]

The SNAP program has a broad reach in IL. In 2018, (the most recent data available at the time of reporting), 100 percent of individuals eligible for SNAP in IL received SNAP benefits, more than the national average (82 percent).[27] Meanwhile only 48 percent of adults eligible for WIC receive benefits in IL, compared to the national average of 51 percent.[28] In IL, slightly more eligible infants (100 percent) receive WIC benefits than the national average (98 percent), but fewer children aged 1 – 4, (33 percent) receive WIC benefits than the national average (45 percent).

Housing Assistance

The AHHN attributed region has a similar proportion of residents experiencing severe housing problems (18 percent)[29] as the national average (17 percent).[30] In the AHHN attributed region, 87 percent of total Section 8 units are occupied; similar to the national occupancy estimate.[31] Meanwhile, only 66 percent of public housing units are occupied compared to a national average of 87 percent.[31]

Additionally, U.S. Department of Housing and Urban Development data show that among the approximately 3,875 people experiencing homelessness in the city of Chicago,[o] roughly

---

[o] Due to data availability constraints, we used the unit of analysis that most closely aligned with the InCK attributed region. In the case of these data, the unit of analysis was the relevant Continuum of Care (CoC). The purpose of these estimates is to give a high-level overview of the extent of homelessness. These data may over or underestimate the reality of homelessness within the attributed ZIP codes.

33 percent are unsheltered.[p,32] Data from 2022 show there were 0 individuals in families[q] who were unsheltered in the city of Chicago. IL designates a sizable portion of its shelter beds (47 percent) to households with children and an additional nine percent to youth.[32]

Child Welfare and Foster Care

The child welfare system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18.[33] All states are responsible for compliance with federal requirements; however, states differ in the way that child welfare services are delivered. Child welfare systems involve a complicated array of agencies and organizations at the national, state, and local levels. States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities. For example, funding can focus on maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children that a child welfare investigation determines are victims of abuse or neglect.[35] Rates vary across and within attributed regions. The 2020 victimization rate per 1,000 children in IL (11.0) was higher than the national average (8.4).[35]

The high victimization rate could include high frequency of reported neglect (77 percent). The federal government defines neglect as the failure of a parent or caregiver to provide needed food, clothing, shelter, medical care or supervision to the degree that a child's health, safety or well-being are threatened.[36] However, the high victimization rate may result from the structure and funding of IL's child welfare program. States use a combination of federal, state, and local funds to finance their child welfare agencies. IL spent a total of $1.2 billion on child welfare in 2020[37] but allocated more federal and state money to children in foster care (described as out of home placement [OOHP] in Exhibit 4.3) and less to prevention efforts.

Exhibit 4.3. IL Child Welfare Agency Spending Differs from National Spending Breakdown (2020).

Child Welfare Spending Category	IL	National
Federal funds[a] spent on Child Protective Services	20%	13%
State funds[b] spent on Child Protective Services	15%	22%
Federal funds spent on OOHP[c]	50%	49%
State funds spent on OOHP	51%	42%

---

[p]   HUD defines unsheltered as living in a place not meant for human habitation. This includes living in cars, parks, sidewalks, abandoned buildings, or on the street.

[q]   HUD defines family as a parent and a child for whom that adult has custody. This could include children (up to age 18). Parents under 18 are also considered families if they are seeking housing with their children.

Source:
1. Child Trends. Child Welfare Agency Spending in Illinois in SFY 2020. Retrieved at: https://cms.childtrends.org/wp-content/uploads/2023/05/Illinois_SFY2020CWFS_ChildTrends_May2023.pdf

Notes:
a. State and local child welfare agency funding comes from several funding streams. Federal spending values indicate child welfare money obtained from federal funding sources.
b. State and local child welfare agency funding comes from several funding streams. State spending values indicate child welfare money obtained from state funding sources.
c. OOHP=Out of Home Placement

A large proportion of money coming into IL's child welfare system (40 percent)[37] is from Title IV-E grants,[r] which can be used for foster care, adoption, guardianship, and support for transition-age youth. The Families First Preventive Services Act of 2018 enables states to get reimbursed from Title IV-E funds for preventive services that are provided to families with children at risk of entering foster care.[37] IL did not have an approved Prevention Plan in 2020, which would have impacted their ability to use federal funds for prevention services. This plan was approved late in 2021, which may shift how IL allocates future funding for preventive services. As of 2020, IL still devoted more resources to child maltreatment outcomes (i.e., OOHP) than prevention.[38]

4.2.4 Lead Organization Characteristics that Enhance Service Accessibility

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care, support implementation, and influence the potential impact of the model locally. Lurie Children's Hospital, the AHHN Lead Organization, is a specialty children's hospital that provides extensive pediatric services to families in the AHHN attributed region. It is a trusted and well-regarded hospital that has made significant efforts to be considered a reliable community resource and medical care provider for the predominately Black and Hispanic neighborhoods within the AHHN attribution region, which have been historically underserved.

4.2.5 IL Policies Facilitating or Hindering Access to Services

Through an environmental scan of peer-reviewed and grey literature, the evaluation team identified additional factors that may impact access to behavioral health services and CCS for individuals and families. The following sections describe policies in IL that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model among InCK attributed populations.

---

r   Title IV-E grants are for the federal Foster Care Program. This funding supports the provision of safe and stable out-of-home care for foster children, until permanent homes through reunification with their family, adoption, or other permanent placements are secured. More information at: https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care

Medicaid Initiatives in Illinois

IL launched Pathways for Success, a Medicaid care coordination program that provides wraparound services for children with significant behavioral health needs in early 2023. As of fall 2022, in preparation for the launch of Pathways to Success, AHHN was finalizing details for how they would coordinate with the Pathways for Success program for children eligible for the InCK Model.

Immigration Policy Context

As reported in [Evaluation Report 1](#), children in families with mixed immigration status face additional barriers to maintaining engagement in services. These families may particularly want to avoid eliciting unwanted attention toward family members residing in the U.S. without documentation. Additionally, many social service programs (e.g., food banks) require identification or a valid address to receive assistance. These requirements make it difficult for undocumented immigrants and individuals who are homeless or transient to receive assistance. Exhibit 4.4 includes estimates from 2019 of the undocumented population and percent of the undocumented population in the counties in the AHHN attributed region. Chicago, where the AHHN attributed region is located, is a sanctuary city, which means municipal laws protect undocumented immigrants from deportation or prosecution despite federal immigration law.[39] This designation may help reduce hesitancy to access needed services among mixed immigration status families. In fall 2022, the city of Chicago saw a notable increase in the number of undocumented immigrants; about 8,000 (including children) arrived in 2022.[40] AHHN leadership and resource coordinators noted an increase in individuals without documentation seeking care at Lurie and asking for help at community events and resource fairs.

Exhibit 4.4. The Undocumented Population in AHHN Attributed Region.[1]

Characteristic	Cook County
Total estimated undocumented population, 2019	257,000
Percent of population that is undocumented, 2019[a]	5.0%

Sources:
1. Migration Policy Institute. (n.d.). *State and County Estimates of Unauthorized Immigrants.* https://www.migrationpolicy.org/sites/default/files/datahub/Unauthorized-Profiles_ACS%202015-19_State-County-Topline-Estimates.xlsx Accessed January 9, 2023.

Notes:
a. Data is according to population as reported by the U.S. Census Bureau in 2019.

4.3 SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **BRONX EQUITY INCK NEW YORK (BE-INCK NY)**

4.3.1 *Key Findings from BE-InCK NY in Evaluation Report 1*

BE-InCK NY leadership, providers, Service Integration Consultants (SICs), Partnership Council members, and caregivers identified several challenges beneficiaries and their caregivers had accessing behavioral health care and CCS:

1. **The number of children's behavioral health providers in the Bronx (where BE-InCK NY operates), particularly child psychiatrists, is insufficient.** Behavioral health needs rose in the InCK Model population during the COVID-19 public health emergency (PHE), and the number of providers available cannot meet demand. Telehealth has helped expand access to behavioral health services, but long wait times and inconsistent access to technology and the internet mean barriers to access 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, medical services were not consistently linked with CCS (e.g. housing, child welfare, and food). Families and providers are often not aware of the breadth of services that exist, let alone eligibility criteria. Families often struggle to understand application processes.

3. **Bronx families face many barriers to access services, including mixed immigration status.** Many CCS programs (e.g., food banks) require identification, which creates access challenges for undocumented immigrants, families with mixed immigration status, and families who are homeless.

4.3.2 Summary of Factors Shaping BE-InCK NY Context

The evaluation team reviewed publicly available data about the CCS policy context in the state of NY and the BE-InCK NY attributed region when possible and determined BE-InCK NY has resources equivalent to national averages in most domains (Exhibit 4.5).

Exhibit 4.5. Key Contextual Factors in the BE-InCK NY Attributed Region Which May Influence InCK Model Design and Implementation

Contextual Factor	Status in BE-InCK NY Attributed Region	BE-InCK NY Compared to Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care . For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out of home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	NY = 9%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	NY = 7%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode.	NY = 20%	At or near the U.S. average (20%)[1]

Contextual Factor	Status in BE-InCK NY Attributed Region	BE-InCK NY Compared to Benchmarks
Cash Assistance The Temporary Assistance Program for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attend appointments because one can pay for transportation or gas).[13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean more InCK beneficiaries and their caregivers qualify. A policy flag for low TANF utilization may indicate a cumbersome application process or other barriers to accessing, enrolling in, or receiving TANF. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly benefits.	NY = $789	Nationally the maximum monthly benefits range from $170 to $1,086.[2] NY is ranked 4th out of all 50 states and DC.
Monthly income limit at application.	NY = $879	The monthly limit at TANF application ranges from $268 to $2,359.[2] NY is ranked 24th out of all 50 states and DC.
Utilization among households experiencing poverty.	NY = 39%	TANF utilization is higher in NY than it is in other states. The U.S. average is 21%.[3]
Food Assistance The Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and contributes to improved health outcomes.[14,15] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[16] For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly SNAP benefits.	NY = $939	NY's maximum monthly SNAP benefits are the same as the U.S average ($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	NY = 150%	NY's income eligibility for SNAP is higher than federal eligibility guidelines (130% FPL).[4]
Percent of eligible individuals receiving SNAP.	NY = 87%	The percent of eligible individuals who receive SNAP in NY is higher than the U.S. average (82%).[5]
Percent of eligible individuals receiving WIC.	NY = 52%	The percent of eligible individuals who receive WIC in NY is at or near the U.S. average (51%).[6]

Contextual Factor	Status in BE-InCK NY Attributed Region	BE-InCK NY Compared to Benchmarks
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. For the InCK Model, positive assessments for housing instability will not be easily addressed due to the lack of available housing.		
Total homeless population. % unsheltered	61,840 6%	The proportion of homeless individuals who are unsheltered in New York City is lower than the U.S. average (40%).[7]
Total homeless population under 18. % unsheltered	16,979 0%	The proportion of homeless individuals under 18 who are unsheltered in NY is lower than the U.S. average (10%).[7]
Proportion of occupied Section 8 units.	NY = 83.1%	The proportion of occupied Section 8 units in New York City is at or near the U.S. average (84.8%).[8]
Proportion of occupied public housing units.	NY = 92.8%	The proportion of occupied public housing units in New York City is higher than the U.S. average (87.4%).[8]
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs that are associated with increased risk for child welfare involvement and OOHP. Service Integration Coordinators (SICs) play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		
Rate of reported instances of child abuse and neglect per 1,000 children.[a]	Bronx County = 22.1	The rate of reported instances of child abuse and neglect in the Bronx is higher than the U.S. rate (8.4)[9]
Maltreatment type (%): Neglect	NY = 96%	NY's percent of reported instances of maltreatment is higher than the U.S. average (76%).[10]
Maltreatment type (%): Physical abuse	NY = 9%	NY's percent of reported instances of physical abuse is lower than the U.S. average (17%).[10]

Sources:
1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions. https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen
4. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits
5. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (FY2018). Retrieved at http://www.fns.usda.gov/usamap#
6. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5

7. U.S Department of Housing and Urban Development. (2023). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
8. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about
9. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0
10. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:
a. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a Child Protective Services (CPS) agency that are determined to require a response by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[s]
b. NY = New York; BE-InCK NY = Bronx Equity Integrated Care for Kids New York.

4.3.3 Details on Notable Factors Influencing BE-InCK NY Context

This section includes further details about the behavioral health service system, reproductive health services, cash assistance, food assistance, housing assistance, and the child welfare system within the BE-InCK NY attributed region. It also describes characteristics of the Lead Organization and policies in the state of NY that may enhance or alternatively moderate the impact of the InCK Model, as well as pose barriers to access medical care and CCS.

Behavioral Health

Identification, early intervention, and referral to behavioral health services is a core component of successful implementation of the InCK Model.[t] Understanding the availability of behavioral health services, prevalence of behavioral health needs, and behavioral health service utilization in InCK Model attributed regions will help the evaluation team understand the progress of model implementation and the corresponding impacts of the model.

Bronx County is designated a mental health HPSA for the Medicaid population. BE-InCK NY leadership, providers, and Partnership Council members identified limited provider supply resulting in significant unmet behavioral health needs. The number of behavioral health providers accepting Medicaid in the BE-InCK NY attributed region is insufficient to serve the attributed population. The lack of behavioral health providers accepting Medicaid may pose challenges for InCK beneficiaries to be connected to needed behavioral health services and timely access to behavioral health treatment.

---

[s] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

[t] InCK Model Notice of Funding Opportunity. View Opportunity | GRANTS.GOV

Reproductive Health Services

BE-InCK NY chose to serve pregnant and postpartum adults 21 years and older as part of their program. For these InCK Model attributed beneficiaries, access to regular, quality reproductive healthcare is critical, including preventive screenings, contraception, prenatal care, maternal fetal medicine, and postpartum care. This is particularly important for individuals who identify as Black, Hispanic, American Indian/Alaskan Native (AIAN), and Native Hawaiian and Other Pacific Islander (NH/PI), given mortality rates are two to three times higher for these groups relative to their White counterparts.[41] Pregnant people who are Black, AIAN, and NH/PI also experience higher rates of preterm birth, low birthweight birth, or births for which they received late or no prenatal care compared to White pregnant people.[42] Several elements are critical to reduce these disparities. Access to culturally competent prenatal and postpartum care is needed to ameliorate healthcare racial bias; establish trust from the prenatal, birthing, and postnatal care team; and support patient-centered pregnancy care. Given the racial and cultural diversity in the BE-InCK NY attributed population, access to timely, culturally competent prenatal care is of particular importance.

The supply of obstetricians/gynecologists and certified nurse midwives in the BE-InCK NY attributed region is high.[u] As of 2021, there were 209 obstetricians/gynecologists and 23 certified nurse midwives[v] who accept Medicaid per 10,000 InCK beneficiaries. Other indicators of access to reproductive health are not as strong. For example, Bronx County is designated a HPSA for primary care for Medicaid eligible populations.[18] Notably, primary care providers are often the source of reproductive health care and early prenatal care.

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the Earned Income Tax Credit, which is a tax credit provided to families with low household income.[19]

NY's TANF program has an annual total budget of $5.3 billion, which is the 2nd highest budget out of all 50 states. Twenty-eight percent of the budget goes toward providing basic assistance (i.e., cash benefits),[20] which is higher than the 2021 national average (23 percent).[20] Despite higher than average cash benefits it is important to note that New York City has a cost of living that is among the highest in the country. Basic assistance comprises

---

u   Numbers reflect the service locations of providers located in the New-York-Newark-Jersey City, NY-NJ-PA (35620) Core Based Statistical Area who accepted New York or New Jersey Medicaid or CHIP-covered patients at any time during 2021. BE-InCK NY and NJ InCK are both located in the New York-Newark-Jersey City, NY-NJ-PA (35620) Core Based Statistical Area.

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

the largest proportion of NY's TANF funding, followed by refundable tax credits (19 percent), state pre-K and Head Start programs (15 percent), and administration (8 percent).[20]

NY's TANF cash assistance benefits are more generous than most states. NY's maximum benefit limit is among the highest (ranked 4th out of all 50 states),[21] and pregnant people are eligible. The monthly income eligibility limit for NY TANF is $879, ranked 24th of all 50 states.[21] Additionally, the proportion of NY residents experiencing poverty who receive TANF cash assistance is 39 percent, much higher than the national rate of 21 percent.[22] This means that 61 percent of NY households experiencing poverty do not receive cash assistance.

Food Assistance

The food insecurity rate in the BE-InCK NY attributed region (18 percent) is higher than the national average (13 percent).[23] Caregivers and providers in the BE-InCK NY attributed region reported observing high rates of food insecurity among the attributed population, as described in [Evaluation Report 1](link).

SNAP is a means-tested federal entitlement program. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food.[25] Maximum monthly benefits are determined by household size. For example, for an individual the maximum monthly benefit is $281. Some states use state funding to augment SNAP and increase the minimum eligibility threshold and maximum benefit allotment, so program characteristics vary by award recipient state. The monthly benefit for a family of four in NY is $939, which is relatively generous compared to other states.[43] The SNAP program has a broad reach. In 2018, 87 percent of individuals eligible for SNAP in NY received SNAP benefits while nationally only 82 percent reported the same.[27] Only 51.5 percent of eligible individuals received WIC benefits. There are notable differences in WIC coverage among eligibility groups. For example, 80 percent of eligible infants receive WIC benefits, but only 41.3 percent of eligible children aged 1-4 receive WIC benefits.[44]

Housing Assistance

New York City has a substantially higher proportion of residents experiencing severe housing problems (31 percent)[29] than the national average (17 percent).[30] Occupancy rates for Section 8 units and public housing units in New York City are similar to national occupancy rates: 83 percent of all Section 8 units and 93 percent of public housing units are occupied compared to a national average of 85 percent and 87 percent, respectively.

Additionally, U.S. Department of Housing and Urban Development data show that among the approximately 61,840 people experiencing homelessness in New York City,[w] only six percent

---

w   Due to data availability constraints, we used the unit of analysis that most closely aligned with the InCK attributed region. In the case of these data, the unit of analysis was the relevant Continuum of Care (CoC). The purpose of these estimates is to give a high-level overview of the extent of

are unsheltered.[x,32] Data from 2022 show there were no unsheltered families[y] and no unsheltered individual under 18 in the New York City attributed region. Compared to most InCK Model states, NY designates a higher proportion of its total shelter bed supply to households with children (57 percent) and a relatively small proportion to unaccompanied youth (two percent), leaving 41 percent of shelter beds for the remaining general population.[32] In New York City, unsheltered individuals—those who are living in places such as cars, parks, or abandoned buildings—represent the smallest proportion of the overall homeless population, which suggests that New York City had a robust emergency shelter system.

Child Welfare and Foster Care

The child welfare system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18;[33] however, definitions of maltreatment and neglect vary by state. NY's child welfare system is administered at the county level, which means that child welfare programs and how they are funded vary across the city's five counties (commonly referred to as boroughs). States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities: for example, maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children for whom a child welfare investigation determines the child is a victim of abuse or neglect.[35] Rates vary across and within attributed regions. The 2020 victimization rate per 1,000 children in Bronx County, which encompasses the BE-InCK NY attributed region, was almost three times higher than the national average (22.1 vs. 8.4).[35]

The relatively high victimization rate could be partly due to how NY state funds and structures its child welfare program. States use a combination of federal, state, and local funds to finance their child welfare agencies. NY spent a total of $33 billion on child welfare in 2018.[45] NY state spends less federal money on child protective services (CPS) and preventive services and more money on children in foster care than the national average (Exhibit 4.6), though state spending shows the opposite pattern.

---

homelessness. These data may over or underestimate the reality of homelessness within the attributed ZIP codes.

[x] HUD defines unsheltered as living in a place not meant for human habitation. This includes living in cars, parks, sidewalks, abandoned buildings or on the street.

[y] HUD defines family as a parent and a child for whom that adult has custody. This could include children (up to age 18). Parents who are under 18 are also considered families if they are seeking housing with their children.

Exhibit 4.6. NY Child Welfare Agency Spending Differs from National Spending (2018)

Child Welfare Spending Category	NY	National
Federal funds[a] spent on Child Protective Services	<1%	12%
State funds[b] spent on Child Protective Services	33%	20%
Federal funds spent on OOHP[c]	66%	48%
State funds spent on OOHP	30%	44%
Federal funds spent on preventive services	1%	13%
State funds spent on preventive services	25%	15%

Source:
1. Child Trends. Child Welfare Agency Spending in New York in SFY 2018. Retrieved at: https://cms.childtrends.org/wp-content/uploads/2021/01/New-York_SFY2018-CWFS_03.03.2021.pdf

Notes:
a. State and local child welfare agency funding comes from several funding streams. Federal spending values indicate child welfare money obtained from federal funding sources.
b. State and local child welfare agency funding comes from several funding streams. State spending values indicate child welfare money obtained from state funding sources.
c. OOHP=Out of home placement

The largest proportion of federal money coming into NY's child welfare system (74 percent)[45] is from Title IV-E grants,[z] which can be used for foster care, adoption, guardianship, and support for transition-age youth. The Families First Preventive Services Act of 2018 enables federal Title IV-E funds to reimburse states for preventive services to avoid foster care placements.[45] NY's prevention plan was not approved until 2022, which may have limited the proportion of funds that the state could spend on preventive services in 2020 (Exhibit 4.6).[46]

4.3.4 Lead Organization Characteristics that Enhance Service Accessibility

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care among their attributed populations, support implementation, and moderate the potential impact of the model locally.

Montefiore Medical System, the BE-InCK NY Lead Organization, is a large hospital system with an array of services for children, including specialty services (e.g., treatment for sickle cell disease) and a large school health program. Sites are embedded throughout the Bronx with an array of services and community connections. The widespread network of services and connections may facilitate linkages for families; help address gaps in social services, including child welfare services; and improve maternal and child health outcomes in the Bronx.

---

z   Title IV-E grants are for the federal Foster Care Program. This funding supports the provision of safe and stable out-of-home care for foster children, until permanent homes through reunification with their family, adoption, or other permanent placements are secured. More information at: https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care

4.3.5 NY Policies Facilitating or Hindering Access to Services

Through an environmental scan of peer-reviewed and grey literature, the evaluation team identified additional factors that may impact access to behavioral health services and CCS for individuals and families. The following sections describe policies in NY that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model.

Medicaid Initiatives in NY

In NY, a number of Medicaid programs potentially overlap with the InCK Model, including:

- Two health homes serving Medicaid beneficiaries: 1) Health Homes Serving Children (HHSC), which NY State Medicaid operates to serve children with complex medical needs, and 2) Health Homes for individuals with intellectual and developmental disabilities (CCO/HH), operated by the NY State Office for People with Developmental Disabilities, and

- Managed care entities that provide care coordination for long-term services and supports and also serve children in the InCK Model Attributed Population.

A beneficiary enrolled in either HHSC or CCO/HH has a code in their Medicaid claims. The BE-InCK NY SICs use these codes to identify InCK Model beneficiaries who are receiving services from either HHSC or CCO/HH. These InCK Model attributed beneficiaries continue to receive care coordination services from the HHSC or CCO/HH program staff rather than the InCK Model SICs.

During the pre-implementation period, BE-InCK NY partnered closely with the HHSC program to determine how enrollment in HHSC would impact InCK Model service integration, as they anticipated overlap between BE-InCK NY and HHSC. Once BE-InCK NY finalizes plans for coordination with HHSC, they plan to initiate similar processes with CCO/HH and the managed care entities.

Eligibility for and enrollment in the HHSC program has no impact on InCK Model eligibility or SIL assignment. Beneficiaries enrolled in HHSC have a HHSC-assigned case manager who serves as the single point of contact. The BE-InCK NY SICs monitor families enrolled in HHSC to ensure they receive needed services, conducting needs assessment annually if the beneficiary is in SIL 2 and every six months if the beneficiary is in SIL 3.

As previously described, local providers and caregivers identified unmet behavioral health needs as a challenge for the BE-InCK NY attributed population. States have used various strategies to address Medicaid behavioral health workforce shortages. In a 2022 survey of state Medicaid officials, NY indicated that they increased fee-for-service rates in fiscal year 2022 or plan to do so in fiscal year 2023 to help attract or retain Medicaid behavioral health professionals.[47]

State Reproductive Health Policies

Access to Doulas

All InCK Model state Medicaid agencies have extended or plan to extend postpartum coverage to 12 months.[aa] Healthcare coverage for birthing people during the postpartum period has the potential to decrease adverse pregnancy-related and associated outcomes, including death.[48,49,50]

A two-generational approach that is person- and family-centered is another core component of the InCK Model. For pregnant and postpartum people and their infants, doulas can provide and advocate for person and family centered care. Doulas provide culturally aligned care and advocate to clinicians and care teams on behalf of the pregnant or birthing person. Doulas have been shown to ameliorate deleterious impacts of racism for many patients of color who report negative experience using the healthcare system.[51] Doulas can provide valuable support to birthing individuals and their families during the early postpartum period, shown to help support well-being and reduce postpartum mood disorders.[52]

NY will begin providing Medicaid coverage of doula services in 2024.[53] There are numerous pilot programs operating in the interim, and advocates continue efforts to expand access to doula care for Black patients and Medicaid enrollees.[53]

Access to Reproductive Health Care

Reproductive health care, such as family planning, is an essential part of health and well-being.[54] After the Supreme Court overturned Roe v. Wade in June 2022, some states explored or implemented various restrictions on reproductive health care. However, NY strengthened policies around reproductive health. In NY, abortion is legal until fetal viability, and state Medicaid covers abortion services.[55] Comprehensive abortion rights legislation has been in place in NY since 2019, and additional protections for abortion providers and helpers was added in 2022.[56] In NY, minors can consent to contraceptive services, and a state-funded program provides minors access to confidential contraceptive care statewide.[57] Ensuring access to high quality reproductive services supports the impact of the model for pregnant persons and their families, especially for people already facing systemic barriers to access such as racism, sexism, homophobia, or poverty.

Immigration Policy Context

As reported in [Evaluation Report 1](link), children in families with mixed immigration status face additional barriers to maintaining engagement in services. These families may particularly want to avoid eliciting unwanted attention toward family members living in the U.S without documentation. Additionally, many social service programs (e.g., food banks) require identification or a valid address to receive assistance. These requirements make it difficult for undocumented immigrants and individuals who are homeless or transient to receive assistance. Exhibit 4.7 includes estimates from 2019 of the undocumented population and percentage of the population that is undocumented in the county in the BE-InCK NY

[aa]   As of March 2023, New York State Department of Health is waiting for CMS approval of its 1115 waiver to extend postpartum Medicaid coverage to 12 months postpartum.

attributed region. Bronx County has one of the largest undocumented populations in the United States. Bronx County is also classified as a sanctuary locality, which is a city, county, or state whose municipal laws protect undocumented immigrants from deportation or prosecution despite federal immigration law.[39]

Exhibit 4.7. The Undocumented Population in BE-InCK NY Attributed Region[1]

Characteristic	Bronx County
Total estimated undocumented population, 2019	115,000
Percent of population that is undocumented, 2019[a]	8.1%

Sources:
1. Migration Policy Institute. (n.d.). *State and County Estimates of Unauthorized Immigrants.* https://www.migrationpolicy.org/sites/default/files/datahub/Unauthorized-Profiles_ACS%202015-19_State-County-Topline-Estimates.xlsx Accessed January 9, 2023.

Notes:
a. Data is according to population as reported by the U.S. Census Bureau in 2019.

4.4   SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **CONNECTICUT (CT) INCK EMBRACE NEW HAVEN**

4.4.1   *Key Findings from CT InCK Embrace New Haven in Evaluation Report 1*

CT InCK Embrace New Haven leadership, members of the Partnership Council, medical and behavioral health providers, parents and caregivers, and community health organizers (CT InCK Embrace New Haven's term for SICs) identified several challenges and common service gaps related to accessing behavioral health care and CCS:

- **Families in the CT InCK Embrace New Haven attributed region have significant CCS needs, and the systems for addressing those needs are siloed.** The fragmentation makes it difficult for families to navigate. The pediatric and adult behavioral health systems are bifurcated, which presents challenges to providing family centered care and sometimes creates service gaps for adolescents as they transition from pediatric to adult providers.

- **Beyond CCS needs, many families in the CT InCK Embrace New Haven attributed region experience both primary and secondary trauma.** Trauma can create an additional need for CCS and simultaneously be a barrier to ongoing service engagement. Partnership Council members and Clifford Beers, the CT InCK Embrace New Haven lead organization, acknowledge deep mistrust of health and social services institutions among New Haven residents given a history of negative interactions and failed short-term interventions.

- **Medical providers in the CT InCK Embrace New Haven attributed region are siloed**, with limited information sharing both among medical providers and between medical providers and CCS organizations. Providers are often not aware that children and families are accessing services, such as supportive therapies in school, unless they

hear directly from the family. Available pediatric behavioral health services in the attributed region are insufficient to address increasing needs.

4.4.2 Summary of Factors Shaping CT InCK Embrace New Haven Context

The evaluation team reviewed publicly available data about the CCS policy context in the state of CT and the CT InCK Embrace New Haven attributed region when possible and determined CT InCK Embrace New Haven has resources equivalent to national averages in most domains (Exhibit 4.8).

Exhibit 4.8. Key Contextual Factors in CT InCK Embrace New Haven Attributed Region Which May Influence InCK Model Design and Implementation

Contextual Factor	Status in CT InCK Embrace New Haven Attributed Region	CT InCK Embrace New Haven Compared to Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care. For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out of home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	CT = 9%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	CT = 7%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode.	CT = 20%	At or near the U.S. average (20%)[1]
Cash Assistance The Temporary Assistance for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attend appointments because one can pay for transportation or gas).[13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean more InCK beneficiaries and their caregivers qualify. A policy flag for low TANF utilization may indicate a cumbersome application process or other barriers to accessing, enrolling in, or receiving in TANF. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly benefits.	CT = $597	Nationally the maximum monthly benefits range from $170 to $1,086.[2] CT is ranked 15th out of all 50 states and DC.

Contextual Factor	Status in CT InCK Embrace New Haven Attributed Region	CT InCK Embrace New Haven Compared to Benchmarks
Monthly income limit at application.	CT = $908	The monthly income limit at application ranges from $268 to $2,359.[2] CT is ranked 21st out of all 50 states and DC.
Utilization among households experiencing poverty.	CT = 22%	TANF utilization in CT is at or near the U.S. average (21%).[3]
Food Assistance Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and improves health outcomes.[14,15] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[15] For the InCK Model Attributed Population, the role of the SICs may help improve enrollment and engagement with these programs.		
Maximum monthly SNAP benefits.	CT = $939	CT's maximum monthly SNAP benefits are the same as the US average ($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	CT = 200%	CT's income eligibility for SNAP is higher than federal eligibility guidelines (130% FPL).[5]
Percent of eligible individuals receiving SNAP.	CT = 92%	The percent of eligible individuals who receive SNAP in CT is higher than the U.S. average (82%).[6]
Percent of eligible individuals receiving WIC.	CT = 46%	The percent of eligible individuals who receive WIC in CT is at or near the U.S. average (51%).[7]
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. For the InCK Model, positive assessments for housing instability will not be easily addressed due to the lack of available housing.		
Total homeless population. % unsheltered	2,327 10%	The proportion of homeless individuals who are unsheltered in CT is lower than the U.S. average (40%).[a,8]
Total homeless population under 18. % unsheltered	440 0%	The proportion of homeless individuals under 18 who are unsheltered in CT is lower than the U.S. average (10%).[a,8]
Proportion of occupied Section 8 units.	CT = 89.7%	The proportion of occupied Section 8 units in CT is higher than the U.S. average (84.8%).[9]
Proportion of occupied public housing units.	CT = 71.6%	The proportion of occupied public housing units in CT is lower than the U.S. average (87.4%).[9]

Contextual Factor	Status in CT InCK Embrace New Haven Attributed Region	CT InCK Embrace New Haven Compared to Benchmarks
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs associated with increased risk for child welfare involvement and OOHP. SICs play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		
Rate of reported instances of child abuse and neglect per 1,000 children[b]	CT = 11.5	CT's rate of reported instances of child abuse and neglect is at or near the U.S. rate (8.4).[10]
Maltreatment type (%): Neglect	CT = 85%	CT's percent of reported instances of maltreatment is higher than the U.S. average (76%).[11]
Maltreatment type (%): Physical abuse	CT = 6%	CT's percent of reported instances of physical abuse is lower than the U.S. average (17%).[11]

Sources:
1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions. https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen
4. CT.gov. SNAP Eligibility. Retrieved at: https://portal.ct.gov/DSS/SNAP/Supplemental-Nutrition-Assistance-Program---SNAP/Eligibility
5. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits
6. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (FY 2018). Retrieved at http://www.fns.usda.gov/usamap#
7. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5
8. U.S Department of Housing and Urban Development. (2023). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
9. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about
10. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0
11. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:
a. The state of Connecticut collects information about homelessness in two regions. The Bridgeport metropolitan area and the rest of the state. This data reflects information about homelessness in the state of CT minus those individuals in the Bridgeport metropolitan area.
b. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a Child Protective Services (CPS) agency that are determined to require

       a response by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[bb]

   c.   CT = Connecticut.

4.4.3 Details on Notable Factors Influencing CT InCK Embrace New Haven Context

This section includes further details about the behavioral health service system, reproductive health services, cash assistance, food assistance, housing assistance, and the child welfare system within the CT InCK Embrace New Haven attributed region. It also describes characteristics of the Lead Organization and Connecticut policies that may enhance or alternatively moderate the impact of the InCK Model, as well as pose barriers to accessing medical care and CCS.

Behavioral Health

The CT InCK Embrace New Haven attributed region is not designated as a Mental Health Professional Shortage Area (HPSA); however, CT InCK leadership, providers, resource coordinators, and Partnership Council members identified significant unmet behavioral health needs that they attribute to limited provider supply, discussed in Evaluation Report 1.

Reproductive Health Services

CT InCK Embrace New Haven chose to serve pregnant and postpartum adults 21 and older as part of their program. For these InCK Model attributed beneficiaries, access to regular, quality reproductive healthcare, including preventive screenings, contraception, prenatal care, maternal fetal medicine, and postpartum care, is critical. This is particularly important for individuals who identify as Black, Hispanic, American Indian/Alaskan Native (AIAN), and Native Hawaiian and Other Pacific Islander (NH/PI), given mortality rates are two to three times higher for these groups relative to their White counterparts.[41] Pregnant people who are Black, AIAN, and Native Hawaiian and Other Pacific Islander also experience higher rates of preterm births, low birthweight births, or births for which they received late or no prenatal care compared to White pregnant people.[42] Several elements are critical to reduce these disparities. Access to culturally competent prenatal and postpartum care is needed to ameliorate healthcare racial bias; establish trust from the prenatal, birth and postnatal care teams; and support patient-centered pregnancy care.

Supply of Reproductive Health Providers

The supply of reproductive healthcare providers who accept Medicaid in the CT InCK Embrace New Haven attributed region is high. Analysis of secondary data identified 392 obstetricians/gynecologists and 120 certified nurse midwives who accept Medicaid in the CT InCK Embrace New Haven attributed region.[58] Many of these providers work at Yale New Haven, but the presence of these providers in the attributed region does not necessarily mean that all pregnant individuals access timely prenatal care. Based on findings reported

---

[bb]   U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

in [Evaluation Report 1](#), residents in the attributed region, particularly Black residents, report mistrust in the provider community.

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the Earned Income Tax Credit, which is a tax credit provided to families with low household income.[19]

CT's TANF program has an annual total budget of $475.9 million, which ranks as the 16th highest budget among all 50 states. Only seven percent of the budget, however, goes toward providing basic assistance (i.e., cash benefits)[20]; considerably lower than the 2021 national average (23 percent).[20] CT spends the largest proportion of its TANF funding on child welfare (15 percent), state pre-K and Head Start programs (14 percent), subsidized childcare (12 percent), and the Earned Income Tax Credit (11 percent).[20]

Most of CT's cash assistance benefits are generous compared to other states, including the cash benefit. For example, while CT's maximum monthly benefit limit for a single-parent with one child is higher than most states (ranked 13th), pregnant people are eligible for TANF,[59] and the monthly income eligibility limit is $908, ranked 21st of all 50 states.[21] The proportion of CT residents experiencing poverty who receive TANF cash assistance is 22 percent, similar to the national rate of 21 percent.[20] This means that 78 percent of CT households experiencing poverty do not receive TANF cash assistance. Additionally, there is a short participation limit in CT's TANF program (21 months) compared to other InCK attributed regions (60 months).[21]

Food Assistance

The food insecurity rate in the CT InCK Embrace New Haven attributed region (12 percent) is similar to the national average (13 percent).[23] Beneficiaries, caregivers, and providers in the CT InCK Embrace New Haven attributed region reported experiencing high rates of food insecurity, as reported in [Evaluation Report 1](#).

SNAP is a means-based federal entitlement program. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food.[25] CT uses state funding to augment SNAP and increase the minimum eligibility threshold and maximum benefit allotment, so for example, the monthly benefit for a family of four in CT is $939, which is generous compared to other states.[60] CT set high asset limits ($4,250) and a high gross monthly income limit to receive benefits, which makes a large number of people eligible for the program.[60] Subsequently, 92 percent of eligible individuals in CT receive SNAP benefits.[27]

Overall, 46 percent of eligible individuals in CT receive WIC benefits. Receipt of WIC services varies by eligibility type. For example, 84 percent of eligible infants receive WIC benefits, but only 36 percent of eligible children aged 1 – 4 receive WIC benefits.

Housing Assistance

The CT InCK Embrace New Haven attributed region has a similar proportion of residents experiencing severe housing problems (19 percent)[29] as the national rate (17 percent).[30] In CT, 89 percent of Section 8 units are occupied, which is similar to national rate (85 percent). Only 71 percent of public housing units are occupied in CT, as compared to 85 percent nationally.[31]

Additionally, U.S. Department of Housing and Urban Development data show that among the approximately 2,327 people experiencing homelessness in the CT,[cc] 10 percent are unsheltered.[dd,32] Data from 2022 show that none of the 692 homeless people in families[ee] and 440 homeless people under 18 are unsheltered.[32] The region designates 42 percent of its total shelter bed supply to households with children and six percent to unaccompanied youth, leaving about half (52 percent) of shelter beds for the remaining general population.[32] CT operates a free and confidential 211 line to connect residents to emergency shelter and other human services.[61] The state also offers legal aid to tenants, such as mediation services, funds for attorney fees, and free access to representation in court to reduce evictions.[62]

Child Welfare and Foster Care

The child welfare system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18;[33] however, definitions of maltreatment and neglect vary by state. While states are required to comply with federal law, they have flexibility in how child welfare services are operationalized and implemented. States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities: for example, maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children for whom a child welfare investigation determines the child is a victim of abuse or neglect.[35] Rates vary across and

---

[cc] Due to data availability constraints, we used the unit of analysis that most closely aligned with the InCK attributed region. In the case of these data, the unit of analysis was the relevant Continuum of Care (CoC). The purpose of these estimates is to give a high-level overview of the extent of homelessness. These data may over or underestimate the reality of homelessness within the attributed ZIP codes. CT reports data about homeless individuals in two regions. One is the Bridgeport metropolitan area, and the other is for the rest of the state. This data reflects the state of CT minus the Bridgeport metropolitan area.

[dd] HUD defines unsheltered as living in a place not meant for human habitation. This includes living in cars, parks, sidewalks, abandoned buildings or on the street.

[ee] HUD defines family as a parent and a child for whom that adult has custody. This could include children (up to age 18). Parents who are under 18 are also considered families if they are seeking housing with their children.

within attributed regions. The 2020 the victimization rate per 1,000 children in CT (11.5) was higher than the national average (8.4).[35]

The relatively high victimization rate could be partly due to how CT funds and structures its child welfare program. Child welfare spending in CT decreased 11 percent from 2010 to 2020, and CT spent a total of $807 million on child welfare in 2020.[63] CT spends more money on children in foster care (described as OOHP in table below) and less money on child protective services (CPS) and adoption and guardianship than the national average (Exhibit 4.9).

Exhibit 4.9. CT Child Welfare Agency State/Local Spending Differs from National Spending Breakdown (2020)

Child Welfare Spending Category	CT	National
State funds[a] spent on OOHP[b]	49%	42%
State funds spent on Child Protective Services	10%	22%
State funds spent on adoption and guardianship	13%	16%
State funds spent on preventive services	17%	16%
State funds spent on services and assistance for older youth	4%	2%

Source:
1. Child Trends. Child Welfare Agency Spending in Connecticut in SFY 2020. Retrieved at: Connecticut_SFY2020CWFS_ChildTrends_May2023.pdf

Notes:
a. Child welfare funding in CT comes from state, local, and federal funding sources. The table shows spending breakdown for state and local funding. Similar breakdowns for federal spending were unavailable.
b. OOHP=Out of home placement

Most of CT's federal child welfare funding comes from TANF (52 percent) and Title IV-E grants (33 percent).[63] Title IV-E grants can be used for foster care, adoption, guardianship, and support for transition-age youth.[ff] The Families First Preventive Services Act of 2018 enables states to get reimbursed from Title IV-E funds for preventive services provided to families with children at risk of entering foster care.[63]

4.4.4 Lead Organization Characteristics that Enhance Service Accessibility

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care among their attributed populations, support implementation, and moderate the potential impact of the model locally. For example, a Lead Organization's relationships with other service providers, reputation in the local community, and provision of specialty services may facilitate access to behavioral health, specialty services, and CCS.

[ff] Title IV-E grants are for the federal Foster Care Program. This funding supports the provision of safe and stable out-of-home care for foster children, until permanent homes through reunification with their family, adoption, or other permanent placements are secured. More information at: https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care

As a community behavioral health organization and mobile crisis intervention provider, Clifford Beers has deep community connections and has worked to build these connections and trust throughout New Haven for decades. This may 1) help engage families who have experienced trauma and systemic oppression from healthcare and social service systems, and 2) facilitate more seamless access to behavioral health services in the CT InCK Embrace New Haven attributed region.

Clifford Beers has been working to improve integration of services for families across multiple health care and community-based institutions over the last few years. In 2016, Clifford Beers was the recipient of a CMS Health Care Innovation Award (WrapAround New Haven) to advance their integration work. CT InCK Embrace New Haven designed their local InCK Model activities to build on previous work to improve family engagement, screening, family-focused care plans, care coordination services, and wellness and social support services to address chronic and toxic stress.

4.4.5 CT Policies Facilitating or Hindering Access to Services

The evaluation team identified additional factors that may impact access to behavioral health services and CCS for individuals and families through an environmental scan of peer-reviewed and grey literature. The following sections describe policies in CT that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model among InCK attributed populations.

Medicaid initiatives

The CT InCK Embrace New Haven Model builds upon the progress and lessons learned through other transformation efforts in CT such as person-centered medical homes, WrapAround New Haven, Family First, and the Center for Medicare and Medicaid Innovation's Accountable Health Communities Model. CT InCK Embrace New Haven Leadership is adopting training materials, tools, and approaches from these previous initiatives, which may enhance local impact.

The CT InCK Embrace New Haven Model aligns with the broader goals of CT Department of Social Services (DSS),[78,u] which oversees Medicaid in the state. These priorities include improving services for pregnant people, children, and youth, and bolstering community-based behavioral health services. For example, CT DSS implemented statewide person-centered medical homes for Medicaid beneficiaries in 2012, which support care coordination and serve 50 percent of CT's Medicaid beneficiaries.

State Reproductive Health Policies

Access to Doulas
In July 2022, CT expanded access to postpartum Medicaid coverage through 12 months postpartum.[64] Healthcare coverage for birthing people during the postpartum period is shown to decrease adverse pregnancy-related and associated outcomes, including death.[65,48,49]

A two-generational approach that is person- and family-centered is a core component of the InCK Model. For pregnant and postpartum people and their infants, care from doulas contributes to more person- and family-centered care. Doulas have been shown to ameliorate deleterious impacts of racism for many patients of color who report negative experience using the healthcare system.[66] Doulas provide valuable support to birthing individuals and their families during the early postpartum period, shown to help support well-being and reduce postpartum mood disorders.[52]

CT is in the process of implementing Medicaid coverage of doula care.[67] CT DSS is also incorporating doula care as part of a bundled payment related to maternity care.[68]

Access to Reproductive Health Care
Access to reproductive health care, such as contraception and abortion care, is an essential part of health and well-being.[54] After the Supreme Court overturned Roe v. Wade in June 2022, some states explored or implemented various restrictions on reproductive health. As of spring 2023, pregnant individuals in CT can seek an abortion up to 24 weeks gestation. CT Medicaid will cover transportation to and from an abortion if needed and the state runs a 24-hour hotline for residents seeking legal assistance related to abortion rights and access.[69] Access to contraception, particularly for minors, is another important component of comprehensive access to reproductive health care. Unless married, CT minors need consent from a parent or guardian to receive contraceptive services.[57]

4.5 SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **NORTH CAROLINA (NC) INCK**

4.5.1 *Key Findings from NC InCK in Evaluation Report 1*

NC InCK leadership, medical and CCS providers, and caregivers identified several challenges beneficiaries and their caregivers had accessing behavioral health care and CCS:

1. **Specific types of providers and services are not reliably available.** The supply of physical health providers is sufficient; however, there are limited Medicaid-enrolled behavioral health and supportive services providers. Rural areas in the state have the fewest resources. Caregivers reported that they frequently cannot access providers who speak Spanish or who provide care in a culturally informed manner.
2. **Children and families sometimes do not or cannot maintain engagement in services.** Primary barriers to long-term engagement for families include the complexity of the system, prohibitive eligibility requirements, and challenging life circumstances.
3. **The system is complex and often overwhelming to navigate.** Accessing CCS 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. Time and transportation are also barriers to accessing services at different locations.

4.5.2 Summary of Factors Shaping NC InCK Context

The evaluation team reviewed publicly available data about the CCS policy context in the state of NC and the NC InCK attributed region when possible and determined NC InCK has resources equivalent to national averages in most domains (Exhibit 4.10).

Exhibit 4.10. Key Contextual Factors in the NC InCK Attributed Region Which May Influence InCK Model Design and Implementation

Contextual Factor	Status in NC InCK Attributed Region	NC InCK Compared to Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care. For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out of home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	NC = 6%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	NC = 6%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode	NC = 18%	At or near the U.S. average (20%)[1]
Cash Assistance The Temporary Assistance for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attending appointments because one can pay for transportation or gas). [13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean more InCK beneficiaries and their caregivers qualify. A policy flag for low TANF utilization may indicate a cumbersome application process or other barriers to accessing, enrolling in, or receiving TANF. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly benefits.	NC = $272	Nationally, the maximum monthly benefits range from $170 to $1,086.[2] NC ranked 45th out of all 50 states and DC.
Monthly income limit at application.	NC = $681	The monthly income limit at application ranges from $268 to $2,359.[2] NC ranked 33rd out of all 50 states and DC.
Utilization among households experiencing poverty.	NC = 5%	TANF utilization is lower in NC than it is in other states. The U.S. average is 21%.[3]

Contextual Factor	Status in NC InCK Attributed Region	NC InCK Compared to Benchmarks
Food Assistance Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women Infants and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and contributes to improved health outcomes.[14,15,16] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[16] For the InCK Model Attributed Population, the role of the SICs may help improve enrollment and engagement with these programs.		
Maximum monthly SNAP benefits.	NC = $939	NC's maximum monthly SNAP benefits are the same as most states ($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	NC = 200%	NC's maximum monthly SNAP benefits are higher than the federal eligibility guidelines (130% FPL).[5]
Percent of eligible individuals receiving SNAP.	NC = 69%	The percent of eligible individuals who receive SNAP in NC is lower than the U.S. average (82%).[6]
Percent of eligible individuals receiving WIC.	NC = 57%	The percent of eligible individuals who receive WIC in NC is at or near the U.S. average (51%).[7]
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. The limited supply of housing will make it difficult for the InCK Model to address housing instability.		
Total homeless population. % unsheltered	Durham and Orange Counties=592[a] Durham and Orange Counties= 29%[a]	The proportion of homeless individuals who are unsheltered in Durham and Orange counties is lower than the U.S. average (40%).[8]
Total homeless population under 18. % unsheltered	Durham and Orange Counties=88[a] Durham and Orange Counties= 23%[a]	The proportion of homeless individuals under 18 who are unsheltered in Durham and Orange counties is higher than the U.S. average (10%).[8]
Proportion of occupied Section 8 units	NC = 87.1%	The proportion of occupied Section 8 units in NC is at or near the U.S. average (84.8%).[9]
Proportion of occupied public housing units.	NC = 87.2%	The proportion of occupied public housing units in NC is lower than the U.S. average (87.4%).[10]
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs that are associated with increased risk for child welfare involvement and OOHP. SICs play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		

Contextual Factor	Status in NC InCK Attributed Region	NC InCK Compared to Benchmarks
Rate of reported instances of child abuse and neglect per 1,000 children.[b]	NC = 10.4	NC's rate of reported instances of child abuse and neglect is higher than the national rates (8.4).[11]
Maltreatment type (%): Neglect	NC = 89%	NC's percent of reported instances of maltreatment is higher than the U.S. average (76%).[12]
Maltreatment type (%): Physical abuse	NC = 5%	NC's percent of reported instances of physical abuse is lower than the US average (17%).[12]

Sources:

1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions. https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen
4. North Carolina Department of Health and Human Services. (n.d.) Food and Nutrition Services (Food Stamps). Retrieved at https://www.ncdhhs.gov/divisions/child-and-family-well-being/food-and-nutrition-services-food-stamps.
5. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits
6. Congressional Research Service, the Supplemental Nutrition Assistance Program (SNAP): Categorical Eligibility. Retrieved at https://crsreports.congress.gov/product/pdf/R/R42054
7. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (FY 2019). Retrieved at http://www.fns.usda.gov/usamap#
8. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5
9. U.S Department of Housing and Urban Development. (2023). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
10. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about
11. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0
12. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:

a. HUD only has data on homelessness from Durham and Orange Counties. Data from Alamance, Granville and Vance are not available.

b. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a Child Protective Services (CPS) agency that are determined to require a response by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[gg]

c. NC = North Carolina

4.5.3 Details on Notable Factors Influencing NC InCK Context

This section includes further details about behavioral health service system, cash assistance, food assistance, housing assistance, and the child welfare system within the NC InCK attributed region. It also describes characteristics of the Lead Organization (Duke University) and NC InCK policies that may enhance or alternatively moderate the impact of the InCK Model, as well as pose barriers to accessing medical care and CCS.

Behavioral Health

Early identification of behavioral health needs and referral to appropriate treatment services are core components of the InCK Model.[hh] Understanding the availability of behavioral health services, prevalence of behavioral health needs, and behavioral health service utilization in InCK Model attributed regions helps to evaluate the progress of model implementation and the corresponding impacts of the model.

The NC InCK attributed region is not designated as a Mental Health HPSA for Medicaid enrollees, but NC InCK leadership, providers, resource coordinators and Partnership Council members identified significant unmet behavioral health needs due to limited provider supply, especially in rural counties, which we highlighted in Evaluation Report 1.

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (i.e., cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the Earned Income Tax Credit, which is a tax credit provided to families with low household income.[19]

NC's TANF program has an annual total budget of $578 million, which is 13th highest among all states. Only six percent of the budget, however, goes toward providing cash benefits;[20] considerably lower than the 2021 national average (23 percent).[20] NC spends the largest proportion of its TANF funding on state childcare programs (38 percent), child welfare programs (26 percent), and state pre-K and Head Start programs (13 percent).[20]

NC TANF cash assistance benefits are less generous than other states. The monthly income eligibility limit for NC TANF is $681; ranked 33rd of all 50 states. The maximum monthly

---

[gg]   U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

[hh]   InCK Model Notice of Funding Opportunity. View Opportunity | GRANTS.GOV

benefit is $272; ranked 45th out of all 50 states. Further, the proportion of people in poverty receiving TANF (5 percent) is much lower than the national average (21 percent).[21]

Food Assistance

The food insecurity rate in the NC InCK attributed region is the same as the national average (13 percent).[23] Still, beneficiaries, caregivers, and providers in the NC InCK attributed region reported experiencing high rates of food insecurity, as reported in Evaluation Report 1.

SNAP is a means-based federal entitlement program for which income primarily determines eligibility. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food. The maximum monthly benefit is determined by household size. For example, the maximum monthly benefit for an individual is $281.[25] Some states use state funding to augment SNAP and increase the minimum eligibility threshold and maximum benefit allotment, so program characteristics vary by award recipient state. The average monthly benefit for households with children in NC is $403.[70] It is not known how many individuals are included in these households; however, the average monthly benefits for households of three to six individuals ranges from $577 to $1,011.[25]

The SNAP program serves a lower proportion of eligible individuals in NC (69 percent) than the national average (87 percent). The WIC program in NC serves 56 percent of eligible individuals, which is higher than the national average of 51 percent. Eligibility varies by eligibility group. For example, 85.5 percent of eligible infants receive WIC benefits while only 47.1 percent of eligible children aged 1 – 4 receive WIC benefits.

Housing Assistance

The NC InCK attributed region has a similar proportion of residents experiencing severe housing problems (14 percent)[29] as the national rate (17 percent).[30] The occupancy rate for Section 8 housing in NC (87 percent) is similar to the national rate (85 percent). Similarly, the occupancy rate of public housing units in NC (85 percent) is similar to the national rate (87 percent).[31]

Additionally, U.S. Department of Housing and Urban Development data show that among the approximately 592 people experiencing homelessness in Durham and Orange counties,[ii] (the largest counties in the NC InCK attributed region), roughly 29 percent are unsheltered.[jj,32] Of all InCK Model states, NC designates the smallest proportion of its total

---

[ii] Due to data availability constraints, we used the unit of analysis that most closely aligned with the InCK attributed region. In the case of these data, the unit of analysis was the relevant Continuum of Care (CoC). The purpose of these estimates is to give a high-level overview of the extent of homelessness. These data may over or underestimate the reality of homelessness within the attributed ZIP codes.

[jj] HUD defines unsheltered as living in a place not meant for human habitation. This includes living in cars, parks, sidewalks, abandoned buildings or on the street.

shelter bed supply to households with children (39 percent) and none are designated for unaccompanied youth. Data from 2022 show that 23 percent of homeless individuals under 18 were unsheltered, [32] but there were no unsheltered families[kk] in Durham and Orange counties.

Child Welfare and Foster Care

The child welfare system involves a complicated array of agencies and organizations at the national, state, and local levels. The system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18;[33] however, definitions of maltreatment and neglect vary by state. NC's child welfare program is state supervised but administered at the county level, which may mean that counties differ in how the program is operationalized and funding is allocated. States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities: for example, maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children for whom a child welfare investigation determines the child is a victim of abuse or neglect.[35] The rate of child abuse and neglect in NC is similar to the national rate. The 2020 victimization rate per 1,000 children in NC was 10.4, close to the national average of 8.4.[35] NC had a similar proportion of child welfare referrals that met the criteria for an investigation or assessment as the national average, 56 percent and 51 percent, respectively. The NC rate of investigation or assessment is identical to the national rate of 40 per 1,000 children.[71] Sixty-two percent of children experiencing maltreatment in NC received post response services, similar to the national average of 58 percent. One notable difference, however, is that the NC victimization rate increased between 2018 and 2022 while the national rate decreased during the same time (Exhibit 4.11). It is unclear why this is the case. NC has been working to implement a new child welfare information sharing system since 2019 and they have encountered significant challenges with implementation which has caused operational barriers to data collection and reporting which may contribute to inconsistencies in data collected.[72]

[kk] HUD defines family as a parent and a child for whom that adult has custody. This could include children (up to age 18). Parents who are under 18 are also considered families if they are seeking housing with their children.

Exhibit 4.11. Rates of Maltreated Children per 1,000 Children Increased between 2018 – 2021 in North Carolina.

Year	NC	National
2018	2.8	9.1
2019	2.4	8.9
2020	9.7	8.4
2021	9.2	8.1

Source:
1. Child Trends. Number and rate of maltreated children. Retrieved at: https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states.

A large proportion of money coming into NC's child welfare system (54 percent)[73] is from Title IV-E grants,[ll] which can be used for foster care, adoption, guardianship, and support for transition-age youth. The Families First Preventive Services Act of 2018 enables states to get reimbursed from Title IV-E funds for preventive services provided to families with children at risk of entering foster care.[73] NC funding focuses more on substance use prevention and treatment (30 percent of funds) and mental health treatment (30 percent of funds) relative to the national averages. They allocate considerably less on caseworker visits and administration than the national average (5 percent and 37 percent, respectively).

4.5.4 *Lead Organization Characteristics that Enhance Service Accessibility*

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care among their attributed populations, support implementation, and influence the potential impact of the model locally. For example, a Lead Organization's relationships with other service providers, reputation in the local community, and provision of specialty services may facilitate access to behavioral health, specialty services, and CCS.

Duke University includes the Duke University School of Medicine, Duke University Health System, and Duke Children's Hospital in Durham, NC. The University of North Carolina at Chapel Hill (UNC) is a key InCK partner. Together, Duke and UNC serve more than 80 percent of the Medicaid/CHIP enrollees in the NC InCK attributed region. Duke Children's Hospital provides healthcare for children from birth to young adulthood. In addition to neonatal and pediatric inpatient units, the hospital provides outpatient care in more than 28 pediatric medical and surgical specialties and primary care at several locations within and surrounding Durham County.

[ll] Title IV-E grants are for the federal Foster Care Program. This funding supports the provision of safe and stable out-of-home care for foster children, until permanent homes through reunification with their family, adoption, or other permanent placements are secured. More information at: https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care

The NC InCK Leadership dedicates substantial time and effort to engaging CCS organizations and regional champions to build community connections related to CCS provision and medical providers not affiliated with Duke or UNC.

4.5.5 NC Policies Facilitating or Hindering Access to Services

Through an environmental scan of peer-reviewed and grey literature, the evaluation team identified additional factors that may impact access to behavioral health services and CCS for individuals and families. The following sections describe policies in NC that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model among InCK attributed populations.

Medicaid Initiatives in NC

NC has a state-wide Medicaid 1115 waiver called the Healthy Opportunities Pilot (HOP), a program that provides evidence-based, non-medical interventions to address housing, food, transportation, and interpersonal safety and toxic stress needs among Medicaid enrollees.[74] The NC InCK attributed region does not currently implement HOP, but opportunities exist for co-learning among state partners engaged in either of the programs and HOP could expand statewide if shown to be effective.

In 2015, NC passed legislation to transition from fee-for-service to managed care, originally planned for November 2019 but delayed until July 2021 to accommodate other priorities during the COVID-19 PHE.[76,77] The NC InCK lead organization designed the NC InCK Model concurrently with this transition, creating opportunities for alignment of key elements and collaboration with essential partners. The NC House of Representatives voted to expand Medicaid to cover low-income adults in March 2023,[75] a change that will take effect in January 2024.

Immigration Policy Context

As reported in Evaluation Report 1, children in families with mixed immigration status face additional barriers to maintaining engagement in services. Families may be concerned about stigma around seeking social services or eliciting unwanted attention toward family members in the U.S. without documentation. Additionally, many social service programs (e.g., food banks) require identification or a valid address to receive assistance. These requirements make it difficult for immigrants and individuals who are experiencing homelessness or transience to receive assistance. Exhibit 4.12 includes estimates from 2019 of the total population that is not documented and the percent of the population that is not documented in NC. Only two counties in the NC InCK attributed region—Durham and Orange—are classified as sanctuary localities.

Exhibit 4.12.The Undocumented Population in the State of NC and Two Counties in the InCK Attributed Region.[1,a,b]

Characteristic	Durham County	Orange County	North Carolina
Total estimated population that is undocumented, 2019	20,000	4,000	296,000
Percent of the population that is undocumented, 2019[a]	6.2%	2.7%	2.8%

Sources:

1. Migration Policy Institute. (n.d.). *State and County Estimates of Unauthorized Immigrants.* https://www.migrationpolicy.org/sites/default/files/datahub/Unauthorized-Profiles_ACS%202015-19_State-County-Topline-Estimates.xlsx. Accessed January 9, 2023.

Notes:

a. Data is according to population as reported by the U.S. Census Bureau in 2019
b. Data not available for Alamance, Granville, or Vance counties.

4.6 SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **NEW JERSEY (NJ) INCK**

4.6.1 *Key Findings from NJ InCK in Evaluation Report 1*

NJ InCK leadership, care integration managers (NJ InCK's term for SICs), and Partnership Council members—including CCS providers—identified several challenges beneficiaries and their caregivers had accessing behavioral health care and CCS:

1. **The number of behavioral health providers in the NJ InCK attributed region is insufficient to meet the demand for services.** Provider enrollment in Medicaid is low, and interviewees agreed that low Medicaid reimbursement rates discourage providers from participating. The COVID-19 PHE increased demand for behavioral health services and created additional barriers to care by extending already lengthy waitlists.

2. **Primary care and medical specialties (beyond behavioral health) are readily available; however, provider coordination is inconsistent, and primary care providers need more support to follow up on all referrals.** There are two children's hospitals in the NJ InCK attributed region; three large primary care practices; four federally qualified health centers; and many small, independent private practices. The number of providers and services is adequate, but caregivers and local providers reported that finding available providers who accept Medicaid is difficult. Additionally, caregivers reported difficulty navigating services from different providers.

3. **There are few bilingual and culturally competent providers, and the population of individuals with limited English proficiency is growing.** Few providers speak Spanish or other non-English languages prevalent among local families. The area needs more culturally competent and representative providers to

ensure beneficiaries receive care that is family-centered and aligned with their goals and priorities for their children.

4. **Service delivery is fragmented and may not be able to meet the needs of many beneficiaries and their families.** NJ's managed behavioral health system (Children's System of Care) and Medicare Managed Care Entities (MCEs) provide care coordination and care management services. However, limited funds, highly specific eligibility criteria, and low beneficiary enrollment in MCE-provided care coordination programs create barriers to accessing needed services.

5. **Transportation is a barrier to services for many beneficiaries.** Medicaid-covered transportation services are sometimes underutilized because families often do not understand how to access Medicaid transportation or find it too cumbersome to use (e.g., long wait times or restrictions on bringing other children). Public transportation in the region is limited, and some families need to travel long distances to obtain care. The geographical location of provider offices is widespread, creating both transportation and time barriers, and negotiating multiple appointments at different locations compounds challenges.

6. **Individuals in the NJ InCK attributed region experience high rates of food insecurity.** Many small stores, restaurants, or other food vendors/establishments where residents can purchase healthy foods closed during the COVID-19 PHE. Community-based organizations and faith-based centers offset some food shortages, but these institutions have been insufficient to fully address the magnitude of needs.

4.6.2   Summary of Factors Shaping NJ InCK Context

The evaluation team reviewed publicly available data about the CCS policy context in the state of NJ and the NJ InCK attributed region when possible and determined NJ InCK has resources equivalent to national averages in most domains (Exhibit 4.13).

Exhibit 4.13. Key Contextual Factors in the NJ InCK Attributed Region Which May Influence InCK Model Design and Implementation

Contextual Factor	Status in NJ InCK Attributed Region	NJ InCK Compared to Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care. For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out of home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	NJ = 7%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	NJ = 7%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode.	NJ = 19%	At or near the U.S. average (20%)[1]

Contextual Factor	Status in NJ InCK Attributed Region	NJ InCK Compared to Benchmarks
Cash Assistance The Temporary Assistance for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attend appointments because one can pay for transportation or gas). [13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean more InCK beneficiaries and their caregivers qualify. A policy flag for low TANF utilization may indicate a cumbersome application process or other barriers to accessing, enrolling in, or receiving TANF. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly benefits.	NJ = $559	Nationally the maximum monthly benefits range from $170 to $1,086.[2] NJ is ranked 18th out of all 50 states and DC.
Monthly income limit at application.	NJ = $838	The monthly income limit at application ranges from $268 to $2,359.[2] NJ is ranked 26th out of all 50 states and DC.
Utilization among households experiencing poverty.	NJ = 16%	TANF utilization is lower in NJ than it is in other states. The U.S. average is 21%.[3]
Food Assistance Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and contributes to improved health outcomes.[14,15] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[16] For the InCK Model Attributed Population, the role of the SICs may help improve enrollment and engagement with these programs.		
Maximum monthly SNAP benefits.[6]	NJ = $835	NJ's maximum monthly SNAP benefits are lower than U.S average($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	NJ = 185%	NJ's income eligibility for SNAP is above the federal eligibility guidelines (130% FPL).[4]
Percent of eligible individuals receiving SNAP.	NJ = 81%	The percent of eligible individuals who receive SNAP in NJ is at or near the U.S. average (82%).[5]
Percent of eligible individuals receiving WIC.	NJ = 49%	The percent of eligible individuals who receive WIC in NJ is at or near the U.S. average (51%).[6]

Contextual Factor	Status in NJ InCK Attributed Region	NJ InCK Compared to Benchmarks
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. The limited supply of housing will make it difficult for the InCK Model to address housing instability.		
Total homeless population. % unsheltered.	Monmouth and Ocean counties=872 Monmouth and Ocean counties=4% unsheltered	The proportion of homeless individuals who are unsheltered in Monmouth and Ocean counties is lower than the U.S. rate (40%).[7]
Total homeless population under 18. % unsheltered.	Monmouth and Ocean counties=250 Monmouth and Ocean counties=0% unsheltered	The proportion of homeless individuals under 18 in Monmouth and Ocean counties who are unsheltered is at or near the U.S. rate (10)%.[7]
Proportion of occupied Section 8 units.	NJ = 87.1%	The proportion of occupied Section 8 units in NJ is at or near the U.S. average (84.8%).[8]
Proportion of occupied public housing units.	NJ = 85.4%	The proportion of occupied public housing units is at or near the U.S. average (87.4%).[8]
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs that are associated with increased risk for child welfare involvement and OOHP. SICs play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		
Rate of reported instances of child abuse and neglect per 1,000 children[a]	Monmouth County= 1.2 Ocean County=1.5	NJ's rate of reported instances of child abuse and neglect is lower than the US rate (8.4).[9]
Maltreatment type (%): Neglect	NJ = 71%	NJ's percent of reported instances of maltreatment is lower than the U.S. average (76%).[10]
Maltreatment type (%): Physical abuse	NJ = 14%	NJ's percent of reported instances of physical abuse is lower than the US average (17%).[10]

Sources:
1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions. https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen
4. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits
5. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (FY 2019). Retrieved at http://www.fns.usda.gov/usamap#

6. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5
7. U.S Department of Housing and Urban Development. (2023). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
8. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about
9. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0
10. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:
a. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a CSP agency that are determined to require a response by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[mm]
b. NJ = New Jersey.

4.6.3 Details on Notable Factors Influencing NJ InCK Context

This section includes further details about behavioral health service system, cash assistance, food assistance, housing assistance, and the child welfare system within the NJ InCK attributed region. This section also describes characteristics of the Lead Organization that may facilitate or hinder successful implementation and ultimately the impact of the model.

Behavioral Health

Early identification of behavioral health needs, and referral to appropriate treatment services are core components of the InCK Model.[nn] Understanding the availability of behavioral health services, prevalence of behavioral health needs, and behavioral health service utilization in InCK Model attributed regions will help understand the implementation and impact of the model.

While the NJ InCK attributed region is not designated as a Mental Health HPSA, NJ InCK leadership, care integration managers, and Partnership Council members identified significant unmet behavioral health needs resulting from limited provider supply, highlighted in Evaluation Report 1.

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (i.e., cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the

---

[mm] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

[nn] InCK Model Notice of Funding Opportunity. https://www.grants.gov/web/grants/view-opportunity.html?oppId=312759

Earned Income Tax Credit, which is a tax credit provided to families with low household income.[19]

NJ's TANF program has an annual total budget of $1.49 billion, which is the 3rd highest TANF budget in the country.[20] Only six percent of the budget, however, goes toward providing basic assistance (i.e., cash benefits)[20], considerably lower than the 2021 national average (23 percent).[20] NJ spends the largest proportion of its TANF funding on state pre-K and Head Start programs (42 percent), Earned Income Tax Credits (28 percent), and subsidized childcare (10 percent).[20]

NJ's TANF cash assistance benefits are mixed in terms of generosity—some features of the TANF program are generous and others are less generous compared to other states. While NJ's maximum benefit limit is higher than most states (ranked 18th), NJ does not extend TANF eligibility to pregnant people, unlike many other states.[78] The monthly income eligibility limit for NJ TANF is $838, ranked 26th nationwide.[21] Although the income eligibility limit is on par with most states, a small proportion of NJ residents experiencing poverty receive TANF cash assistance (16 percent compared to a national rate of 21 percent).[22]

Food Assistance

The food insecurity rate in the NJ InCK attributed region (8 percent) is lower than the national average (13 percent).[23] Still, beneficiaries, caregivers, and providers in the NJ InCK attributed region reported experiencing high rates of food insecurity, as reported in Evaluation Report 1.

SNAP is a means-based federal entitlement program. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food.[25] Some states use state funding to augment SNAP and increase the minimum eligibility threshold and maximum benefit allotment, so program characteristics vary by award recipient state. The monthly benefit for a family of four in NJ is $939, which is relatively generous compared to other states but may not go as far because of NJ's high cost of living.[79]

The program reach for SNAP and WIC in NJ is close to national averages. Eighty-one percent of eligible individuals in NJ receive SNAP as compared to 82 percent nationally. Overall, 49 percent of eligible individuals receive WIC benefits. Receipt of WIC varies by age. For example, 72.7 percent of eligible infants receive WIC benefits, but only 42.1 percent of eligible children aged 1 — 4 receive WIC benefits.

Housing Assistance

The proportion of people experiencing severe housing problems provides insight into the potential need for housing assistance in Monmouth and Ocean counties (the NJ InCK attributed region). The NJ InCK attributed region has a similar proportion of residents experiencing severe housing problems (18 percent)[29] as the national rate (17 percent).[30] In Monmouth and Ocean counties, 87 percent of Section 8 units and 85 percent of public

housing units are occupied, compared to a national averages of 85 percent and 87 percent, respectively.

Additionally, U.S. Department of Housing and Urban Development data show that among the approximately 870 people experiencing homelessness in Monmouth and Ocean counties (the NJ InCK attributed region),[oo] roughly four percent are unsheltered.[pp,32] However, 2022 data show there were no unsheltered families or individuals under 18 in Monmouth and Ocean counties. NJ has a strong support network to ensure youth and families are linked to emergency or temporary housing, which may partly explain why no families[qq] or individuals under 18 are reported to be unsheltered in NJ. NJ designates a large proportion of its total shelter bed supply to households with children (67 percent) and unaccompanied youth (eight percent), leaving only 25 percent of shelter beds for the remaining general population.[32] NJ also operates a free and confidential 211 phone line to connect residents to emergency shelters and other human services.[80] Local organizations in the NJ InCK attributed region operate shelters and transitional housing for targeted populations, including adults with disabilities, victims of domestic violence, and vulnerable youth, such as those who are homeless, runaway, or neglected.

Child Welfare and Foster Care

The child welfare system involves a complicated array of agencies and organizations at the national, state, and local levels. The system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18;[33] however, definitions of maltreatment and neglect vary by state. States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities: for example, maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children for whom a child welfare investigation determines the child is a victim of abuse or neglect.[35] The 2020 victimization rates per 1,000 children in Monmouth (1.5) and Ocean (1.2) counties are lower than the national average (8.4).[35]

[oo] Due to data availability constraints, we used the unit of analysis that most closely aligned with the InCK attributed region. In the case of these data, the unit of analysis was the relevant Continuum of Care (CoC). The purpose of these estimates is to give a high-level overview of the extent of homelessness. These data may over or underestimate the reality of homelessness within the attributed ZIP codes.

[pp] HUD defines unsheltered as living in a place not meant for human habitation. This includes living in cars, parks, sidewalks, abandoned buildings or on the street.

[qq] HUD defines family as a parent and a child for whom that adult has custody. This could include children (up to age 18). Parents who are under 18 are also considered families if they are seeking housing with their children.

The relatively low victimization rate could be partly due to how NJ funds and structures its child welfare program. NJ spent a total of $1.1 billion on child welfare in 2018.[73] NJ spends more money on CPS and less money on children in foster care (captured as OOHP below) than the national average (Exhibit 4.14). The state also noted that there had been a 68% reduction in the number of children entering foster care between 2006 and 2020, likely due to an increased emphasis on prevention.[81]

Exhibit 4.14. NJ Child Welfare Agency Spending Differs from the National Spending Breakdown (2018)

Child Welfare Spending Category	NJ	National
Federal funds[a] spent on Child Protective Services	34%	12%
State funds[b] spent on Child Protective Services	36%	20%
Federal funds spent on OOHP[c]	38%	48%
State funds spent on OOHP	16%	44%
Federal funds spent on parent skill-based programs	51%	43%
State funds spent on parent skill-based programs	63%	37%

Source:
1. Child Trends. Child Welfare Agency Spending in New Jersey in SFY 2018. Retrieved at: https://cms.childtrends.org/wp-content/uploads/2021/01/New-Jersey_SFY2018-CWFS_03.03.2021.pdf

Notes:
a. State and local child welfare agency funding comes from several funding streams. Federal spending values indicate child welfare money obtained from federal funding sources.
b. State and local child welfare agency funding comes from several funding streams. State spending values indicate child welfare money obtained from state funding sources.
c. OOHP = Out of home placement

A large proportion of money coming into NJ's child welfare system (47 percent)[73] is from Title IV-E grants,[rr] which can be used for foster care, adoption, guardianship, and support for transition-age youth. The Families First Preventive Services Act of 2018 enables states to get reimbursed from Title IV-E funds for preventive services provided to families with children at risk of entering foster care.[73] NJ appears to focus more on child maltreatment prevention by virtue of allocating more funds to parent skill-based programs relative to the national average (Exhibit 4.14).

[rr]   Title IV-E grants are for the federal Foster Care Program. This funding supports the provision of safe and stable out-of-home care for foster children, until permanent homes through reunification with their family, adoption, or other permanent placements are secured. More information at: https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care

4.6.4 Lead Organization Characteristics that Enhance Service Accessibility

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care among their attributed populations, support implementation, and influence the potential impact of the model locally. For example, a Lead Organization's relationships with other service providers and their reputation in the local community may facilitate access to behavioral health, specialty services, and CCS.

Hackensack Meridian Health (HMH) is a large regional, integrated health care network in central NJ that includes an array of services for children. HMH is partnering with the Visiting Nurse Association of Central NJ and the NJ Health Care Quality Institute to serve as the Lead Organization. HMH encompasses 17 hospitals, which includes four academic medical centers, two children's hospitals, nine community hospitals, a behavioral health hospital, two rehabilitation hospitals, and 500 other care sites throughout the state.[82] This extensive care network may serve as an asset to HMH in its role as Lead Organization. Providers operating within the same system can easily make referrals, communicate, and share information about beneficiaries with one another. HMH's prominent presence in the attributed region and existing community partnerships have the potential to facilitate connections to services for NJ InCK beneficiaries.

4.6.5 NJ Policies Facilitating or Hindering Access to Services

Through an environmental scan of peer-reviewed and grey literature, the evaluation team identified additional factors that may impact access to behavioral health services and CCS for individuals and families. The following sections describe policies in NJ that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model among InCK attributed populations.

Medicaid Initiatives in NJ

States have used various strategies to address Medicaid behavioral health workforce shortages. In a 2022 survey of state Medicaid officials, NJ indicated that they increased fee-for-service rates in fiscal year 2022 or plan to do so in fiscal year 2023 to help attract and retain Medicaid behavioral health professionals.[47]

Immigration Policy Context

As reported in [Evaluation Report 1](#), children in families with mixed immigration status face additional barriers to maintaining engagement in services. Families may be concerned about stigma around seeking social services or eliciting unwanted attention toward family members in the U.S. without documentation. Additionally, many social service programs (e.g., food banks) require identification or a valid address to receive assistance. These requirements make it difficult for undocumented immigrants and individuals who are homeless or transient to receive assistance. Exhibit 4.15 includes estimates from 2019 of the undocumented population and percent of the undocumented population in the counties in the NJ InCK attributed region. Monmouth and Ocean counties are not classified as sanctuary localities.[39]

Exhibit 4.15. The Undocumented Population in NJ InCK Attributed Region.

Characteristic	Monmouth County	Ocean County
Total estimated undocumented population, 2015-2019[1]	17,000	11,000
Percent of population that is undocumented, 2019[a]	2.7%	1.8%

Sources:

1. Migration Policy Institute. (n.d.). *State and County Estimates of Unauthorized Immigrants.* https://www.migrationpolicy.org/sites/default/files/datahub/Unauthorized-Profiles_ACS%202015-19_State-County-Topline-Estimates.xlsx. Accessed January 9, 2023.

Notes:

a. Data is according to population as reported by the U.S. Census Bureau in 2019.

4.7 SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **OHIO (OH) INCK**

4.7.1 *Key Findings from OH InCK in Evaluation Report 1*

OH InCK leadership, medical and CCS providers, and caregivers identified several challenges beneficiaries and their caregivers had accessing behavioral health care and CCS:

1. **The supply of behavioral health providers in the OH InCK attributed region is limited.** Families often need to travel long distances to access behavioral health care, especially any kind of specialty care, which is burdensome and often unsustainable. Some providers and caregivers reported that emergency departments, juvenile detention centers, or the child welfare system often substitute for needed care.
2. **Social risk factors are prevalent, and significant silos exist between health care and social services.** Housing instability is common in the OH InCK Model attributed region and difficult to address. Providers and caregivers agreed that medical care and CCS is often siloed, which can lead families to "fall through the cracks" while some organizations provide redundant services.
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 care or asking for any kind of help. In some families, a caregiver's own substance use disorders or mental health needs can be a barrier for a child's engagement in care.

4.7.2 *Summary of Factors Shaping OH InCK Context*

The evaluation team reviewed publicly available data about the CCS policy context in the state of OH and the OH InCK attributed region when possible and determined OH InCK has resources equivalent to national averages in most domains (Exhibit 4.16).

Exhibit 4.16. Key Contextual Factors in the OH InCK Attributed Region Which May Influence InCK Model Design and Implementation

Contextual Factor	Status in OH InCK Attributed Region	OH InCK Compared to Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care. For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out of home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	OH = 8%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	OH = 8%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode.	OH = 22%	At or near the U.S. average (20%)[1]
Cash Assistance The Temporary Assistance for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attend appointments because one can pay for transportation or gas). [13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean more InCK beneficiaries and their caregivers qualify. A policy flag for low TANF utilization may indicate a cumbersome application process or other barriers to accessing, enrolling in, or receiving TANF. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly benefits.	OH = $505	Nationally the maximum monthly benefit ranges from $170 to $1,086.[2] OH is ranked 24th out of all 50 states and DC.
Monthly income limit at application.	OH = $905	The monthly income limit at application ranges from $268 to $2,359.[2] OH is ranked 22nd out of all 50 states and DC.
Utilization among households experiencing poverty.	OH = 25%	TANF utilization is higher in OH than it is in other states. The U.S. average is 21%.[3]
Food Assistance Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women Infants and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and contributes to improved health outcomes.[14,15] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[16] For the InCK Model Attributed Population, the role of the SICs may help improve enrollment and engagement with these programs.		

Contextual Factor	Status in OH InCK Attributed Region	OH InCK Compared to Benchmarks
Maximum monthly SNAP benefits.	OH = $680	OH's maximum monthly SNAP benefits are lower than most states ($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	OH = 130%	OH's income eligibility for SNAP is at the federal eligibility guidelines (130% FPL).[4]
Percent of eligible individuals receiving SNAP.	OH = 85%	The percent of eligible individuals who receive SNAP in OH is higher than the U.S. average (82%).[5]
Percent of eligible individuals receiving WIC.	OH = 42%	The percent of eligible individuals who receive WIC in OH is lower than the U.S. average (51%).[6]
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. The limited supply of housing will make it difficult for the InCK Model to address housing instability.		
Total homeless population.	Data unavailable.	Unavailable
Total homeless population under 18.	Data unavailable.	Unavailable
Proportion of occupied Section 8 units.	OH = 83.7%	The proportion of occupied Section 8 units in OH is at or near the U.S. average (84.8%). [7]
Proportion of occupied public housing units.	OH = 98.4%	The proportion of occupied public housing units in OH is higher than the U.S. average (87.4%).[8]
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs that are associated with increased risk for child welfare involvement and OOHP. SICs play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		
Rate of reported instances of child abuse and neglect per 1,000 children[a]	Licking County = 9.7 Muskingum County = 21.9	OH's rates of reported instances of child abuse and neglect are higher than the US rate (8.4).[9]
Maltreatment type (%): Neglect	OH = 44%	OH's percent of reported instances of child neglect is lower than the U.S. average (76%). [10]
Maltreatment type (%): Physical abuse	OH = 48%	OH's percent of reported instances of physical abuse is higher than the U.S. average (17%).[10]

Sources:

1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions.

https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen

4. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits

5. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (2018). Retrieved at http://www.fns.usda.gov/usamap#

6. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5

7. U.S Department of Housing and Urban Development. (2023). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/

8. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about

9. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0

10. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:
a. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a Child Protective Services (CPS) agency that are determined to require a response by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[ss]
b. OH = Ohio; OH InCK = Ohio Integrated Care for Kids.

4.7.3 Details on Notable Factors Influencing OH InCK Context

This section includes further details about behavioral health service system, cash assistance, food assistance, housing assistance, and the child welfare system within the OH InCK attributed region. It also describes characteristics of the Lead Organization and OH policies that may enhance or alternatively moderate the impact of the InCK Model, as well as pose barriers to accessing medical care and CCS.

Behavioral Health

Early identification of behavioral health needs and referral to appropriate treatment services are core components of the InCK Model.[tt] Understanding the availability of behavioral health services, prevalence of behavioral health needs, and behavioral health service utilization in InCK Model attributed regions helps to evaluate the progress of model implementation and the corresponding impacts of the model.

Though the OH InCK attributed region is not designated as a HPSA for mental health, OH InCK leadership, providers, and caregivers identified significant unmet behavioral health needs due to limited provider supply, which we highlighted in Evaluation Report 1. Those

---

[ss] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

[tt] InCK Model Notice of Funding Opportunity. https://www.grants.gov/web/grants/view-opportunity.html?oppId=312759

interviewed attributed provider shortages to the rural nature of the OH InCK attributed region and noted that accessing services often required burdensome travel.

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the Earned Income Tax Credit, which is a tax credit provided to families with low household income.[19]

OH's TANF program has an annual total budget of $1.15 billion, which ranks 5th out of all states. Twenty-one percent of the budget goes toward providing basic assistance (i.e., cash benefits);[20] comparable to the 2021 national average (23 percent).[20] OH also spends a large proportion of its TANF funding on child care (36 percent) and other costs (21 percent).[20]

OH's TANF cash assistance benefits are average in terms of generosity — most features of the TANF program are similar to national averages or trends. OH's maximum benefit limit ranked 24th, and pregnant people are eligible for TANF.[83] The monthly income eligibility limit for OH TANF is $905, ranked 22nd of all 50 states.[21] Additionally, the proportion of OH residents experiencing poverty who receive TANF cash assistance is 25 percent, slightly better than the national rate of 21 percent.[22]

Food Assistance

The food insecurity rate in the OH InCK attributed region (13 percent) is the same as the national average.[23]

SNAP is a means-tested federal entitlement program. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food.[25] Some states use state funding to augment SNAP and increase the minimum eligibility threshold and maximum benefit allotment, so program characteristics vary by award recipient state. The monthly benefit for a family of four in OH is $680, which is much less than national average of $939.[84]

The reach of SNAP and WIC in OH are overall lower than national averages. Eighty-five percent of eligible individuals in OH receive SNAP benefits which is similar to the national average (82 percent). Forty-two percent of eligible individuals receive WIC in OH which is lower than the national average (51 percent). Receipt of WIC services varies by eligibility group. For example, 97.2 percent of eligible infants receive WIC services in OH, while only 26.8 percent of eligible children aged 1 – 4 receive WIC services.

Housing Assistance

The OH InCK attributed region has a lower proportion of residents experiencing severe housing problems (11 percent in Licking county and 13 percent in Muskingum county)[29] than the national rate (18 percent).[30] The occupancy rate for Section 8 units in the OH InCK attributed region is similar to the national occupancy rate, but the occupancy rate for public housing units is higher compared with the national rate. In the OH InCK attributed region,

84 percent of total Section 8 units are occupied compared to a national average of 85 percent; however, 98 percent of public housing units are occupied compared to 87 percent nationally.[31] Providers and frontline staff reported that housing instability was a common challenge in their area.

Data on people experiencing homelessness was not available for the OH InCK attributed region.

Child Welfare and Foster Care

The child welfare system involves a complicated array of agencies and organizations at the national, state, and local levels. The system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18;[33] however, definitions of maltreatment and neglect vary by state. OH administers its child welfare system at the county level, suggesting service operations and funding allocations may vary by county. States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities: for example, maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children for whom a child welfare investigation determines the child is a victim of abuse or neglect.[35] Rates vary across and within attributed regions. OH is ranked 5th in the number of children served by their child welfare system.[85] The 2020 victimization rate per 1,000 children in OH InCK attributed region counties was higher than the national average at 9.7 (Licking County) and 21.9 (Muskingum County) compared to a national average rate of 8.4.[35]

The high victimization rate could be due to the size of their child welfare program and how OH funds and structures its child welfare program. Overall, OH spent a total of $1.3 billion on child welfare in 2018.[86] OH spends more money on CPS and less money on prevention than the national average (Exhibit 4.17). Data submitted by the state shows that OH is using grant funds on preventive services,[87] so they may not need to rely on federal funds for prevention.

Exhibit 4.17. OH Child Welfare Agency Spending Breakdown Differs from National Spending (2018)

Child Welfare Spending Category	OH	National
Federal funds[a] spent on Child Protective Services	24%	12%
State funds[b] spent on Child Protective Services	33%	20%
Federal funds spent on OOHP[c]	41%	48%
State funds spent on OOHP	49%	44%
Federal funds spent on preventive services	3%	13%
State funds spent on preventive services	2%	15%

Source:
1. Child Trends. Child Welfare Agency Spending in Ohio in SFY 2018. Retrieved at: https://cms.childtrends.org/wp-content/uploads/2021/01/Ohio_SFY2018-CWFS_03.03.2021.pdf

Notes:
   a.   State and local child welfare agency funding comes from several funding streams. Federal spending values indicate child welfare money obtained from federal funding sources.
   b.   State and local child welfare agency funding comes from several funding streams. State spending values indicate child welfare money obtained from state funding sources.
   c.   OOHP=Out of home placement

A large proportion of money coming into OH's child welfare system (83 percent)[86] is from Title IV-E grants,[uu] which can be used for foster care, adoption, guardianship, and support for transition-age youth. The Families First Preventive Services Act of 2018 enables states to get reimbursed from Title IV-E funds for preventive services provided to families with children at risk of entering foster care.[86]

4.7.4 Lead Organization Characteristics that Enhance Service Accessibility

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care among their attributed populations, support implementation, and influence the potential impact of the model locally. For example, a Lead Organization's relationships with other service providers, reputation in the local community, and provision of specialty services may facilitate access to behavioral health, specialty services, and CCS.

Nationwide Children's Hospital is a specialty children's hospital that provides extensive pediatric services to families around Columbus and extending throughout the OH InCK attributed region in rural counties to the east of Columbus. Nationwide Children's Hospital includes pediatric specialty care for OH and neighboring states. The Partners for Kids pediatric accountable care organization may increase access to pediatric services for families in the attributed region.

4.7.5 OH Policies Facilitating or Hindering Access to Services

Through an environmental scan, the evaluation team identified additional factors that may impact access to behavioral health services and CCS for individuals and families. The following sections describe policies in OH that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model among InCK attributed populations.

Medicaid Initiatives in OH

All Medicaid beneficiaries in OH are enrolled in one of five MCEs. OH InCK expects that each of those managed care entities has its own care coordination program that may be serving OH InCK attributed beneficiaries. OH InCK will likely need to coordinate with these programs to determine a single point of contact. OhioRISE (Resilience through Integrated Systems

---

[uu]   Title IV-E grants are for the federal Foster Care Program. This funding supports the provision of safe and stable out-of-home care for foster children, until permanent homes through reunification with their family, adoption, or other permanent placements are secured. More information at: https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care

and Excellence) is a statewide program which provides wraparound services for youth with complex behavioral health needs. Staff from OhioRISE will serve as the single point of contact for OH InCK children assigned to either SIL 2 or SIL 3 who are also in OhioRISE.

As described earlier, timely identification, intervention, and referral to behavioral health services are integral to the successful implementation of the InCK Model. While the OH InCK attributed region is not designated as a HPSA for mental health, OH InCK leadership, providers, and caregivers reported that limited provider supply in the region leads to unmet behavioral health needs.

States have used various strategies to address Medicaid behavioral health workforce shortages. In a 2022 survey of state Medicaid officials, OH indicated that they increased fee-for-service rates in fiscal year 2022 or would do so in fiscal year 2023 to help attract or retain Medicaid behavioral health professionals.[47] Although Medicaid MCEs are prominent in all InCK Model states except CT, states require their MCEs to relay fee increases to behavioral health providers to reduce workforce shortages and ensure adequate provider networks.[47]

4.8 SERVICE AVAILABILITY AND CORE CHILD SERVICES CONTEXT SPOTLIGHT: **VILLAGE INCK**

4.8.1 *Key Findings from Village InCK in Evaluation Report 1*

Village InCK leadership, medical and CCS providers, and caregivers identified several challenges beneficiaries and their caregivers had accessing behavioral health care and CCS:

- **Southern IL's rural counties have limited access to public transportation and the internet, which limits health care access.** The Village InCK attributed region is geographically large and isolated, with limited infrastructure. 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.

- **The area lacks specialists, especially dentists and behavioral health providers, who accept Medicaid.** Individuals often travel hours and across state lines to access specialty care in person. For example, some caregivers described driving to St. Louis, Missouri to seek specialty care for their children. Demand for the limited supply of behavioral health providers increased during the ongoing COVID-19 PHE, leading some primary care providers to practice behavioral health services beyond their usual scope.

- **Stigma and caregiver substance use disorder (SUD) may prevent children and families from receiving behavioral health services.** Despite recent efforts to reduce stigma, patients (including Lesbian Gay Bisexual Transexual and Queer (LGBTQ+) youth) are still hesitant to seek behavioral health services. This is in part due to the rural nature of the community. Caregivers reported not wanting to be seen by neighbors

at the clinic where behavioral health services are offered. There are high rates of opioid use and other substance use in the Village InCK attributed region. Children with behavioral health needs may not receive services if their caregivers' own substance use disorder and related health concerns take precedence.

4.8.2 Summary of Factors Shaping Village InCK Context

The evaluation team reviewed publicly available data about the CCS policy context in the state of IL and the Village InCK attributed region when possible and determined Village InCK has resources equivalent to national averages in most domains (Exhibit 4.18).

Exhibit 4.18. Key Contextual Factors in Village InCK Attributed Region Which May Influence InCK Model Design and Implementation

Contextual Factor	Status in Village InCK Attributed Region	Village InCK Compared to Benchmarks
Behavioral Health High behavioral health needs coupled with an inadequate supply of mental health providers accepting Medicaid patients create barriers to appropriate and timely mental health care. For the InCK Model, inadequate or untimely care may increase preventable psychiatric inpatient stays and behavior health related out of home placements (OOHPs).		
Proportion of 12-17-year-olds reporting illicit drug use in the past month.	IL = 8%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting alcohol use in the past month.	IL = 9%	At or near the U.S. average (7%)[1]
Proportion of 12-17-year-olds reporting having a major depressive episode.	IL = 23%	At or near the U.S. average (20%)[1]
Cash Assistance The Temporary Assistance for Needy Families (TANF) program is a federal program to promote financial stability and economic security for families experiencing financial hardship. Receipt of cash assistance may improve economic security that then leads to improved health outcomes (e.g., attend appointments because one can pay for transportation or gas).[13] States have flexibility in how they design and implement program benefits. States with more generous TANF benefits (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) may mean more InCK beneficiaries and their caregivers qualify. A policy flag for low TANF utilization may indicate a cumbersome application process or other barriers to accessing, enrolling in, or receiving TANF benefits. For the InCK Model Attributed Population, cash assistance programs may be a valuable tool to address CCS needs.		
Maximum monthly benefits.	IL = $533	Nationally the maximum monthly benefits range from $170 to $1,086.[2] IL is ranked 20th out of all 50 states and DC.
Monthly income limit at application.	IL = $889	The monthly income limit at application ranges from $268 to $2,359.[2] IL is ranked 23rd out of all 50 states and DC.

Contextual Factor	Status in Village InCK Attributed Region	Village InCK Compared to Benchmarks
Utilization among households experiencing poverty.	IL = 16%	TANF utilization is lower in IL than it is in other states. The U.S. average is 21%.[3]
Food Assistance Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are the two largest federally funded food assistance programs. Receipt of SNAP and WIC reduces food insecurity and contributes to improved health outcomes.[14,15] States have flexibility in the design and administration of both programs. States with more generous SNAP and WIC programs (i.e., higher monthly income eligibility limits and higher maximum monthly benefits) mean more InCK beneficiaries and their caregivers qualify for SNAP assistance or have better benefits. A policy flag for lower proportions of eligible individuals receiving SNAP and WIC may indicate barriers to accessing benefits, such as lack of streamlined enrollment for Medicaid and WIC, or WIC and SNAP.[16] For the InCK Model Attributed Population, the role of the SICs may help improve enrollment and engagement with these programs.		
Maximum monthly SNAP benefits.	IL = $939	IL's maximum monthly SNAP benefits are the same as U.S average ($939).[4]
Gross monthly income eligibility requirement as a percentage of the national poverty rate.	IL = 165%	IL's income eligibility for SNAP is higher than federal eligibility guidelines (130% FPL).[4]
Percent of eligible individuals receiving SNAP.	IL = 100%	The percent of eligible individuals who receive SNAP in IL is higher than the U.S. average (82%).[5]
Percent of eligible individuals receiving WIC.	IL = 37%	The percent of eligible individuals who receive WIC in IL is lower than the U.S. average (51%).[6]
Housing Assistance Affordable housing has been cited as a common CCS need across award recipients. The number of people experiencing homelessness, coupled with the supply of subsidized and public housing units, provides insight into the potential availability of housing for InCK beneficiaries in need. The limited supply of housing will mean it is difficult for the InCK Model to address housing instability.		
Total homeless population. % unsheltered	248 14%	The proportion of homeless individuals who are unsheltered in southern IL is lower than the U.S. average (40%).[7]
Total homeless population under 18. % unsheltered	67 4% unsheltered	The proportion of homeless individuals under 18 who are unsheltered in southern IL is lower than the U.S. average (10%).[7]
Proportion of occupied Section 8 units.	Village InCK attributed region = 50.5%	The proportion of occupied Section 8 units in the Village InCK attributed region is lower than the U.S. average (84.8%).[8]
Proportion of occupied public housing units.	Village InCK attributed region = 92.6%	The proportion of occupied public housing units in the Village InCK attributed region is above the U.S. average (87.4%).[8]

Contextual Factor	Status in Village InCK Attributed Region	Village InCK Compared to Benchmarks
Child Welfare and Foster Care Being in the child welfare system increases a child's risk for OOHP and poor health outcomes, which may also increase needs for CCS and service coordination. Through the needs assessment process, the InCK Model may identify CCS needs that are associated with increased risk for child welfare involvement and OOHP. SICs play a role in facilitating access to and coordination with CCS providers, which may result in a family being able to stay together.[17] SICs may improve care coordination for children in the child welfare system.		
Rate of reported instances of child abuse and neglect per 1,000 children[a]	Village InCK attributed region ranges from 25 to 39	The range of rates of reported instances of child abuse and neglect in Village InCK's attributed region are higher than the US rate (8.4).[9]
Maltreatment type (%): Neglect	IL = 77%	IL's percent of reported instances of maltreatment is at or near the US average (76%).[10]
Maltreatment type (%): Physical abuse	IL = 17%	IL's percent of reported instances of physical abuse is at or near the U.S. average (17%).[10]

Sources:
1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. https://www.samhsa.gov/data/report/2021-nsduh-state-specific-tables
2. Knowles, S., Dehry, I., Shantz, K., and Minton, S. (January 2022). Graphical Overview of State TANF Policies as of July 2020. Retrieved at https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf
3. Shrivastava, A. and Thompson, G.A. (February 18, 2022). TANF Cash Assistance Should Reach Millions More Families to Lessen Hardship: Access to TANF Hits Lowest Point Amid Precarious Economic Conditions. https://www.cbpp.org/research/family-income-support/tanf-cash-assistance-should-reach-millions-more-families-to-lessen
4. Center on Budget and Policy Priorities. (2023). A Quick Guide to SNAP Eligibility and Benefits. Retrieved at: https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits
5. United States Department of Agriculture Food and Nutrition Services. (n.d.) SNAP Participation Rates by State, All Eligible People (FY2019). Retrieved at http://www.fns.usda.gov/usamap#
6. United States Department of Agriculture, Food and Nutrition Services. (2022) WIC 2019 Eligibility and Coverage Rates. Retrieved at: www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5
7. U.S Department of Housing and Urban Development. (2023). PIT and HIC Data Since 2007-2022 Point-in-Time Estimates by State. Retrieved at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
8. U.S Department of Housing and Urban Development. Office of Policy Development and Research. 2022 Public Housing Authorities Dataset. Retrieved at: https://hudgis-hud.opendata.arcgis.com/datasets/HUD::public-housing-authorities/about
9. Children's Bureau – Data Analytics and Reporting Team. (2022, November 7). Victimization and Child Abuse and Neglect FY 2020. ArcGIS StoryMaps. Retrieved at: https://storymaps.arcgis.com/stories/46631a5276e54f6fa1763e222e4feed0
10. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Retrieved at: https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Notes:
a. Data are from the National Child Abuse and Neglect Data System (NCANDS), which captures all instances of child abuse and neglect received by a Child Protective Services (CPS) agency that are determined to require a response

by CPS. Responses are either an investigation or an alternative response, which do not determine if a child was maltreated but focus on the needs of the family.[vv]

b. IL = Illinois

4.8.3 Details on Notable Factors Influencing Village InCK Context

This section includes further details about behavioral health service system, cash assistance, food assistance, housing assistance, and the child welfare system within the Village InCK attributed region. It also describes characteristics of the Lead Organization and IL policies that may enhance or alternatively moderate the impact of the InCK Model, as well as pose barriers to accessing medical care and CCS.

Behavioral Health

Early identification of behavioral health needs and referral to appropriate treatment services are core components of the InCK Model.[ww] Understanding the availability of behavioral health services, prevalence of behavioral health needs, and behavioral health service utilization in InCK Model attributed regions helps to evaluate the progress of model implementation and the corresponding impacts of the model.

The Village InCK attributed region is a Mental Health HPSA for Medicaid enrollees. Village InCK leadership, providers, caregivers, SICs, and Partnership Council members identified significant unmet behavioral health needs resulting from both limited provider supply and stigma that families in the area associate with accessing behavioral health, which was reported in [Evaluation Report 1](#).

Cash Assistance

States use funding from TANF block grants to pay for a range of services and programs, including basic (i.e., cash) assistance for participating families, subsidized childcare, state-funded pre-kindergarten (pre-K) programs, child welfare support, and state add-ons to the Earned Income Tax Credit, which is a tax credit provided to families with low household income.[19]

IL's TANF program has an annual total budget of $1.1 billion, which is the 6th highest budget in the country. Only five percent of the budget, however, goes toward providing basic assistance (i.e., cash benefits);[20] considerably lower than the 2021 national average (23 percent).[20] IL spends the largest proportion of its TANF funding on childcare (47 percent), child welfare (20 percent), and pre-k and Head Start (10 percent).[20]

Most benefits in IL's TANF program are around the national Average. IL's maximum monthly benefit limit is $533 (ranked 20th of all 50 states) and the monthly income eligibility limit

---

[vv] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

[ww] InCK Model Notice of Funding Opportunity. https://www.grants.gov/web/grants/view-opportunity.html?oppId=312759

for IL TANF is $889 (ranked 23rd of all 50 states).[21] Additionally, the proportion of IL residents experiencing poverty who receive TANF cash assistance is only 16 percent, while the national rate is 21 percent.[22] This means that 84 percent of eligible IL households do not receive TANF cash assistance.

Food Assistance

The food insecurity rate in the Village InCK attributed region (14 percent) is similar to the national average (13 percent).[23] Beneficiaries, caregivers, and providers in the Village InCK attributed region reported experiencing high rates of food insecurity, as reported in Evaluation Report 1.

SNAP is a means-tested federal entitlement program. Individuals and households with monthly earnings less than 130 percent of the federal poverty level ($3,007 for a family of four in 2022) are eligible for SNAP.[24] SNAP provides individuals who qualify with a minimum monthly benefit of $23 per month to buy food.[25] Some states use state funding to augment SNAP and increase the minimum eligibility threshold and maximum benefit allotment, so program characteristics vary by award recipient state. The monthly benefit for a family of four in IL is $939, which is relatively generous compared to other states.[26]

Federally funded food assistance programs in IL have vastly different participation rates. 100 percent of families eligible for SNAP in IL receive SNAP benefits, which is higher than the national average (82 percent), while only 37 percent of individuals eligible for WIC receive benefits, which is lower than the national average (51 percent). Receipt of WIC services varies by eligibility group. For example, 77.5 percent of eligible infants receive WIC services but only 26.1 percent of eligible children aged 1 – 4 receive WIC services.

Housing Assistance

Only 10 percent of residents in the Village InCK attributed region reported experiencing severe housing problems[29] far lower than the national rate (17 percent).[30] However, as noted in Evaluation Report 1, providers in Village InCK reported that the region has limited resources to address housing concerns. Approximately 50 percent of the Section 8 units in the region are occupied and 93 percent of public housing units are occupied. Nationally, 85 percent of Section 8 units are occupied and 87 percent of public housing units more broadly.[31]

Additionally, U.S. Department of Housing and Urban Development data show that there are approximately 248 people experiencing homelessness in Southern IL,[xx] less than 10 percent of whom under the age of eighteen. Almost 14 percent of those experiencing homelessness

---

[xx] Due to data availability constraints, we used the unit of analysis that most closely aligned with the InCK attributed region. In the case of these data, the unit of analysis was the relevant Continuum of Care (CoC). The purpose of these estimates is to give a high-level overview of the extent of homelessness. These data may over or underestimate the reality of homelessness within the attributed ZIP codes.

are unsheltered.[yy,32] IL designates 50 percent of the state's total shelter beds for households with children.[32]

Child Welfare and Foster Care

The child welfare system involves a complicated array of agencies and organizations at the national, state, and local levels. The system aims to prevent child maltreatment, broadly defined as abuse or neglect by primary caregivers toward people under the age of 18;[33] however, definitions of maltreatment and neglect vary by state. States have flexibility in how they operate and implement their child welfare programs. States receive federal funding to support child welfare activities, including reporting, investigation, and case management. The federal government also funds public and private agencies to support child welfare system activities: for example, maltreatment prevention, researching effective strategies to address child maltreatment, and providing technical assistance.[34]

The victimization rate refers to the number of children for whom a child welfare investigation determines the child is a victim of abuse or neglect.[35] Rates vary across and within attributed regions. The 2020 victimization rates per 1,000 children in the Village InCK attributed region counties (Gallatin, Hamilton, Saline, Wayne, and White) was considerably higher than the national average. The rates in these counties ranged from 26.9 (Wayne County) to 38.5 (Gallatin County) compared to a national average rate of 8.4.[35]

The high victimization rate could be partly due to the higher levels of neglect reported (77%), which is a type of maltreatment related to poverty. It also could be due to how IL funds and structures its child welfare program. IL spent a total of $1.2 billion on child welfare in 2020.[37] IL spends more money on children in foster care (described as OOHP in the exhibit below) than the national average and less money on prevention efforts including CPS (Exhibit 4.19).

Exhibit 4.19. IL Child Welfare Agency Spending Breakdown Differs from National Spending (2020)

Child Welfare Spending Category	IL	National
Federal funds[a] spent on Child Protective Services	20%	13%
State funds[b] spent on Child Protective Services	15%	22%
Federal funds spent on OOHP[c]	50%	49%
State funds spent on OOHP	51%	42%

Source:
1. Child Trends. Child Welfare Agency Spending in Illinois in SFY 2020. Retrieved at: https://cms.childtrends.org/wp-content/uploads/2023/05/Illinois_SFY2020CWFS_ChildTrends_May2023.pdf

Notes:
a. State and local child welfare agency funding comes from several funding streams. Federal spending values indicate child welfare money obtained from federal funding sources.

---

yy   HUD defines unsheltered as living in a place not meant for human habitation. This includes living in cars, parks, sidewalks, abandoned buildings or on the street.

> b. State and local child welfare agency funding comes from several funding streams. State spending values indicate child welfare money obtained from state funding sources.
>
> c. OOHP=Out of home placement

A large proportion of money coming into IL's child welfare system (40 percent) is from Title IV-E grants, which can be used for foster care, adoption, guardianship, and support for transition-age youth. The Families First Preventive Services Act of 2018 enables states to get reimbursed from Title IV-E funds for preventive services provided to families with children at risk of entering foster care. IL appears to focus more on child maltreatment outcomes than prevention by virtue of allocating more funds to OOHP than to other preventative areas.

4.8.4 Lead Organization Characteristics that Enhance Service Accessibility

Each InCK Model Lead Organization has unique characteristics that may facilitate access to care among their attributed populations, support implementation, and influence the potential impact of the model locally. For example, a Lead Organization's relationships with other service providers, reputation in the local community, and provision of specialty services may facilitate access to behavioral health, specialty services, and CCS.

Egyptian Health Department is a public health department and behavioral health provider in the Southern IL region. Through this role it has developed strong pre-existing relationships with medical and CCS providers in the community that may be advantageous to improving care coordination in a rural geographic region.

4.8.5 IL Policies Facilitating or Hindering Access to Services

Through an environmental scan of peer-reviewed and grey literature, the evaluation team identified additional factors that may impact access to behavioral health services and CCS. The following sections describe policies in IL that may facilitate or hinder service accessibility and enhance or impede the potential impact of the model among InCK attributed populations.

Medicaid Initiatives in IL

IL launched a Medicaid care coordination program in January 2023 called Pathways for Success. The program provides care coordination and wraparound services for Medicaid eligible children with significant behavioral health needs. As of late 2022, Village InCK was preparing to participate in the Pathways for Success program as a care coordination services provider. Additionally, EHD was preparing to launch the Integrated Care for Adults (InCA) program, an InCK counterpart for adults aged 21 and over in January 2023. InCA covers the same five-county attributed region as Village InCK and is available for all Medicaid beneficiaries in the attributed region, including beneficiaries who age out of the InCK Model but still qualify for Medicaid. EHD is uncertain about the timeline for integration of InCA with Village InCK.

4.9 CONCLUSION

Award recipients are implementing the InCK Model in complex and diverse environments. Policy contexts have influenced local model design and will likely shape future amendments to model design. Furthermore, the contextual factors presented in this chapter have the potential to influence model implementation and potentially affect the InCK Model impacts. For example, the availability of behavioral health, specialty physical health care, and CCS providers will influence the extent to which award recipients are able to make successful referrals to address attributed beneficiaries' needs. Local policies – including eligibility for and administration of CCS programs, as well as Medicaid and immigration policies – may influence the extent to which award recipients can address beneficiaries' identified needs. The resource and policy contexts of InCK regions will evolve concurrently with the model.
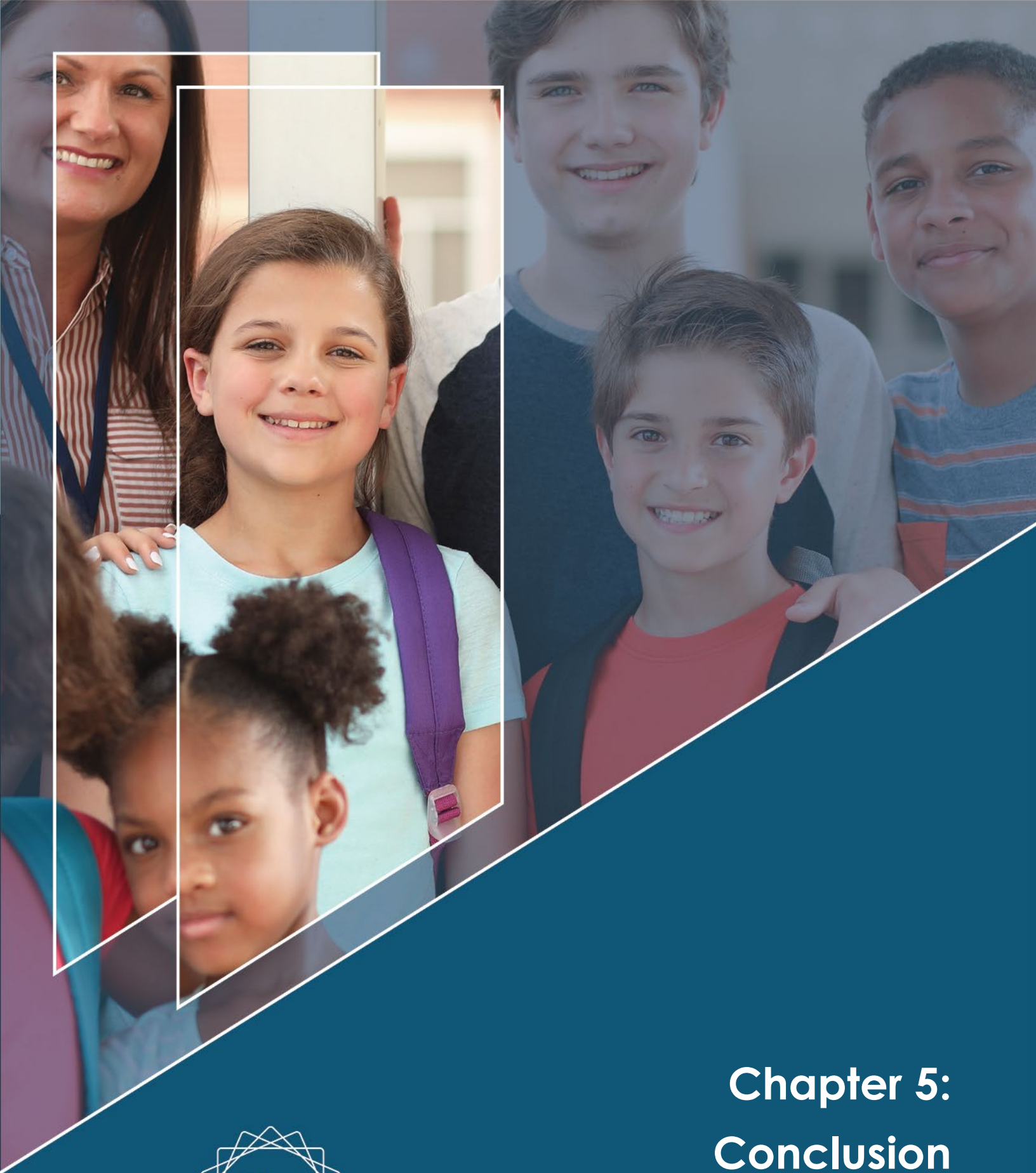
Chapter 5:
Conclusion

5. Conclusion

This chapter summarizes InCK Model Award Recipients' activities in the first year of the model implementation period (2022) and aspects of the local context that may influence implementation and impact of the model.

5.1   NEEDS ASSESSMENT AND SIL STRATIFICATION

As of the end of 2022, award recipients' approaches to assessing CCS needs and SIL stratification varied with respect to how they identify and confirm needs in the various domains; how those needs inform SIL stratification; and the eligibility criteria used to assign beneficiaries to SIL 1, SIL 2, and SIL 3. All award recipients use a combination of administrative data (such as Medicaid claims) and data collected via screening tools. Award recipients that rely primarily on administrative data for initial SIL assignment (AHHN, BE-InCK NY, NC InCK, and OH InCK) assigned greater proportions of attributed beneficiaries to a SIL in early 2022 than those relying primarily on screening tools (CT InCK Embrace New Haven, NJ InCK, and Village InCK). Both data sources have benefits and challenges. Using administrative data enables award recipients to make preliminary or initial SIL assignments so they can target initial outreach to those who are likely to have greater needs; however, administrative data primarily measures historical utilization rather than unmet need or "rising risk." Using screening data allows award recipients to capture emergent needs; however, it requires significant staff time and other investments to successfully execute and requires active beneficiary engagement to complete the screening tools. Award recipients will likely adjust their needs assessment and SIL stratification processes as the implementation period progresses; as a result, the number of beneficiaries screened, and the needs identified through those screenings, may change.

5.2   APM DESIGN AND IMPLEMENTATION

The Centers for Medicare & Medicaid Services (CMS) required each InCK Model Award Recipient to implement one or more alternative payment models (APM) to sustain their InCK intervention after model funding ceases at the end of 2026. The expectation is that InCK Model APMs will support care coordination, and case management, while promoting accountability for improved outcomes and lower cost. Most of the award recipients implemented per-member-per-month (PMPM) payments, where eligible providers receive a small monthly payment per InCK beneficiary if they carry out certain activities or achieve certain quality benchmarks. Award recipients are linking incentive payments to increased use of preventive care, improved care coordination, lower unnecessary utilization, and completed screenings. Exhibit 5.1 outlines the types of measures award recipients are using

in their APMs. BE-InCK NY was still finalizing the quality measures for their APM as of the end of 2022.

Exhibit 5.1. InCK Model Award Recipients are Using a Variety of Quality Measures in their InCK Alternative Payment Models.

Award Recipient	Measure Type					
	Preventive Care	Care Coordination	Behavioral Health	Utilization	Social Determinants of Health	Cost
AHHN	Well-child/care visits (0 – 17) Childhood Immunization Status					Total cost of care
BE-InCK NY	TBD					
CT InCK Embrace New Haven		Referral Efficacy Successful completion of needs assessment			Collection of race, ethnicity, and language data	
NJ InCK		Needs assessment interpretation Care management services to beneficiaries in SIL 2 and SIL 3				
NC InCK	Well-child visits (0 – 15 months)	Shared action plan for beneficiaries in SIL 2 and SIL 3	Screening and follow up for clinical depression (12 – 17)	Ambulatory care Emergency Department visits	Kindergarten Readiness bundle Food insecurity and housing instability screening	
OH InCK		Health Risk Assessment				
Village InCK	Well-child/care visits (0 – 17)	Universal plan of care	Follow-up after hospitalization for mental illness (6-17)			

Over the course of the first three years of funding, InCK Model Award Recipients worked toward full implementation of the InCK Model APMs with varying levels of progress. As of the end of 2022, only NJ InCK was providing payments to providers through their APM

structure. AHHN and CT InCK Embrace New Haven anticipated going live in 2023, while BE-InCK NY, NC InCK, and Village InCK will not begin providing payments to providers until 2024. OH InCK was still finalizing the details of their APM at the end of 2022.

InCK Award Recipients worked closely with their Partnership Councils and APM workgroups in the first three years of the model to design and then implement their InCK APMs. State Medicaid agencies and managed care entities (MCEs), when applicable, were critical partners in this work. Some award recipients encountered challenges engaging MCEs due to insufficient interest in pediatric APMs or difficulty aligning an InCK APM with other initiatives that the MCEs were undertaking. Award recipients also reported that obtaining the needed state and/or federal approval to implement a new APM within existing Medicaid contracts required more time and effort than they originally anticipated.

5.3   CORE CHILD SERVICE CONTEXT

Children, youth, and young adults in all InCK Model Attributed Regions experience challenges accessing needed health and health-related services, referred to as Core Child Services (CCS). Caregivers, providers, and award recipient staff reported in [Evaluation Report 1](#) that this is due both to observable factors, such as the limited supply of CCS providers and policies that hinder access to those services, and unobservable factors such as stigma and mistrust. Low provider and service availability may diminish the model's potential to address CCS needs. Chapter 4 in this report includes a detailed summary of CCS availability and access issues in each award recipient attributed regions.

Overall, across award recipients, caregivers and providers reported significant barriers to accessing behavioral health services, particularly specialty behavioral health care. Barriers such as long wait times, limited transportation, and little to no paid time off continue to be significant for families. There is mixed availability of cash assistance, food assistance, and safe and affordable housing across award recipient regions. For example, in Illinois 100 percent of eligible individuals receive food assistance through the Supplemental Nutrition Assistance Program (SNAP), which is notably higher than the national average of 82 percent. Meanwhile, the proportion of eligible individuals in Illinois who receive food assistance through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) (48 percent) is much lower than the national average (57 percent). Finally, all award recipients except NJ InCK are operating in counties or local areas in which the rates of child abuse and neglect are higher than the national average. Even in areas with generous supports available, supports are not sufficient to address need.

5.4   SUMMARY

InCK Model Award Recipients made notable progress on the implementation of core model components in 2022. They also encountered challenges and identified barriers to implementation. In some cases, those challenges led them to change their approaches to key model elements. Some aspects of the model, such as the design and implementation of their InCK Model APMs, took longer than anticipated. In 2023, award recipients will fine-

tune their processes for needs assessment and SIL stratification and adjust how they provide services to InCK Model beneficiaries as they move further into the implementation period.

Appendices

Separate appendices provide additional information on the methodology and details in this report.

Appendix A describes the measures and methods used to calculate quarterly trends (2017–2021) in the utilization of healthcare services by InCK beneficiaries, as well as quarterly trends for the number of overall (inpatient and outpatient) Emergency Department (ED) visits and the number of acute care hospital admissions by InCK beneficiaries in the InCK Model Attributed Regions.

Appendix B describes evaluation activities conducted in Model Year 3 and reported in this Evaluation Report.

Appendix C describes Medicaid and CHIP eligibility and enrollment policies in InCK Model states.

Appendix D describes best practices for minimizing churn in Medicaid enrollment.

Appendix E describes historical churn in InCK Model attributed regions.

Appendix F includes details on data and methods used to calculate administrative churn in Medicaid and additional results.

Appendix G includes screening results as of the end of quarter 2, 2022 (June 30, 2022).

Appendix H describes award recipients' use or planned use of administrative data in each domain.

Appendix I describes award recipients' use or planned use of screening data in each CCS domain.

Appendix J describes planned evaluation activities for future years.

APPENDIX A. QUARTERLY TRENDS IN HEALTHCARE UTILIZATION: MEASURES, METHODS, AND ADDITIONAL RESULTS

We used demographic, enrollment, claims, and managed care encounter data from the Interim Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) for calendar years 2017–2021 to calculate rates of healthcare utilization per 1,000 Medicaid or CHIP enrollee months. We created an analytic dataset to determine Medicaid and CHIP enrollment, identify enrollee characteristics, and calculate healthcare utilization measures at both the beneficiary and monthly level. Our analyses included seven measures of healthcare utilization among Medicaid enrolled individuals (and CHIP enrolled individuals in Connecticut, New Jersey, and North Carolina) ages 0 - 20. We calculate the measures in terms of enrollees per month, specified as follows.

- **Number of acute care hospitalizations.** Acute care hospitalizations include admissions to short-stay acute care hospitals (HOSP_TYPE_CD = 01), children's hospitals (HOSP_TYPE_CD = 07), Critical Access Hospitals (HOSP_TYPE_CD = 03), and Indian Health Services hospitals (HOSP_TYPE_CD = 06) identified in the Inpatient TAF. (HOSP_TYPE_CD was unusable in the New York and North Carolina TAF, so we ignored HOSP_TYPE_CD as a criterion for these two states). Acute care hospitalizations are identified as BILL_TYPE_CD 011X, 012X, and 085X and at least one claim line where REV_CNTR_CD = 0101 – 017X or 020X – 021X but not including 0118, 0128, 0138, 0148, or 0158. Multiple claims that represent transfers between facilities (PTNT_DSCHRG_STUS_CD = 02, 66, 82, or 94) are counted as a single admission.

- **Number of days hospitalized for acute care.** This measure is an extension of the measure of the number of acute care hospitalizations, specified above. We counted the total number of days between hospital admission and discharge, inclusive of the day of admission and day of discharge. The days corresponding to a single inpatient hospital stay that spanned more than one calendar month (e.g., admission on January 28th and discharge on February 2nd) were split across the two months accordingly. If a patient was discharged from one hospital and admitted to another on the same day, the day of the transfer was counted as only one day hospitalized.

- **Number of outpatient emergency department (ED) visits.** Outpatient ED visits are ED visits that did not result in the patient being admitted to a hospital for acute or non-acute care (the patient was discharged to the community or another type of medical setting). Visits that do not lead to a hospitalization are identified from outpatient hospital claims using revenue center line items equal to 045X or 0981 (emergency room care), CPT codes 99281–99285, or both a Place of Service code equal to 23 (emergency room – hospital) and at least one line-item procedure code from the Healthcare Effectiveness Data and Information Set (HEDIS) ED Procedure Code Value Set. Multiple claims for ED visits on the same day are counted as a single ED visit. ED visits identified from an outpatient claim with a date of service within one day or during an inpatient stay are excluded. Inpatient stays are identified as inpatient claims with BILL_TYPE_CD

011X, 012X, or 085X and at least one claim line where REV_CNTR_CD = 0101–017X or 020X–021X.

- **Number of inpatient or outpatient ED visits.** Inpatient ED visits are ED visits that lead to a hospitalization for acute or non-acute care. This measure includes elements of the measure of the number of outpatient ED visits, specified above; however, inpatient ED visits are identified from Inpatient claims using revenue center line items equal to 045X and 0981 (emergency room care). ED visits identified from an outpatient claim with a date of service within one day or during an inpatient stay are included.

- **Number of outpatient observation stays.** An observation stay is an outpatient hospital stay during which an individual receives medical services to help the doctor decide whether they should be admitted as an inpatient or discharged. Outpatient observation stays are observation stays that do not lead to or were a result of a hospitalization for acute or non-acute care. Observation stays that do not lead to a hospitalization are identified from outpatient hospital claims using revenue center line items equal to 0760 (treatment or observation room – general classification) and 0762 (treatment or observation room), or CPT codes 99224–99226 and 99234–99236. Multiple claims for observation stays on the same day are counted as a single observation stay. Observation stays identified from outpatient claims with a service date within one day or during an inpatient stay are excluded. Inpatient stays are identified as inpatient claims with BILL_TYPE_CD 011X, 012X, and 085X and at least one claim line where REV_CNTR_CD = 0101–017X or 020X–021X.

- **Well-child Visits with a Primary Care Practitioner in the First 30 Months of Life.** This measure is based on the same measure found in the "Child Core Set", described in the following document: Center for Medicare & Medicaid Services (CMS), Center for Medicaid and CHIP Services. (March 2021). Core Set of Children's Health Care Quality Measures for Medicaid and CHIP: Technical Specifications and Resource Manual for Federal Fiscal year 2021 Reporting. Well-child visits are identified using claims for other services with,

    1. Line-item CPT codes equal to 99381–99385, 99391–99395, and 99461 or Healthcare Common Procedure Coding System (HCPCS) codes equal to G0438–G0439; *and*

    2. Either a primary or secondary diagnosis code in ('Z0000', 'Z0001', 'Z00110', 'Z00111', 'Z00121', 'Z00129', 'Z005', 'Z008', 'Z020', 'Z021', 'Z022', 'Z023', 'Z024', 'Z025', 'Z026', 'Z0271', 'Z0282', 'Z761', or 'Z762'); *and*

    3. The billing or service provider's specialty or taxonomy code corresponds to a primary care practitioner (PCP) (Physician/Family Practice, Physician/Internal Medicine, Physician/Pediatric Medicine, Physician/Geriatric Medicine, Certified Nurse Midwife, Nurse Practitioner, Certified Clinical Nurse Specialist, or Physician's Assistant), Federally Qualified Health Centers (FQHC), or Rural Health Clinic.

We did not exclude visits billed with a telehealth modifier code or place of service code given the increased use of telehealth services during the public health emergency. PCPs are identified using either the billing provider specialty code (BLG_PRVDR_SPCLTY_CD), service provider specialty code (SRVC_PRVDR_SPCLTY_CD), billing provider taxonomy code (BLG_PRVDR_TXNMY_CD), service provider taxonomy code (SRVC_PRVDR_TXNMY_CD), or the type of service code (TOS = 003). The type of service code was used only to identify rural health clinic services if the taxonomy codes are missing. To be able to consistently define PCPs using either specialty codes or taxonomy codes, we define all provider taxonomy codes that map to Medicare specialty codes equal to 1, 8, 11, 37, 38, 42, 50, 89, or 97 as PCPs.

- **Well-care Visits with a PCP or Obstetricians/Gynecologists Among Children and Adolescents.** This measure is based on the same measure found in the "Child Core Set", described in the following document: CMS, Center for Medicaid and CHIP Services. (March 2021). Core Set of Children's Health Care Quality Measures for Medicaid and CHIP: Technical Specifications and Resource Manual for Federal Fiscal year 2021 Reporting. Children and Adolescents are aged three to 20. Well-care visits are identified using claims in the Other Services TAF with,

    1. Line-item CPT codes equal to 99381–99385, 99391–99395, and 99461, or HCPCS codes equal to G0438–G0439; *and*

    2. Either a primary or secondary diagnosis code in ('Z0000', 'Z0001', 'Z00110', 'Z00111', 'Z00121', 'Z00129', 'Z005', 'Z008', 'Z020', 'Z021', 'Z022', 'Z023', 'Z024', 'Z025', 'Z026', 'Z0271', 'Z0282', 'Z761', 'Z762'); *and*

    3. Either the billing or service provider's specialty or taxonomy code corresponds to a PCP (Physician/Family Practice, Physician/Internal Medicine, Physician/Pediatric Medicine, Physician/Geriatric Medicine, Certified Nurse Midwife, Nurse Practitioner, Certified Clinical Nurse Specialist, or Physician's Assistant), OB/GYN, FQHC, or Rural Health Clinic.

We did not exclude visits billed with a telehealth modifier code or place of service code given the increased use of telehealth services during the public health emergency. PCPs are identified using either the billing provider specialty code (BLG_PRVDR_SPCLTY_CD), service provider specialty code (SRVC_PRVDR_SPCLTY_CD), billing provider taxonomy code (BLG_PRVDR_TXNMY_CD), service provider taxonomy code (SRVC_PRVDR_TXNMY_CD), or the type of service code (TOS = 003). The type of service code was used only to identify Rural health clinic services if the taxonomy codes are missing. To be able to define PCPs consistently using either specialty codes or taxonomy codes, we define all provider taxonomy codes that map to Medicare specialty codes equal to 1, 8, 11, 16, 37, 38, 42, 50, 89, or 97 as PCPs.

Methods

Six of these seven measures are discrete counts of events. The seventh is a measure of the number of days hospitalized for acute care. To calculate quarterly trends among enrollees in each InCK Model Attributed Region we perform the following steps:

1. Sum the number of events or the number of days eligible beneficiaries were hospitalized in each calendar quarter.
2. Sum the number of months all individuals in the data were enrolled in Medicaid or CHIP in each calendar quarter (the denominator is the same for all count-measures).
3. Divide the numerator by the denominator and multiply by 1,000 to obtain quarterly number of events or days per 1,000 enrollee months.

To obtain trends by age and race/ethnicity, we use the enrollees' age as of January 1st of the given year and the RACE_ETHNICITY_CD in the Demographic and Enrollment TAF, and aggregate the numerator and denominator by quarter, InCK Model Attributed Region, and subgroup category.

Quarterly Trends in All Emergency Department Visits and Hospital Admissions

Exhibit A.1. Inpatient and Outpatient Emergency Department Visits Among Enrollees Aged 20 or Younger in the InCK Model Attributed Populations Declined Substantially During 2020, Then Gradually Returned to Close to Pre-PHE Rates.
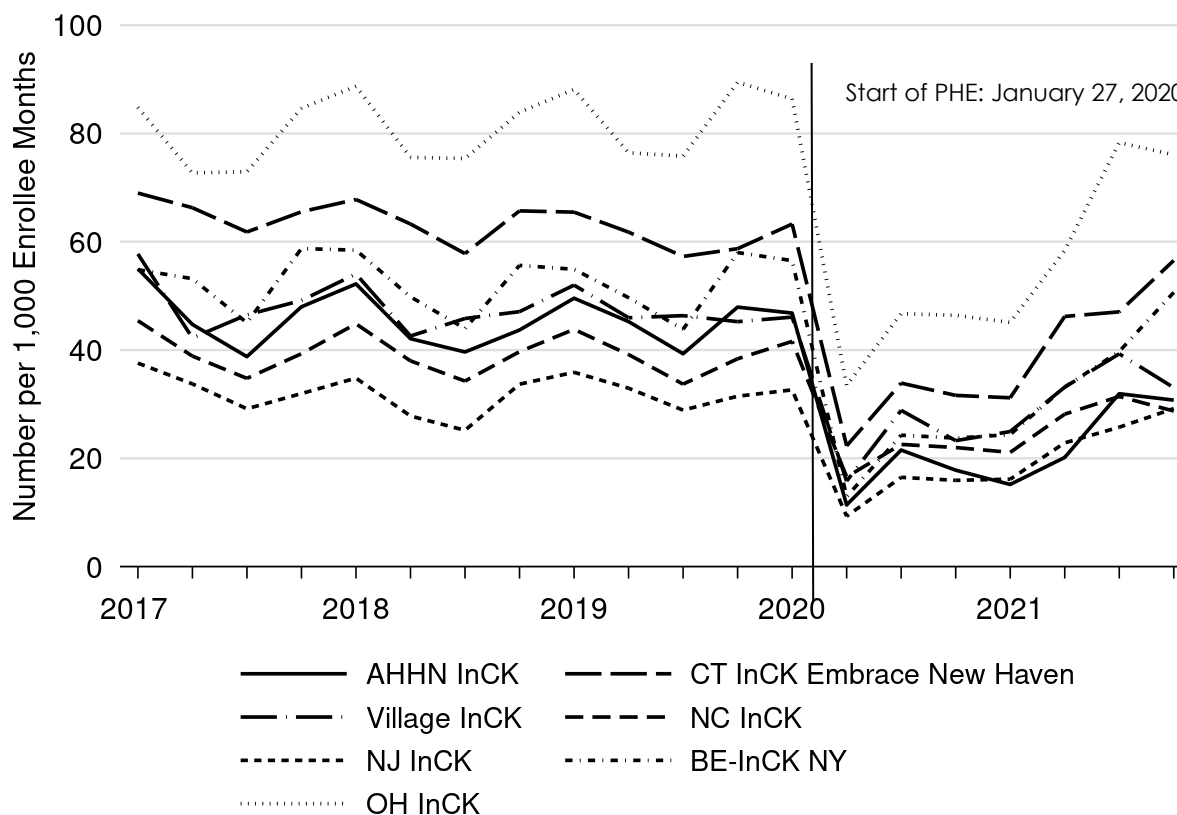
Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Other Services, Inpatient, Demographic and Enrollment.

Notes: Quarterly trends in emergency department visits that did and did not result in hospital admission per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 0 to < 21 years in each InCK Model Attributed Region, and CHIP enrollees aged 0 to < 21 years in CT InCK Embrace New Haven, NJ InCK, and NC InCK's attributed regions. Sample sizes vary by quarter. PHE=Public Health Emergency

Exhibit A.2. Quarterly Trends in Acute Care Hospital Admissions per 1,000 Medicaid or CHIP Enrollee Months Remained Stable between 2017 – 2021 Among Enrollees Aged 20 or Younger in InCK Model Attributed Populations.
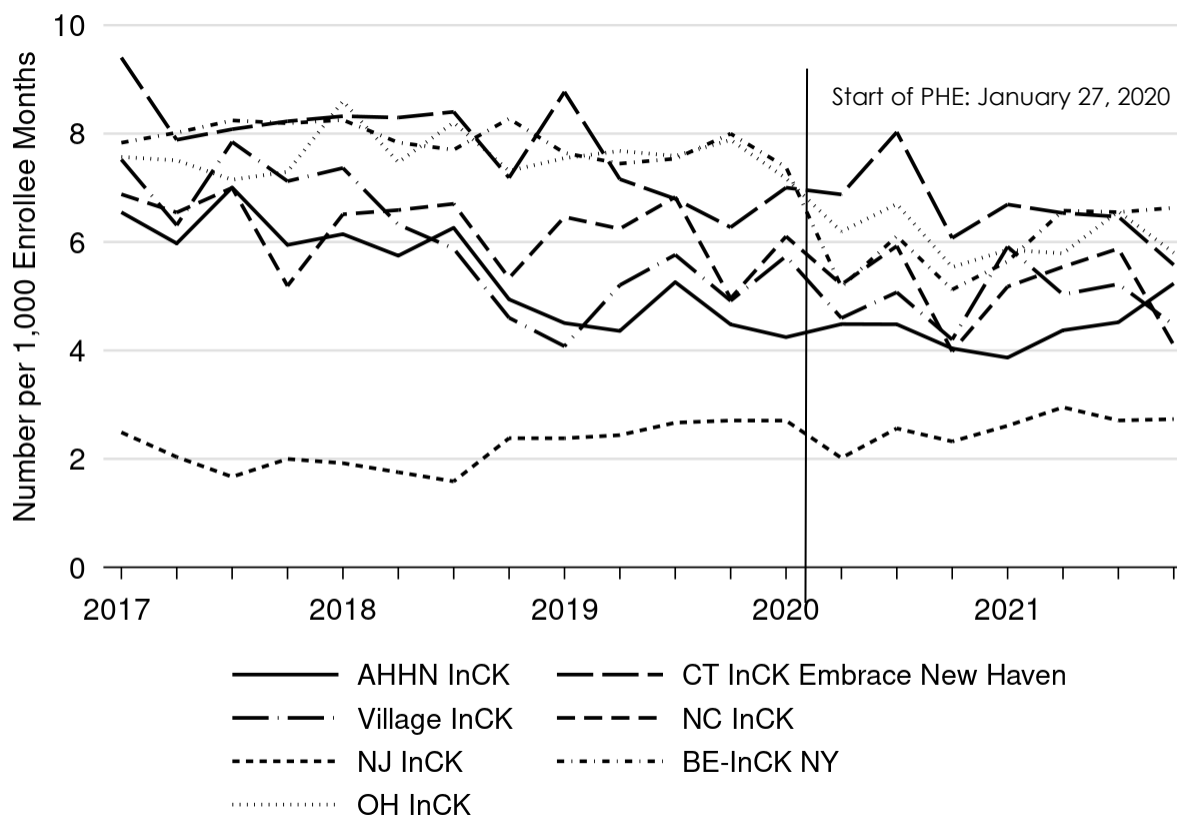
Start of PHE: January 27, 2020

Legend:
- AHHN InCK
- CT InCK Embrace New Haven
- Village InCK
- NC InCK
- NJ InCK
- BE-InCK NY
- OH InCK

Source: Abt analyses of Interim T-MSIS Analytic Files, 2017–2021: Inpatient, Demographic and Enrollment.

Notes: Quarterly trends in admissions to an acute care hospital per 1,000 Medicaid and CHIP enrollee months. Samples include Medicaid enrollees aged 0 to < 21 years in each InCK Model Attributed Region, and CHIP enrollees aged 0 to < 21 years in CT InCK Embrace New Haven, NJ InCK, and NC InCK's attributed regions. Sample sizes vary by quarter. PHE=Public Health Emergency

APPENDIX B. EVALUATION ACTIVITIES IN IMPLEMENTATION YEAR 1 (2022)

In Model Implementation Year 1 (2022), the InCK Model Evaluation Team conducted diverse activities to gather data, capture insights, and obtain information in support of the evaluation. Findings related to Research Question 1 are included in this report. B.1 details the activities conducted in Implementation Year 1. The evaluation team began some activities in Implementation Year 1, which will ultimately inform additional research questions.

Exhibit B.1. The InCK Model Evaluation Engaged in Numerous Activities in Implementation Year 1 (2022).

Data Sources	Research Questions[a]	Purpose	Process	Procedures (Analytic)	Period of Activities
Award recipient document review	1	• Augment the evaluation team's understanding of each award recipient's model. • Classify the context within which the model is operating. • Identify changes during program implementation. • Prepare site visit teams for interviews with award recipients, model partners, local providers, beneficiaries, and caregivers. • Identify explanatory variables that could affect model implementation or outcomes.	1. Develop an inventory of materials. 2. Identify key variables, develop abstraction tool, and create analysis plan to identify key themes aligned with the Practical Robust Implementation and Sustainability Model framework. 3. Train team members on the inventory and process to extract data from award recipients' documentation. 4. Abstract information, analyze results, develop summary, and assess completeness of measures for each award recipient.	1. Conduct content analysis and synthesis of data abstracted into award recipient-specific abstraction tools. 2. Review findings within and across award recipients.	Quarterly
Environmental scan	1	• Provide insight into statewide initiatives and activities occurring in the award recipients' community and state that may affect care processes and influence implementation and impact of the model. • Identify additional data and sources for potential moderating factors for Impact Study.	1. Assess the availability of national data sets and policy compendiums identified through the literature review. 2. Refine parameters of the scan, search strategy, and sources. 3. Assess materials, determine completeness, and further search as needed. 4. Synthesize materials collected, identify gaps, summarize results, and finalize scan.	1. Conduct searches using defined scan parameters. 2. Compile source materials into central repository (i.e., EndNote library). 3. Review source materials in full, extracting relevant information.	Semi-annually

Data Sources	Research Questions[a]	Purpose	Process	Procedures (Analytic)	Period of Activities
Literature Review	1	• Identify local and national trends in health and Core Child Service (CCS) utilization in InCK Model states and attributed regions. • Collect information about the healthcare and CCS policy and program context where InCK Model Award Recipients are implementing their models.	1. Refine parameters of the literature review, search strategy and sources. 2. Assess materials, determine completeness, and further search, as needed. 3. Synthesize materials collected, identify gaps, and summarize results.	1. Conduct searches using defined search parameters. 2. Compile source materials into a central repository. 3. Review source material in full, extracting relevant information.	As needed
Virtual Interviews with Lead Organizations, State Medicaid Agencies (SMAs), and project officers (POs)	1	• Provide award recipient-specific information on model design, local context, implementation, provider and beneficiary/family engagement, other care redesign activities, and both facilitators and barriers of successful implementation using data from the Lead Organizations, state Medicaid agencies (SMAs), and Project Officers (POs).	1. Develop protocols for each respondent type or activity and customize questions to probe on award recipient-specific context and programming. 2. Conduct interviews. 3. Clean and code interview data using a universal inductive codebook, and deductively identified codes using qualitative analytic software (Dedoose). 4. Analyze results, identifying within- and across-award recipient themes and findings.	1. Conduct within- and across-case thematic analyses using a universal codebook in qualitative analytic software (Dedoose). 2. Produce memoranda describing findings for each award recipient.	Fall 2023

Data Sources	Research Questions[a]	Purpose	Process	Procedures (Analytic)	Period of Activities
Retrospective Attribution File (RAF)	2, 3, 5	• Obtain identifying information and Medicaid eligibility dates for the award recipients' attributed populations. • Describe InCK Model Attributed Population. • Link data across files.	1. Acquire Retrospective Attribution Files (RAFs) and related documentation that the award recipients provide to CMS. 2. Review data and conduct analyses for quality control. 3. Produce detailed memoranda that document data discrepancies, anomalies, and format-deviations; send correction requests to award recipients. 4. Submit the memoranda to CMS, which CMS releases to the award recipients. 5. Repeat the process as the award recipients respond to the memoranda and resubmit the files.	1. Conduct analyses for quality control. 2. Produce detailed memoranda addressed to award recipients. 3. Use identifying information and eligibility dates to extract Medicaid eligibility, claims, and encounter data for attributed populations from T-MSIS files.	Semi-annually
Service Integration Level (SIL) Data	2, 3, 5	• Determine the needs of beneficiaries across CCS areas. • Link service needs to receipt of services during the implementation period.	1. Assess quality of and validate data provided by award recipients. 2. Link to Transformed Medicaid Statistical Information System (T-MSIS) data.	1. Run frequencies against RAF. 2. Develop measure specifications. 3. Conduct analyses to describe needs of the attributed populations.	Quarterly
Core Child Services (CCS) data	2, 3, 4, 5	• Understand the characteristics of the attributed populations in terms of beneficiaries' encounters with state (or local) systems related to CCS.	1. Examine the quality of CCS data submitted by award recipients in terms of reliability and validity and determine if data are usable for the evaluation. 2. Link data to SIL and T-MSIS data. 3. Run descriptive analyses and benchmark to national datasets.	1. Run frequencies and compare data against other data sources (e.g., the National Child Abuse and Neglect Data System data), as possible. 2. Develop measure specifications for outcomes of interest. 3. Conduct descriptive analyses.	Semi-annually

Data Sources	Research Questions[a]	Purpose	Process	Procedures (Analytic)	Period of Activities
T-MSIS	2, 3, 4, 5	• Define baseline and pre-implementation period's primary outcomes of the Impact Study (accounting for the COVID-19 Public Health Emergency). • Identify beneficiary characteristics. • Inform qualitative data collection activities.	1. Examine data quality in the Interim Research Identifiable Files (TAF RIF) for InCK Model Attributed Regions, updating as CMS releases new TAF RIF. 2. Assess whether changes in data quality in new TAF RIFs could invalidate primary outcomes given existing measure specifications. 3. Update analytic data sets with beneficiary outcomes and descriptive information using new TAF RIFs. 4. Create trends in utilization, enrollment, and quality outcomes.	1. Replicate data quality analyses conducted during pre-implementation period. 2. Compare results of data quality analyses to existing measure specifications. 3. Rerun existing SAS programs to incorporate new data releases into the analytic data set. 4. Analyze data to create trends.	Monthly

Note:

a. Five research questions provide the focus for the InCK Model Implementation Period Evaluation:
   1. How was the InCK Model implemented by each award recipient?
   2. How has the InCK Model implemented by each award recipient affected children and families in the following four areas: navigation and coordination; utilization and expenditures; quality of care; and beneficiary and caregiver experience of care?
   3. To what extent did service changes or disruptions (e.g., transitioning between 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 award recipient?
   4. What is the return on investment of the InCK Model by each award recipient?
   5. To what extent do the effects of the InCK Model vary?

APPENDIX C. MEDICAID AND CHIP ELIGIBILITY AND ENROLLMENT POLICIES IN INCK MODEL STATES

Because states and the federal government jointly administer the Medicaid program, variation in Medicaid policies and operations exist across states. This appendix details some of the Medicaid and Children's Health Insurance Program (CHIP) policies in award recipient states that are relevant to eligibility, enrollment, and administrative churn. All data shown here are reproduced from data compiled by the Kaiser Family Foundation's State Health Facts indicators, supplemented with additional data sources, where indicated.

Exhibit C.1. InCK Model States Vary in Key Medicaid/CHIP Design Features (2022)[a]

Characteristic	CT	IL	NJ	NY	NC	OH
Modified Adjusted Gross Income (MAGI)-based income limits (%FPL) by age (years) (Medicaid)[a,b,c]						
0 - <1	201%	147%	199%	223%	215%	211%
1 - 5	201%	147%	147%	154%	215%	211%
6 - 18	201%	147%	147%	154%	138%	211%
MAGI-based income limits (%) for parents (Medicaid)[b,d]						
	160%	138%	138%	138%	39%	138%
MAGI-based income limits (%) for children (CHIP)[b]						
0 -18	323%	318%	355%	405%	216%	NA
Minimum income (%FPL) for CHIP premiums						
	249%	157%	200%	160%	159%	N/A
Monthly CHIP premium amounts (USD) at selected income levels (%FPL) per enrollee[e-k]						
151%	$0	$0	$0	$0	$0	N/A
201%	$0	$15	$0	$9	$0	
251%	$30	$40	$0	$30	N/A	
301%	$30	$40	$0	$45	N/A	
351%	N/A	N/A	$0	$60	N/A	

Notes:

a. Data shown are state-reported income eligibility standards as of January 2022. Data presented in this figure represent the upper limit on household income, reported as a percentage of the Federal Poverty Limit (%FPL).CHIP=Childrens Health Insurance Program. FPL=Federal Poverty Level. The household income counting methodology is based on modified adjusted gross income for the populations shown.

b. Data reflect the upper income limits for enrollees of given age group under Medicaid (Title XIX), for whom the state receives Medicaid matching payments, or under a CHIP-funded (Title XXI) Medicaid expansion program, or under a separate, CHIP-funded child health insurance program for children not eligible for Medicaid. Data represent the effective upper income limits that include a standard income disregard equivalent to five percent of FPL.

c. To be eligible in the infant category, a child has not yet reached their first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached their sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached their 19th birthday.

d. Income eligibility limits for parents are calculated based on a family of three.

e. Data for 2020. Source: Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey (kff.org) accessed 1/12/2024.

f. In Illinois, CHIP premiums are $15 per child, $25 for two children, and $5 for each additional child up to a $40 maximum for families with incomes below 208% FPL. Above 208% FPL, families pay $40 per child or $80 for two or more children. Illinois transitioned most children to a Medicaid expansion CHIP effective July 1, 2022. Those that remain in the sperate CHIP program no longer pay premiums.

g. In New York, there is a maximum premium of three times the child rate. NY eliminated this premium effective October 1, 2022.

h. In Connecticut, the family maximum premium is $50.
i. In New Jersey CHIP premiums were eliminated effective July 1, 2021. Source: NJ State Plan Amendment NJ-22-0031. Available at : https://www.medicaid.gov/sites/default/files/2023-03/NJ-22-0031.pdf
j. All award recipient states, besides North Carolina, require monthly premium payments. The North Carolina data reflect the annual enrollment payment per enrollee. In North Carolina, the family maximum annual enrollment fee is $100.

Exhibit C.2. Other Medicaid/CHIP Policies Vary in InCK Model States.[1,a]

Characteristic	CT	IL	NJ	NY	NC	OH
Medicaid adult expansion state[b]	Yes	Yes	Yes	Yes	No[c]	Yes[a]
CHIP waiting period (days)[d]	0	90	90	0	0	0
CHIP premiums suspended during the PHE[e]	No	Yes	Yes	Yes	Yes	NA

Notes:
a. CHIP=Children's Health Insurance Program
b. Many states have approved Section 1115 waivers to operate their Medicaid expansion programs in ways not otherwise allowed under federal law. In states such as Ohio, these included previously approved Section 1115 work requirements that CMS has since withdrawn under the Biden Administration.
c. NC legislature voted to expand Medicaid to low-income adults in 2023. Medicaid adult expansion went into effect in late 2023.
d. CMS currently allows states to establish waiting periods of up to 90 days before they enroll children in CHIP. Source: Medicaid.gov (https://www.medicaid.gov/chip/eligibility-standards/waiting-periods-chip/index.html) accessed 1/12/2024. Source for Ohio data: NASHP. https://nashp.org/ohio-chip-fact-sheet/#:~:text=%5B1%5D%20States%20may%20implement%20waiting,uninsured%20before%20enrollment%20in%20CHIP. Accessed 1/12/2024.
e. PHE= Public Health Emergency
f. IL removed CHIP premiums effective July 1,2022. NJ removed CHIP premiums effective July 1, 2021.

Source:
1. Kaiser Family Foundation. (December 2023) *Status of State Medicaid Expansion Decisions: Interactive Map.* https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Exhibit C.3. Most InCK Model States have streamlined Medicaid/CHIP Eligibility and Enrollment.[a]

Characteristic	CT	IL	NJ	NY	NC	OH
Continuous eligibility for children by program type[b]						
Medicaid	No	Yes	Yes	Yes	Yes	Yes
CHIP	No	Yes	Yes	Yes	Yes	N/A[b]
Extended Postpartum eligibility[d]	Yes	Yes	Yes	Yes	Yes	Yes
Presumptive Medicaid/CHIP eligibility by eligibility group[e]						
Children	Yes	Yes	Yes	Yes	No	Yes
Pregnant People	Yes	Yes	Yes	Yes	Yes	Yes
Medicaid renewals conducted via ex parte processes[f]						
Proportion (%) of all renewals	50-75%	25-50%	<25%	None	Unknown	25-50%
MCEs, navigators, or providers can submit address changes on behalf of beneficiaries[g]						
Third party address changes allowed	No	No	No	Yes	No	No

Notes:
a. CHIP=Children's Health Insurance Program
b. Continuous eligibility for children is a long-standing policy option in Medicaid and CHIP that allows states to cover children for up to a full year unless the child ages out, moves out of state, is disenrolled for nonpayment of premium, or requests voluntary disenrollment.

c. Continuous eligibility is not applicable for Ohio CHIP because the state does not operate a separate CHIP program, only a CHIP-funded Medicaid expansion (M-CHIP).
d. Federal law mandates that pregnant people in Medicaid (and pregnant adults in CHIP, if covered by the state) receive continuous coverage during pregnancy and through the end of the month in which 60 days after the end of the pregnancy falls. These data represent whether states passed legislation that implements an extension of postpartum coverage for a full year following the end of pregnancy, effective once the continuous enrollment requirement ends.
e. Under presumptive eligibility, a state can authorize qualified entities such as hospitals, community health centers, and schools to make presumptive eligibility determinations for Medicaid and/or CHIP and extend coverage to individuals temporarily until the state Medicaid agency makes a full eligibility determination. The Affordable Care Act (ACA) also gave hospitals across the nation the authority to conduct presumptive eligibility determinations regardless of whether a state has otherwise adopted presumptive eligibility.
f. Under the ACA, Medicaid programs are required to conduct ex parte renewals, but practice adoption varies widely across U.S.
g. Illinois, New York, and Ohio authorize third party access to web-based Medicaid accounts. MCE=Managed Care Entity.

APPENDIX D. RECOMMENDED PRACTICES TO MINIMIZE CHURN

To help mitigate administrative churn, stakeholders are promoting evidence-based strategies to ease the burden of redetermination on Medicaid program administrators and beneficiaries alike. This appendix provides information on recommended practices identified through an environmental scan of grey literature. Most of these strategies rely on existing federal authorities available to state Medicaid agencies (SMAs) and are already in use to varying degrees in different states.

Ex parte renewals

Also referred to as "passive," "automated," or "no touch" renewals, ex parte renewals refer to practices used by states to leverage reliable data on income, residency, and household status in existing electronic databases, eliminating the need to contact a beneficiary directly.[88] Data can be considered "reliable" when "verified within the last 6 months" or pertaining to "circumstances generally not subject to change" such as citizenship or immigration status.[88] Under the Affordable Care Act, states must seek to re-determine eligibility through ex parte renewals before requiring enrollees to respond to renewal forms or submit documentation to the state.[89]

Ex parte renewals shift the burden from beneficiaries and reduce administrative slowdowns due to returned mail and out of service phone number.[90]

CMS has released guidance to states on how to increase the share of ex parte renewals in anticipation of the large volume of redeterminations following the COVID-19 Public Health Emergency (PHE).[91,92] The guidance encourages states to incorporate both financial and non-financial data into their ex parte processes (Exhibit D.1).[93]

Exhibit D.1. CMS Provided Guidance to States on Ex Parte Renewals.

CMS-Recommended Databases for Income and Asset Verification	CMS-Recommended Databases for Demographic Information Verification
• State Wage Information Collection Agency • Internal Revenue Service • Social Security Administration • States' Asset Verification Systems	• Department of Motor Vehicles • Supplemental Nutrition Assistance Program • Temporary Assistance for Needy Families • Public Housing Agencies • U.S. Postal Service National Change of Address Database[a]

Note:

a. Use of this database is mandatory. (Centers for Medicare & Medicaid Services. SHO #23-002. RE: Medicaid Continuous Enrollment Conditions Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023. January 27, 2023.)

Express Lane Eligibility

The Children's Health Insurance Program Reauthorization Act of 2009 grants states the authority to rely on enrollment data from other need-based social service programs when

conducting initial and renewal determinations on Medicaid and CHIP-eligible children.[94,95] This option, known as Express Lane Eligibility (ELE), operates similarly to ex parte renewals. ELE allows states to supplement income, asset, and tax data with data obtained from designated state agencies that administer need-based social service programs. Programs eligible to provide ELE data most commonly include but are not limited to:

- Supplemental Nutrition Assistance Program (SNAP)

- Temporary Assistance for Needy Families (TANF)

- Head Start

- National School Lunch Program (NSLP)

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

### *Response Times for Manual Renewals*

Even in states using ex parte and ELE processes, some beneficiaries will need to provide some redetermination information manually, and most likely by mail. Examples include completing renewal forms, verifying addresses, and appealing initial denials of coverage. Federal law mandates that states allow individuals, whose eligibility is determined by income, a minimum of 30 days to respond to renewal information requests; however, states can extend these timeframes.[96] The American Hospital Association recommends that states extend the response window to a minimum of 60 days.[90] As of February 2023, InCK Model states were planning to begin the re-determination process between February and April. Ohio and Connecticut anticipate the first terminations for procedural reasons will start in May. For New Jersey, these are anticipated to start in June; whereas for Illinois, New York and North Carolina, these states anticipate terminations will start in July 2023.[97] To accommodate longer response times by beneficiaries, SMAs may need to begin renewal processes sooner than they otherwise would.[96,98]

Multimodal Communication

SMAs can conduct outreach to beneficiaries to alert them to the redetermination process using individual communications (e.g., mailings, phone calls) and public information campaigns (e.g., television, public space advertising, websites). In January 2023, the Federal Communications Commission waived regulations that prevented state Medicaid agencies from delivering robocalls and texts to beneficiaries; thus, opening these communication avenues to reach beneficiaries.[99]

CMS has developed a state toolkit and consumer-centered materials such as scripting, graphics, and collateral in English as well as six other languages (Spanish, Chinese, Hindi, Korean, Tagalog, and Vietnamese) to support states with their mail and digital outreach campaigns (Exhibit D.2).[100]

Exhibit D.2. CMS Provided Examples of Flyers to Promote Medicaid and CHIP Continuous Enrollment Unwinding in Toolkit Materials.
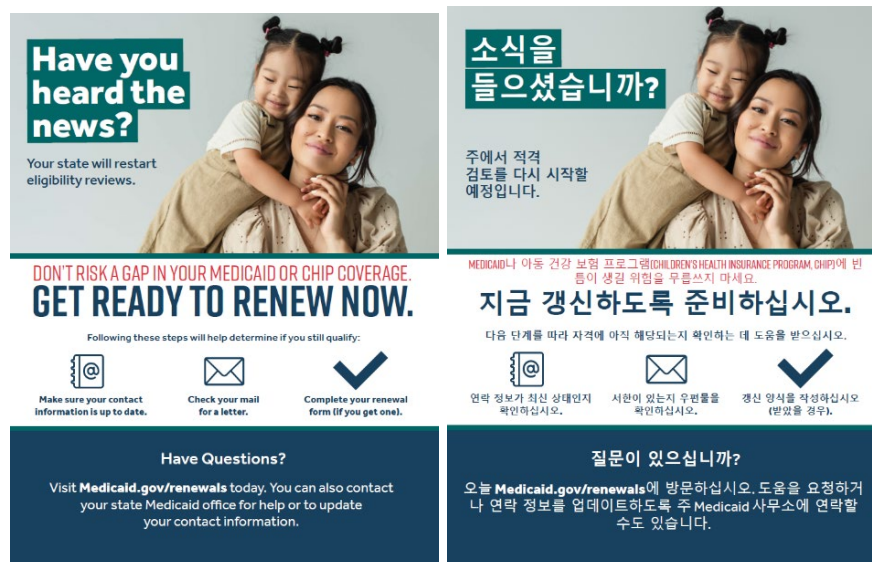
Source : Centers for Medicare & Medicaid Services. *Unwinding and Returning to Regular Operations after COVID-19* https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html

Accessible Communication

SMA websites represent a critical entry point for beneficiaries to receive program information and submit changes to personal information. Federal law requires states "ensure meaningful access" for individuals with limited English proficiency (LEP), including advertising the availability of language assistance services on Medicaid websites and other public facing communication materials.[101] A 2022 analysis of all 50 SMA websites found that 32 states translate their entire home page into languages other than English, and 35 states include multilingual taglines on or within one click of the homepage or application landing page. The number of multilingual offerings on SMA websites is highly variable, ranging from one language (usually Spanish) to more than one hundred languages.[101] SMA websites score significantly higher than websites overall in making accommodations for individuals with disabilities, particularly for visual impairments,[zz] but gaps remain. For example, only 26 states provide information on how to request an American Sign Language (ASL) interpreter, and fewer than half (19 states) provide information on how to obtain materials in large print or braille.[101]

[zz] The study scanned all 50 SMA homepages using WAVE, a set of web accessibility measurement tools to detect errors based on both their observance frequency and their degree of impact on the end user. Test results showed that Medicaid websites performed significantly better (11.4 errors per page) compared to the average for the top 1 million trafficked web pages (50.8 errors per page).

In anticipation of large-scale redeterminations, states can make several improvements to their Medicaid websites to improve accessibility for individuals with LEP, as well as individuals living with disabilities. The following improvements support residents to learn about important updates and submit their personal information to maintain healthcare insurance:

- Include visible taglines on homepages that notify beneficiaries about both the availability of and how to access language assistance services. Taglines should appear in multiple languages, tailored to the languages spoken by their state's beneficiaries.

- Provide full translations of homepages in multiple languages, tailored to the languages spoken by their state's beneficiaries.

- Add the option to change the homepage to "high contrast" mode to improve readability for residents who have low vision and/or colorblindness.

- Include visible taglines on homepages to notify beneficiaries on how to request accommodations, such as large print materials, materials in braille, and ASL interpreters. Taglines should be written in plain language and account for reasonable visual accommodations.

Partnerships with Medicaid Managed Care Entities

Medicaid managed care entities (MCEs) can play a leading role in minimizing the potential impact of administrative churn. MCEs have long cited churn as an impediment to ensuring access and continuity of care for their enrollees, resulting in foregone preventive treatment and higher healthcare costs overall.[102] The aligned incentives between SMA and MCEs to keep individuals enrolled in Medicaid make MCEs a committed partner in maintaining continuous coverage for beneficiaries.

Medicaid agencies can:[103]

- Create channels that guarantee demographic information (e.g., home addresses, phone numbers, emails) collected by MCEs or healthcare providers is integrated into the individual's state Medicaid record.

- Share upcoming renewal files with MCEs ahead of their redetermination date.

MCEs can:[90,99,103]

- Train healthcare providers to remind beneficiaries at the point of care about the importance of updating their contact information with Medicaid.

- Engage in proactive consumer communications and support outreach on behalf of states using beneficiary welcome packets sent via mail, and public awareness campaigns via television and social media. MCEs are also permitted to call and text beneficiaries based on new FCC guidance issued after the end of the PHE.

- Conduct supplemental outreach to individuals who are most at-risk for missing their renewal deadline. For example, MCEs can partner with trusted community organizations to target local media advertising.

Additional Opportunities to Help Children Maintain Health Insurance Coverage

Some children may lose Medicaid eligibility if their household moves out-of-state, increases household income that exceeds Medicaid income limits, or transitions to employer sponsored insurance (ESI). SMAs can employ the following in the event one of these situations occur to ensure children continue to have health insurance coverage.

Streamlining Transitions between State Medicaid and CHIP Programs

In the redetermination process, some children may be found ineligible for Medicaid due to income restrictions; however, these children may be eligible for CHIP. States are required to enact both account transfers and CHIP program enrollment when an eligibility determination can be made using available data.[104] CMS has issued guidance to states on processes for streamlining eligibility determinations and ensuring seamless transitions between Medicaid and CHIP programs, including notifying families of any CHIP premiums to be paid. In addition, CMS recommends strategies to mitigate any disruption of services due to changes in MCEs or provider networks.[104]

Investing in Marketplace Assister Programs

For individuals that are ineligible for Medicaid or CHIP and without access to ESI, assistance navigating Marketplace options is critical for successful coverage transition. Households with incomes between 100 and 400 percent of the federal poverty level qualify for premium tax credits, also known as subsidies, to either reduce or eliminate the cost of Marketplace coverage.[105] However, evaluating the options to select the best plan based on individual circumstances can prove challenging; hence, the importance of assistance from a Marketplace navigator. To elaborate, a study by the Medicaid and CHIP Payment and Access Commission (MACPAC) found 70 percent of adults and children moving from Medicaid to marketplace coverage (state or federally facilitated) experienced enrollment gaps. Research on marketplace transitions has identified premiums and administrative barriers to enrollment as possible causes.[105] At a minimum, states can include basic information on how to access the marketplace and the plan options available in Medicaid disenrollment notices that are mailed to beneficiaries.

Going a step further, CMS is piloting more extensive Marketplace Assister programs to educate and assist beneficiaries who were recently denied Medicaid coverage. The pilot, known as, "Direct Assister to Consumer Outreach Pilot" is active in select counties in Arizona, North Carolina, and Florida. There is no overlap between these counties and the NC InCK attributed region. Under this program, SMAs transfer data to Healthcare.gov, which generates a reminder notice to eligible enrollees 30 days prior to the start of the open enrollment period; thus, reminding them to select a plan. The notice also alerts individuals about a "culturally and linguistically" responsive enrollment navigator who will contact them

to help with both plan selection and the enrollment process. The success of the pilot and its potential scalability has not yet been evaluated.[106]

> ### Activities to Minimize Churn and Keep Eligible Children Enrolled in Medicaid in InCK Model Attributed Regions
>
> As of the end of 2022, SMAs were beginning to plan for Medicaid eligibility redeterminations to commence in April 2023. InCK Model award recipients and SMAs provided insight into the steps that they are taking to minimize churn for Medicaid enrollees and specifically for InCK Model Beneficiaries.
>
> As of fall 2022, statewide initiatives to inform Medicaid enrollees about upcoming redetermination had started and widespread public communications campaigns were underway in all InCK award recipient states. The evaluation team conducted interviews with award recipients in fall 2022 before CMS announced the eligibility redetermination timeline. States likely accelerated their planning once CMS announced the date.
>
> *Anyone who is ever speaking, talking, touching, communicating with any HUSKY Health [Medicaid or CHIP] member is talking to them about the end of the public health emergency. It is on websites. It is on buses. It is everywhere.*
>
> *–Connecticut*
>
> SMAs engaged in ongoing policy and strategy discussions to ensure continuous coverage for children (e.g., Illinois, New York, Ohio). In two states (North Carolina, Ohio), more generous income limits for children compared to those for adults and the opportunity for children to move to CHIP coverage may mitigate concerns related to churn for children. Waivers, including the 1115 waiver, may provide continuity of care for some populations.
>
> *We have a Continuity of Care 1115 [waiver] with some populations and the state is looking at all the strategies available to make sure that they are being as aggressive as possible [in] keeping folks [insured].*
>
> *–Illinois*
>
> Finally, InCK Model Award Recipients see Service Integration Consultants (SICs) and other InCK Model providers as key points of contact to help beneficiaries maintain Medicaid coverage.
>
> *The SICs may be in a really good position to provide some assistance, some guidance, [and] some support in helping people through the redetermination process, which I think would be an important role for them to take.*
>
> *–Connecticut*
>
> *There is a responsibility to the Medicaid member, and this is where I think the care coordination piece will be critical. And you've got the provider partners, you've got the care management partners, you've got the plan partners, to all try to keep an eye on this and help keep the members enrolled, make sure that they're aware.*
>
> *–New York*

APPENDIX E. HISTORICAL CHURN IN INCK MODEL STATES

State Medicaid programs typically review an individual's eligibility for Medicaid once every 12 months,[aaa,bbb] a process called redetermination. Historically, redetermination has led to millions of children losing and then regaining Medicaid coverage, a phenomenon known as administrative churn. In 2018, before the COVID-19 Public Health Emergency (PHE), about 10 percent of Medicaid beneficiaries experienced churn.[89]

Churn, by definition, describes *temporary* loss of Medicaid coverage, but even short coverage gaps can substantially impact health.[92] People who temporarily lose coverage may delay care or access emergency care rather than preventive care, increasing risk for adverse health outcomes and higher costs.[92] Churn also results in additional administrative costs for State Medicaid Agencies (SMAs) and managed care entities (MCEs).[92]

> Appendix C provides a brief overview of state Medicaid policies relevant to coverage and churn in the six InCK Model states.

By disrupting coverage, churn impacts care continuity,[ccc] which is particularly concerning for children with multiple physical and emotional health care needs, such as those in InCK who are assigned to SIL 2 or 3.[107] Households with variable or seasonal income often have fluctuations in Medicaid eligibility and are more likely to face administrative complications during redetermination. State policies such as eligibility criteria and enrollment procedures can facilitate or hinder continuous enrollment.[108]

This chapter uses Medicaid claims, eligibility, and enrollment data to present descriptive analyses of historical churn in the InCK Model Attributed Populations and states. The chapter also summarizes findings from a literature review on strategies to help children and families maintain continuous Medicaid enrollment and includes actions that Model

> Among low-income households, variations in monthly income tied to unsteady work hours are common. Variation in income month to month is a contributing factor to Medicaid churn.
>
> Source: Sherry Glied, PhD; Katherine Swartz, PhD "Stopping the "Medicaid Churn"—Addressing Medicaid Coverage After the COVID-19 Public Health Emergency Ends" JAMA Health Forum, November 3, 2022.

[aaa] If a beneficiary's eligibility is based on their income, SMAs review an individuals' eligibility for Medicaid once every twelve months. For individuals whose eligibility is due to some other qualifying characteristics, SMAs may review their eligibility more frequently.

[bbb] Medicaid eligibility may end when individuals have changes in income or family composition or move out of state.

[ccc] The American Academy of Family Physicians defines continuity of care as the process by which the patient and their physician-led care team are cooperatively involved in ongoing healthcare management toward the shared goal of high quality and cost-effective medical care.

states took in fall 2022 to minimize churn in anticipation of the end of the PHE's continuous coverage provisions.

Administrative Churn in the Medicaid Program

Both procedural factors and family income fluctuations contribute to Medicaid churn. Caregivers may not receive or understand notices from SMAs to renew their benefits, or they may not respond within required time limits. In 2018, renters were three times more likely than homeowners to have moved in the past year,[109] meaning SMA renewal notices may not reach the intended individual.[91] Low-income households are also more likely to have income fluctuations, which can lead to frequent changes in Medicaid eligibility.

Historical Churn in InCK Model Attributed Regions and Respective States

Rates of administrative churn vary by demographic characteristics. In this section, we analyzed administrative data from the Transformed Medicaid Statistical Information System (T-MSIS) and calculated trends in churn from 2018 to 2021 to:

> Appendix F describes the data sources and methods used to examine enrollment trends and calculate churn.

- Compare how frequently Medicaid and Children's Health Insurance Program (CHIP) enrollees in the InCK Model Attributed Regions experience churn before and after the start of the PHE

- Examine whether rates of churn vary according to age, race, and ethnicity

Together, these findings help us to understand historical churn prior to the start of the PHE, the impact of the PHE on churn, and how the InCK Model might affect rates of churn in the attributed regions after the end of the PHE. Additionally, this analysis provides insight into whether certain subgroups of InCK Model Beneficiaries may be disproportionately vulnerable to gaps in enrollment in the future.

#### Trends in Medicaid Churn from 2018 to 2021

Two patterns characterize trends in Medicaid churn among those 20 and under in InCK Attributed Regions:

1. The percentage of beneficiaries experiencing churn from 2018 to 2019 tended to be stable across years (5% to 6% in North Carolina and between 9% and 12% in Connecticut, Illinois, New Jersey, New York, and Ohio) prior to the start of the PHE.
2. By 2021, after the implementation of continuous eligibility during the PHE, less than three percent of beneficiaries experienced churn across all InCK Model Attributed Regions.

Exhibit E.1 uses NJ InCK as an example to illustrate overall trends across award recipient attributed regions. In 2018 and 2019, around 10 percent of Medicaid and CHIP enrollees under age 21 in the NJ InCK attributed region experienced enrollment gaps of 12 months or

less. By 2021, enrollment gaps in the NJ InCK attributed region decreased to under 1 percent. Results for all InCK Model Award Recipients are in Appendix F.

Exhibit E.1. Churn in the NJ InCK Attributed Region Among Medicaid and CHIP Beneficiaries Decreased Notably During the PHE (2018-2021).
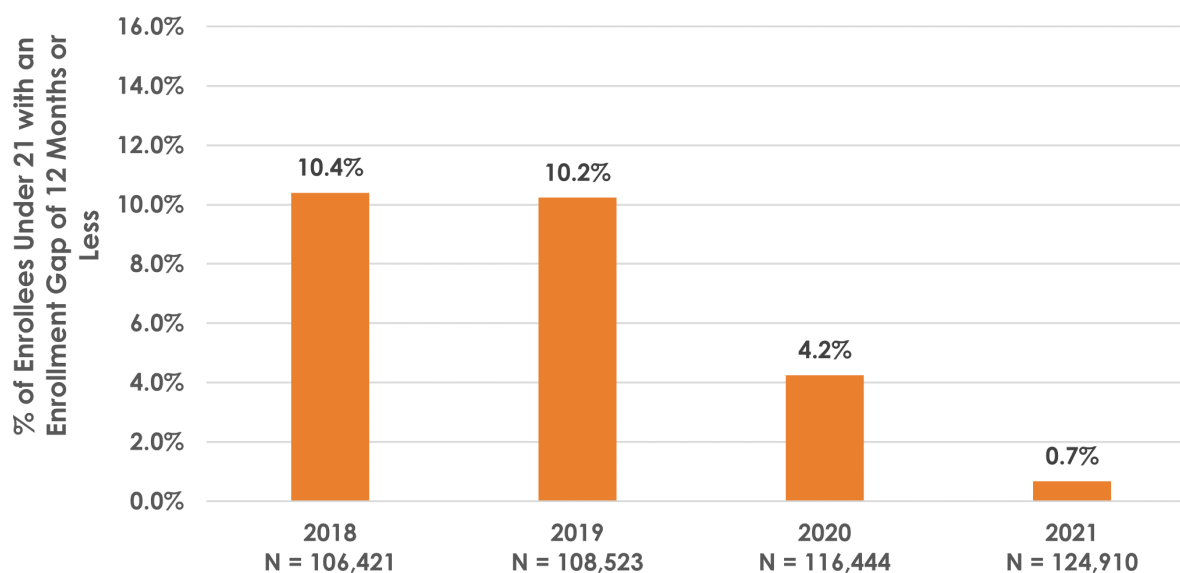
Source: Abt analyses of Interim Transformed Medicaid Statistical Information (T-MSIS) Analytic Files, 2017–2022: Demographic and Enrollment.

Notes: Denominator excludes individuals who enrolled in NJ Medicaid or CHIP during the calendar year but were not enrolled in NJ Medicaid or CHIP during the previous 12 months (i.e., new enrollees). Denominator also excludes Medicaid or CHIP enrollees who disenrolled during the calendar year and did not re-enroll within 12 months (i.e., exits). CHIP=Children's Health Insurance Program.

Appendix F compares the frequency at which beneficiaries experienced churn in all attributed regions and award recipients' states from 2018-2021.

AHHN, BE-InCK NY, CT InCK Embrace New Haven, and NC InCK had higher rates of churn than their corresponding states prior to the PHE; while NJ InCK, OH InCK, and Village InCK had lower rates of churn relative to their states during the same period. NJ InCK had the largest absolute difference in churn between the state and the attributed region.

Overall, the relative differences between the attributed region and statewide percentages of beneficiaries experiencing churn remained stable between 2018 and 2019 (ranging from 5-12%); notably, the two years unaffected by the PHE continuous coverage policy. Rates of churn in all award recipients' attributed regions and their states dropped to 3 percent or lower by 2021, almost certainly because of the PHE's continuous coverage provisions.

Medicaid Churn by Subgroups

Enrollment policies may interact with individual and community level factors. Unobserved factors associated with an individual's demographic characteristics may pose disproportionate burdens to maintaining coverage. For example, racial discrimination may influence housing stability which in turn can contribute to churn. Enrollment practices such as the use of ex parte renewals or ELE might be especially helpful to families more likely to experience frequent changes in address.

> Future analyses will examine trends in enrollment gaps after the PHE ends and how these trends differed between demographic subgroups before and after the PHE.

Subgroup analyses provide insight into children's characteristics that are associated with churn, such as age, race, and ethnicity. Understanding who is more likely to experience churn can inform which specific or appropriate strategies to employ to reduce churn. For example, pediatricians, other medical providers, and their office staff can help families with very young children maintain coverage, and schools and community centers may be a valuable resource for reducing churn among adolescents and young adults.

In the analyses that follow, we examined the patterns of churn among beneficiaries by age, race, and ethnicity during 2019—the most recent year before the PHE continuous coverage provisions took effect—to establish baseline rates. Future evaluation reports will include analyses to determine if patterns changed after the start of the InCK Model Implementation Period and the end of continuous enrollment, including how churn rates compare to in-state comparison regions. Future evaluation reports will also include analyses of enrollment gaps across subgroups to determine disparities in churn.

Medicaid Churn by Age Group for Each Attributed Population

Household income limits often determine a child's eligibility for Medicaid and/or CHIP. These limits can vary by age. Therefore, we assessed whether enrollments gaps differed between age groups of Medicaid-enrolled children within award recipients' attributed regions. Results for all InCK

> For information on income eligibility limits by age in InCK Model states, see Appendix C.

Model Award Recipients are in Appendix F. We summarize the results for each InCK Model Attributed Region below:

- **AHHN:** Young adults (18 – 20) were more likely to experience churn than other enrollees in the AHHN attributed region (14.1 percent of enrollees 18 – 20 experienced churn as compared to 8.9 percent of enrollees ages 1 – 2, 9.9 percent of enrollees ages 3 – 4, 8.9 percent of enrollees ages 5 – 11, and 8.0 percent of enrollees ages 12 – 17). Notably, among all award recipients, AHHN had the highest proportion of young adults experiencing churn.

- **BE-InCK NY:** Young children (ages 1 – 2) were more likely to experience churn than older children and young adults in the BE-InCK NY attributed region (11.7 percent of

enrollees ages 1 – 2, 9.2 percent of enrollees 3 – 4, 9.5 percent of enrollees 5 – 11, 9.9 percent among of aged 12 – 17, and 9.6 percent of enrollees 18 – 20).

- **CT InCK Embrace New Haven:** Young children (1 – 2) were more likely to experience churn than older children and young adults in the CT InCK Embrace New Haven attributed region (14.6 percent among enrollees 1 – 2, 9.5 percent among enrollees 3 – 4, 9.4 percent among enrollees 5 – 11, 10.2 percent among enrollees 12 – 17, and 10.0 percent among enrollees 18 – 20). Notably, CT InCK Embrace New Haven had the highest proportion of young children experiencing churn of all award recipients.

- **NC InCK:** Young children (1 - 2) were somewhat more likely to experience churn than older children and young adults in the NC InCK attributed region (5.9 percent of enrollees 1 – 2, 5.1 percent of enrollees 3 – 4, 5.4 percent of enrollees 5 – 11, 4.7 percent of enrollees 12 – 17, and 4.0 percent of enrollees 18 – 20). Notably, NC InCK had the lowest proportion of churn, regardless of age, of all award recipients.

- **NJ InCK:** Young adults (18 – 20) were somewhat more likely to experience churn than younger enrollees in the NJ InCK attributed region (9.8 percent of enrollees 18 – 20, as compared to 8.6 percent of enrollees 1 – 2, 8.6 percent of enrollees 3 – 4, 8.6 percent of enrollees 5 – 11, and 9.1 percent of enrollees 12 – 17).

- **OH InCK:** Young adults (18 – 20), children 3 – 4, and young children (1 – 2) in the OH InCK attributed region were more vulnerable to churn than enrollees 5 – 11 and enrollees 12 – 17 (10.0 percent of enrollees 1 – 2, 10.0 percent of enrollees 3 – 4, 8.8 percent of enrollees 5 – 11, 8.2 percent of enrollees 12 – 17, and 10.7 percent among enrollees 18 – 20).

- **Village InCK:** Young adults (18 – 20) in the Village InCK attributed region were more likely to experience churn than younger enrollees (8.6 percent among enrollees 1 – 2, 7.1 percent among enrollees 3 – 4, 6.8 percent among enrollees 5 – 11, 6.5 percent among enrollees 12 – 17, and 12.5 percent among enrollees 18 – 20).

Churn by Race and Ethnicity for Each Attributed Population

We used the race and ethnicity information available in the 2019 T-MSIS demographic and enrollment file to assess whether rates of enrollment gaps differ across these groups within InCK Model Attributed Regions.[ddd] All SMAs rely on self-reported race and ethnicity data collected during the Medicaid application and redetermination processes, but they are not permitted to require enrollees disclose their race or ethnicity.[110,111] Unwillingness to disclose

---

[ddd] T-MSIS race/ethnicity data have known limitations, including small cell sizes, missing data, and possible misreporting for minority groups. The race and ethnicity variables vary in completeness across states and years, which influences the reliability of these variables for the evaluation (https://www.kff.org/medicaid/issue-brief/medicaid-administrative-data-challenges-with-race-ethnicity-and-other-demographic-variables/). Throughout this chapter, we consider all race/ethnicity categories other than Hispanic to be non-Hispanic. We combined the Asian race/ethnicity category with the "Other" category, and we report "Unknown" as a separate race/ethnicity category.

one's race and ethnicity may be due to historical race-based discrimination, or it may be that the predefined list does capture the family's self-identification. Data may also be missing because they were not collected or because of administrative error. We categorize all those without race and ethnicity data as "unknown" race and ethnicity.

The award recipients span several regions with different demographic, socioeconomic, and political profiles, and we identified no consistent patterns in enrollment gaps by race and ethnicity across all seven award recipients. We characterize enrollment gaps across race and ethnicity groups in the InCK Model Attributed Regions below:

- **AHHN:** Black enrollees were mostly likely to experience Medicaid churn in the AHHN attributed region (10.9 percent of Black enrollees as compared to 9.3 percent of White enrollees, 8.2 percent of Other race and ethnicity enrollees, 8.8 percent of Hispanic enrollees, and 8.4 percent of enrollees with unknown race or ethnicity).

- **BE-InCK NY:** Enrollees with unknown race or ethnicity were most likely to experience Medicaid churn in the BE-InCK NY attributed region (12.5 percent of enrollees with unknown race or ethnicity as compared to 11.3 percent of White enrollees, 10.7 percent of Black enrollees, 7.9 percent of Other race and ethnicity enrollees, and 4.7 percent of Hispanic enrollees). Hispanic enrollees were much less likely to experience churn than all other enrollees.

- **CT InCK Embrace New Haven:** Black enrollees experienced Medicaid churn more frequently than other groups in the CT InCK Embrace New Haven attributed region (11.7 percent of Black enrollees as compared to 6.8 percent of White enrollees, 8.5 percent of Other race and ethnicity enrollees, 9.8 percent of Hispanic enrollees, and 9.2 percent of enrollees with unknown race or ethnicity). White enrollees experienced churn less frequently than all other groups.

- **NC InCK:** Hispanic enrollees experienced Medicaid churn more frequently than all other groups in the NC InCK attributed region (7.0 percent of Hispanic enrollees as compared to 5.0 percent of White enrollees, 4.2 percent of Black enrollees, 4.6 percent of Other race and ethnicity enrollees, and 0.8 percent among enrollees with unknown race or ethnicity). Enrollees with unknown race or ethnicity were much less likely to experience churn than all other enrollees.

- **NJ InCK:** Black enrollees experienced Medicaid churn more frequently than all other groups in the NJ InCK attributed region (16.4 percent of Black enrollees as compared to 7.0 percent of White enrollees, 11.4 percent of Other race and ethnicity enrollees, 11.8 percent of Hispanic enrollees, and 6.2 percent of enrollees with unknown race or ethnicity). NJ InCK had the highest proportion of Black enrollees experiencing churn of all award recipients.

- **OH InCK:** Enrollees of Other race and ethnicity experienced Medicaid churn more frequently than all other enrollees in the OH InCK attributed region (19.9 percent of Other race and ethnicity as compared to 9.0 percent of White enrollees, 10.1 percent of Black enrollees, 9.2 percent of Hispanic enrollees, and 5.8 percent of enrollees with

unknown race or ethnicity). Enrollees with unknown race or ethnicity were less likely to experience churn than all other enrollees.

- **Village InCK:** Hispanic enrollees experienced Medicaid churn more frequently than all other groups in the Village InCK attributed region (10.5 percent of Hispanic enrollees as compared to 7.5 percent of White enrollees, 9.4 percent of Black enrollees, 4.9 percent of Other race and ethnicity enrollees, and 4.8 percent of enrollees with unknown race or ethnicity). Enrollees with unknown race or ethnicity were less likely to experience churn than all other enrollees.

Medicaid Eligibility and Enrollment During The PHE

The Families First Coronavirus Response Act (FFCRA) mandated continuous Medicaid enrollment beginning March 18, 2020, meaning individuals who gained Medicaid coverage at any point during the PHE were to remain enrolled throughout the PHE. In response to this mandate, CMS temporarily increased the Federal Medical Assistance Percentage (FMAP) by 6.2 percent[91] to help states finance the larger number of individuals maintaining Medicaid coverage.[eee]

While many state Medicaid programs paused outreach to Medicaid beneficiaries during the PHE, enrollment in Medicaid nonetheless increased by 27.1 percent (19.8 million individuals) between February 2020 and August 2022, with some states experiencing as much as a 71.8 percent increase in enrollment.[112] As of September 2022, Medicaid and CHIP enrollment was at an historic high of 91 million individuals.[100]

Anticipated Churn When the PHE's Continuous Coverage Provisions End

Estimates of Churn Following the PHE

The Assistant Secretary for Planning and Evaluation (ASPE) estimated 82.7 percent of Medicaid enrolled individuals (as of August 2022) would retain coverage after the continuous coverage provisions first introduced by the PHE ended in May 2023. Of the disenrolled, ASPE expected that 7.4 percent—6.8 million individuals—would lose Medicaid coverage due to administrative churn. Additionally, ASPE projected almost 75 percent of children aged 0-17 would lose eligibility due to churn.

The remaining 9.5 percent are projected as truly ineligible and require transition to Marketplace or employer-sponsored plans.

---

eee The Federal Medical Assistance Percentage (FMAP) is the federal share of total costs for Medicaid services in each state. FMAP is calculated for each state based on a formula that accounts for the average per capita income for each state relative to the national average. FMAP varies from state to state and year to year but is never less than 50 percent. For more information, see "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate" available at https://www.kff.org/wp-content/uploads/2013/01/8352.pdf.

Source: Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches (Issue Brief HP-2022-20) Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. August 19, 2022.

The Consolidated Appropriations Act, 2023 (CAA) decoupled Medicaid enrollment from the PHE. Per the CAA, the continuous enrollment provision ended on March 31, 2023. States subsequently had up to 12 months to initiate and 14 months to complete redeterminations for all Medicaid-enrolled individuals.[113] Analysts estimate that more than three million children will experience churn as a result of ending the continuous coverage provision.[91]

Policy researchers, program administrators, and advocates have warned that the PHE unwinding may instigate unprecedented Medicaid churn. Several factors complicate Medicaid agencies' redetermination efforts. These include the current size of Medicaid enrollment; disruption in contact between Medicaid agencies and beneficiaries during the PHE; and increased residential mobility due to economic instability and the end of PHE rental protections.[114] For example, out-of-date mailing addresses will present a major hurdle to expedient redeterminations.[109]

Conclusion

Previous evidence suggests that the risk of administrative churn is greatest for children 1 – 17 years, followed by young adults (18 – 20 years). Estimates indicate that when continuous coverage provisions expire, nearly three-quarters of children who lose Medicaid or CHIP coverage will remain eligible.[91,115] Our findings suggest that young children (1 – 2), young adults, and Black and Hispanic beneficiaries in the InCK Model Attributed Regions may be most likely to experience disruptions in coverage after continuous coverage ended in April 2023. In most but not all InCK Model attributed regions, infants, and children (1 – 2 years), and young adults were more likely to experience churn prior to the start of the PHE. Beneficiaries identified as Black and/or Hispanic in T-MSIS were more likely than those identified as White to experience enrollment gaps prior to the start of the PHE in all InCK Model Attributed Regions (except BE-InCK NY), which suggests that these groups may be more likely to experience churn after the end of the PHE. SMAs may implement practices to reduce the likelihood of enrollment gaps by targeting enrollees with increased risk for churn as the unwinding of continuous enrollment progresses. InCK Model activities may support enrollment and re-enrollment, thereby further reducing the risk for churn.

APPENDIX F. METHODS FOR CALCULATING MEDICAID CHURN AND RESULTS

We modeled our approach for estimating Medicaid churn after the Kaiser Family Foundation's (KFF) issue brief, "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies," with three notable exceptions.[116] First, we used Transformed Medicaid Statistical Information System (T-MSIS) data to analyze Medicaid churn among children (aged 0 to less than 21) over four years, between 2018 and 2021; whereas, KFF estimated churn for calendar year 2018 and inclusive of all eligibility groups beyond age. The KFF issue brief defines churn as a gap in continuous coverage for each target year as two periods of enrollment separated by a period of disenrollment, for a length of time less than or equal to 365 days. To avoid truncating our data, we looked back and forward twelve months to identify any periods of enrollment separated by a gap. For this analysis, our preliminary descriptive results identified qualitatively similar findings for churn lasting three, six, and nine months; thus, we limited reporting to churn lasting less than or equal to 12 months.

Example: Identifying a Gap in Enrollment

The target year to calculate churn is calendar year 2018. In this hypothetical example, we identify a beneficiary whose earliest enrollment date for 2018 is on February 1, 2018. To determine churn, we look for prior enrollment through February 2017. The 2017 data shows the beneficiary was enrolled until October 31, 2017. This beneficiary meets the definition of churn for 2018: having an enrollment gap between October 31, 2017, and February 1, 2018, a gap in coverage that took place during the 2018 calendar year.

For all churn analyses, we excluded beneficiaries who had less than 12 months of continuous eligibility if they had either exited Medicaid altogether (exited) or were first time beneficiaries to the Medicaid program (new entrants).

- We define exited as Medicaid beneficiaries who do not have an enrollment date in the 12 months following the last enrollment date of a target year. For example, if a beneficiary's last enrollment for calendar year 2019 is December 1, 2019, and there was no other enrollment from December 2, 2019, to December 1, 2020, then the beneficiary meets the definition of exited. In 2019, the most recent year prior to the public health emergency (PHE), the percentage of Medicaid beneficiaries who met this definition ranged from 8.5 percent (Village InCK) to 16.1 percent (OH InCK). Of those who exited, about two-fifths were young adults (aged 18-20). The remaining exited beneficiaries' administrative Medicaid records included eligibility factors such as death, moved out of the state, exceeded income eligibility threshold, and other factors.

- We define new entrants as Medicaid beneficiaries who do not have an enrollment date in the 12 months prior to the initial enrollment date of a target year. For example, if a beneficiary's initial enrollment for calendar year 2019 is December 1, 2019, and there

was no other enrollment from December 1, 2018, through November 30, 2019, then the beneficiary meets the definition of a new entrant. In 2019, the percentage of Medicaid beneficiaries who were new entrants ranged from 8.4 percent (NC InCK) to 11.7 percent (Village InCK). Of those who are new entrants, about half were newborns (age <1). Other reasons for becoming a new entrant include moving into the state, income eligibility, and other factors.

Exhibit F.1 provides a complete listing of churn for all award recipients' attributed regions and corresponding states from 2018-2021. Medicaid and Children's Health Insurance Program (CHIP) enrollees in AHHN, BE-InCK NY, CT InCK Embrace New Haven, and NC InCK's attributed regions had higher rates of churn than all enrollees in their state prior to the PHE. The opposite pattern is displayed for NJ InCK, OH InCK, and Village InCK. NJ InCK had the largest absolute difference in churn compared to their respective state overall. The rate of enrollment gaps in all award recipients' attributed regions and their respective states dropped 3 percent or lower by 2021, likely due to the PHE continuous coverage provision.

Exhibit F.1. The Frequency of Churn of 12 Months or Less Varied Across InCK Model Attributed Regions and States (2018-2021).

InCK Model Award Recipient	2018		2019		2020		2021	
	N	%	n	%	n	%	n	%
AHHN								
InCK Attributed Region	32,141	**9.32%**	30,337	**11.21%**	29,993	**4.49%**	30,111	**1.21%**
State	1,188,889	8.83%	1,147,332	10.21%	1,188,265	4.78%	1,248,842	1.78%
Percentage Point Difference		0.48*		1.01*		-0.29*		-0.58*
BE-InCK NY								
InCK Attributed Region	33,836	**10.88%**	34,003	**11.99%**	35,684	**6.77%**	37,284	**1.97%**
State	1,877,108	10.96%	1,849,660	11.75%	1,974,065	5.98%	2,106,503	1.43%
Percentage Point Difference		-0.08		0.24		0.79*		0.54*
CT InCK Embrace New Haven								
InCK Attributed Region	7,473	**12.70%**	7,575	**12.38%**	7,817	**7.15%**	8,139	**1.79%**
State	336,978	11.66%	337,760	10.68%	350,658	5.96%	363,125	1.72%
Percentage Point Difference		1.04*		1.70*		1.19*		0.07
NJ InCK								
InCK Attributed Region	106,421	**10.40%**	108,523	**10.23%**	116,444	**4.25%**	124,910	**0.67%**
State	750,044	13.52%	745,055	14.98%	792,454	6.52%	844,950	1.03%
Percentage Point Difference		-3.12*		-4.76*		-2.28*		-0.35*
NC InCK								
InCK Attributed Region	80,115	**5.65%**	79,230	**5.82%**	83,432	**2.76%**	Not reported	Not reported
State	1,166,197	5.09%	1,147,280	5.78%	1,217,108	2.90%	Not reported	Not reported
Percentage Point Difference		0.57*		0.04		-0.13*		-
OH InCK								
InCK Attributed Region	26,352	**9.94%**	25,607	**11.17%**	27,046	**5.48%**	28,820	**1.72%**
State	1,158,870	10.00%	1,124,952	10.98%	1,197,331	5.47%	1,271,013	1.58%
Percentage Point Difference		-0.06		0.19		0.01		0.15*
Village InCK								
InCK Attributed Region	7,037	**8.57%**	7,229	**8.88%**	7,522	**4.76%**	7,770	**2.92%**
State	1,188,889	8.83%	1,147,332	10.21%	1,188,265	4.78%	1,248,842	1.78%
Percentage Point Difference		-0.27		-1.33*		-0.02		1.14*

Source: Abt analyses of Interim Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files, 2017–2022: Demographic and Enrollment.

Note: Table shows the total number of beneficiaries aged 0 < 21 in each area and the percentage with a 12-month or less enrollment gap. Denominator excludes entries and exits. An asterisk indicates a statistically significant difference at the a = 0.05 level. Bolded text is the churn rate InCK Attributed Region. Data are incomplete in North Carolina for 2021 and thus not shown.

Subgroup Analyses of Medicaid Churn

We conducted subgroup analyses to assess variation in Medicaid churn by beneficiary **age** and **race and ethnicity**. For each attributed region, we used z-tests to test for statistically significant differences in the percentage of Medicaid and CHIP enrollees in each age or race and ethnicity group with an enrollment gap less than 12 months, between the attributed region and the overall state.

We group ages using cutoffs based on Medicaid enrollment policy, (e.g., policies for young adults [aged 18-20] versus children). We excluded children less than one year old from the age group comparisons because policies guaranteeing one year of Medicaid enrollment to newborns result in very few experiencing an enrollment gap.

T-MSIS race and ethnicity data have known limitations, including small sample sizes, missing data, and misreporting. The race and ethnicity variable groups all individuals who identify as Hispanic into one group regardless of race; thus, all beneficiaries with a race value are also non-Hispanic. To reduce the risk of disclosure of an individual due to small numbers, we combined two race and ethnicity categories: Asian with the Other. We report Unknown as a separate race and ethnicity category, accounting for missing race and ethnicity values.

Exhibit F.2 shows the percentage of Medicaid and CHIP enrollees in each age group who experienced churn for less than 12 months, in both the attributed region and the overall state. Exhibit F.3 shows the percentage of Medicaid and CHIP enrollees in each race and ethnicity group who experienced churn for less than 12 months, in both the attributed region and the overall state.

Exhibit F.2. The Frequency of Churn of 12 months or Less Varied Across Age Groups, InCK Model Attributed Regions and States (2019).

InCK Model Award Recipient	Aged 1-2 Years		Aged 3-4 Years		Aged 4-11 Years		Aged 12-17 Years		Aged 18-20 Years	
	n	%	n	%	n	%	n	%	N	%
AHHN										
InCK Attributed Region	3,622	**10.33%**	3,433	**9.90%**	13,057	**8.95%**	10,230	**7.97%**	3,884	**14.13%**
State	153,426	9.17%	150,651	7.86%	507,444	7.30%	398,319	7.30%	151,548	12.74%
Percentage Point Diff.		1.16*		2.04*		1.65*		0.67		1.39*
BE-InCK NY										
InCK Attributed Region	4,605	**11.73%**	4,371	**9.17%**	14,553	**9.50%**	11,894	**9.85%**	2,459	**9.60%**
State	253,369	11.30%	246,421	9.64%	836,029	8.94%	652,441	9.12%	127,337	10.64%
Percentage Point Diff.		0.43		-0.47		0.56		0.73		-1.04*
CT InCK Embrace New Haven										
InCK Attributed Region	918	**14.60%**	838	**9.55%**	3,163	**9.42%**	2,387	**10.22%**	1,136	**9.95%**
State	39,233	11.64%	39,191	8.60%	140,172	8.38%	113,884	8.05%	50,428	9.99%
Percentage Point Diff.		2.96*		0.95		1.04		2.17*		-0.04
NJ InCK										
InCK Attributed Region	14,998	**8.65%**	14,575	**8.61%**	46,193	**8.56%**	32,161	**9.12%**	10,991	**9.82%**
State	94,566	13.92%	93,432	12.96%	326,525	12.07%	250,560	11.78%	93,257	12.65%
Percentage Point Diff.		-5.27*		-4.35*		-3.51*		-2.66*		-2.83*
NC InCK										
InCK Attributed Region	10,013	**5.94%**	9,965	**5.15%**	34,542	**5.38%**	25,180	**4.75%**	5,460	**4.05%**
State	145,955	5.94%	147,209	5.04%	503,694	5.11%	381,842	4.51%	83,816	4.52%
Percentage Point Diff.		0.00		0.11		0.27		0.24		-0.47
OH InCK										
InCK Attributed Region	3,477	**9.98%**	3,337	**10.01%**	11,432	**8.76%**	8,443	**8.18%**	3,398	**10.74%**
State	155,306	9.61%	149,550	9.52%	499,383	8.75%	374,313	8.27%	149,803	9.55%
Percentage Point Diff.		0.37		0.49		0.01		-0.09		1.19*
Village InCK										
InCK Attributed Region	930	**8.60%**	958	**7.10%**	2,963	**6.78%**	2,366	**6.51%**	846	**12.53%**
State	153,426	9.17%	150,651	7.86%	507,444	7.30%	398,319	7.30%	151,548	12.74%
Percentage Point Diff.		-0.57		-0.76		-0.52		-0.79		-0.21

Source: Abt analyses of Interim Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files, 2018–2020: Demographic and Enrollment.

Note: InCK = Integrated Care for Kids, Diff = Difference. Table shows the total number of beneficiaries aged 0 - < 21 in each area and the percentage with a 12-month or less enrollment gap. Denominator excludes entries and exits. An asterisk indicates a statistically significant difference at the a = 0.05 level. Bolded text is the churn rate in the InCK Attributed Region.

Exhibit F.3. The Frequency of Churn of 12 Months or Less Varied Across Race and Ethnicity Groups, InCK Model Attributed Regions and States (2019).

InCK Model Award Recipient	White		Black		Other		Hispanic		Unknown	
	n	%	n	%	N	%	n	%	N	%
AHHN										
InCK Attributed Region	9,667	**9.3%**	9,184	**10.9%**	256	**8.2%**	13,652	**8.8%**	1,467	**8.4%**
State	602,216	7.7%	405,925	9.6%	44,738	6.3%	254,868	7.9%	53,641	5.9%
Percentage Point Diff.		1.60*		1.30*		1.90*		0.90		2.50*
BE-InCK NY										
InCK Attributed Region	2,352	**11.3%**	9,302	**10.7%**	3,474	**7.9%**	8,273	**4.7%**	14,481	**12.5%**
State	559,537	8.7%	388,720	11.1%	197,162	7.2%	229,534	4.8%	740,644	11.2%
Percentage Point Diff.		2.60*		-0.40		0.70		-0.10		1.30*
CT InCK Embrace New Haven										
InCK Attributed Region	468	**6.8%**	3,670	**11.7%**	223	**8.5%**	1,709	**9.8%**	2,372	**9.2%**
State	92,634	6.9%	63,067	11.0%	14,058	6.9%	95,667	9.2%	117,482	9.2%
Percentage Point Diff.		-0.10		0.70		1.60		0.60		0.00
NJ InCK										
InCK Attributed Region	73,668	**7.0%**	10,360	**16.4%**	1,858	**11.4%**	25,149	**11.8%**	7,883	**6.2%**
State	287,397	9.5%	197,532	15.1%	40,792	11.2%	271,928	14.6%	60,691	7.6%
Percentage Point Diff.		-2.50*		1.30*		0.20		-2.80*		-1.40*
NC InCK										
InCK Attributed Region	22,321	**5.0%**	35,850	**4.2%**	4,463	**4.6%**	22,285	**7.0%**	241	**0.8%**
State	486,389	4.7%	431,608	4.7%	89,152	5.0%	250,509	6.2%	4,858	0.5%
Percentage Point Diff.		0.30		-0.50		-0.40		0.80*		0.30*
OH InCK										
InCK Attributed Region	23,166	**9.0%**	2,968	**10.1%**	1,171	**14.9%**	574	**9.2%**	2,208	**5.8%**
State	706,950	8.1%	405,265	10.4%	31,903	9.7%	82,018	11.2%	102,219	6.0%
Percentage Point Diff.		0.90		-0.30		5.20*		-2.00*		-0.20
Village InCK										
InCK Attributed Region	7,379	**7.5%**	406	**9.4%**	81	**4.9%**	114	**10.5%**	83	**4.8%**
State	602,216	7.7%	405,925	9.6%	44,738	6.3%	25,4868	7.9%	53,641	5.9%
Percentage Point Diff.		-0.20		-0.20		-1.40		2.60*		-1.10

Source: Abt analyses of Interim Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files, 2018–2020: Demographic and Enrollment.

Note: InCK = Integrated Care for Kids, Diff = Difference. Table shows the total number of beneficiaries aged 0 - < 21 in each area and the percentage with a 12-month or less enrollment gap. Denominator excludes entries and exits. An asterisk indicates a statistically significant difference at the a = 0.05 level. Bolded text is the churn rate in the InCK Attributed Region.

APPENDIX G. NEEDS ASSESSMENTS CONDUCTED THROUGH QUARTER 2, 2022

At the end of 2022, all but one award recipient, CT InCK Embrace New Haven, submitted Service Integration Level (SIL) assignments for Quarter 1 (Q1) and Q2 2022. The number of beneficiaries with SIL data varied across award recipients. This is due to the method award recipients used to collect the data for each Core Child Service (CCS) domain used to inform SIL assignment, and the extent to which the data submission informed a preliminary SIL assignment versus a confirmed final SIL assignment.

Exhibit G.1. Number and Percentage of InCK Model Beneficiaries Assessed for Need by CCS Domain Varied as of Q2 2022.

Award Recipient	AHHN	BE-InCK NY	CT InCK Embrace New Haven	NJ InCK	NC InCK	OH InCK	Village InCK
Total # of Beneficiaries with Any Assessment[a]	**38,470**	**34,132**	-- [g]	**122**	**102,209**	**29,873**	**345**
Percent (Number) of Beneficiaries with Domain Assessment							
Behavioral Health	100% (38,470)	100% (34,132)	--	98% (120)	100% (102,209)	100% (29,873)	98% (337)
Child Welfare Involvement	100% (38,470)	100% (34,132)	--	--	100% (102,209)	97% (28,843)	94% (321)
Food/Nutrition	1% (303)	100% (34,132)	--	52% (64)	--	100% (29,873)	94% (322)
Functional Impairments[c]	1% (303)	100% (34,132)	--	--	--	0% (104)	8% (28)
Functional Symptoms[d]	100% (38,470)	100% (34,131)	--	--	100% (102,209)	100% (29,873)	8% (28)
Housing Instability	1% (303)	100% (34,132)	--	43% (52)	--	100% (29,873)	94% (324)
Maternal and Child Health	1% (303)	100% (34,132)	--	66% (81)	31% (32,123)	100% (29,873)	97% (331)
Out of Home Placement[e]	100% (38,470)	100% (34,132)	--	44% (54)	100% (102,209)	100% (29,873)	97% (333)
Physical Health	100% (38,470)	100% (34,132)	--	98% (120)	100% (102,209)	100% (29,873)	96% (330)
Special Education and Early Intervention	21% (8,247)	100% (34,132)	--	98% (120)	31% (32,123)	97% (28,843)	96% (330)
Other[f]	--	--	--	--	100% (102,209)	--	--

Source: InCK Model Award Recipients' Q1 2022 and Q2 2022 SIL data submissions.

Notes:
   a. The number of beneficiaries with needs assessment data comprises beneficiaries included in either the Q1 2022 or Q2 2022 SIL data submissions.
   b. For each award recipient, the percent of beneficiaries with needs assessment data is calculated as the number of beneficiaries with a need assessment in that domain in either the Q1 2022 or Q2 2022 SIL data submission or

both divided by the total number of beneficiaries with at least one assessment in any CCS domain in the Q1 2022 and Q2 2022 SIL data submissions.

c. Functional impairments are defined based on an inability to perform self-care or to function in the community, in the family, in social relationships, or at school/work/early learning settings.

d. Functional symptoms include substance use, serious emotional disturbance, chronic medical conditions, and medically complex conditions.

e. Out of Home placements may reflect either a current or an imminent risk of Out of Home Placement.

f. Other assessment data reflects assessments award recipients reported separately distinct from assessments for the CMS-defined CCS domains (behavioral health, child welfare involvement, food insecurity, functional impairments, functional symptoms, housing instability, maternal and child health, Out of Home placements, physical health, and special education and early intervention).

g. - - indicates the award recipient did not submit data in Q1 2022 or Q2 2022.

APPENDIX H. DESCRIPTION OF AWARD RECIPIENTS' NEEDS ASSESSMENTS BASED ON ADMINISTRATIVE DATA

All InCK Model Award Recipients are using Medicaid claims data to assess beneficiaries' Core Child Services (CCS) needs. Award recipients are also using Medicaid eligibility and enrollment data and data from other state agencies to assess needs in all or some of the required CCS domains. A detailed description of the data sources by domain follows.

Behavioral Health

All award recipients, except Village InCK, assess behavioral health needs using Medicaid data. Behavioral health needs were identified in Medicaid data based on diagnosis, procedure, and service codes; enrollment and eligibility information; or through validated or proprietary algorithms.

- AHHN defined behavioral health need based on claims for serious emotional disturbance or substance use disorder.

- BE-InCK NY assessed need by using diagnosis codes for acute and chronic disorders, such as depression and phobias, substance abuse, and developmental disorders in claims and medical or health records.

- CT InCK Embrace New Haven will assess behavioral health need for pregnant and postpartum individuals through CareAnalyzer® and will use the Pediatric Medical Complexity Algorithm (PMCA) for all other beneficiaries.

- NC InCK used NC Medicaid's behavioral health complexity designations, such as enrollment in a health plan targeting beneficiaries with mental and behavioral health needs, and behavioral health utilization measures reported in claims data, such as mobile crisis response and anti-psychotic medications.

- NJ InCK used the Pediatric Medical Complexity Algorithm (PCMA) to identify beneficiaries with significant behavioral health needs.

- OH InCK used diagnosis codes in Medicaid claims data but had not finalized a list of codes by the end of Q3 2022.

The PMCA uses diagnosis codes to identify medical complexity for multiple body systems, including mental health. CT InCK Embrace New Haven plans to use and NJ InCK used PMCA diagnoses codes to identify needs in multiple CCS domains. Similarly, CT InCK Embrace New Haven intends to use CareAnalyzer® to identify beneficiaries' behavioral health, functional symptom, and physical health needs.

Child Welfare Involvement

Five award recipients identified child welfare using Medicaid enrollment and eligibility files, data from state child welfare, and Medicaid claims. CT InCK Embrace New Haven plans to use and OH InCK used state child welfare agency data to identify child welfare involvement.

While OH InCK used state child welfare data for out-of-home placement (OOHP) as well, OH InCK also used an open child welfare case to flag child welfare involvement. AHHN, BE-InCK NY, and NC InCK identified involvement through Medicaid enrollment data and eligibility codes. Service integration coordinators for AHHN also assessed beneficiaries for child welfare needs, but this information was not reported in their Q1 and Q2 2022 SIL data submissions. BE-InCK NY also used foster care codes in Medicaid claims to identify child welfare involvement needs.

Food Insecurity

BE-InCK NY and OH InCK used administrative data to assess food insecurity. BE-InCK NY used Z-codes in claims and encounter data to assess food insecurity.[fff,117] OH InCK linked beneficiaries' address data provided in Medicaid data to publicly available, geospatial measures. OH InCK used the Ohio Opportunity Index[ggg,118] and indicators of food access[hhh] as proxies for food insecurity needs.[iii]

While NC InCK plans to use screening data to assess food insecurity, that data was unavailable as of Q2 2022. As a result, NC InCK used the social deprivation index[jjj,119] as a proxy for food insecurity.

Functional Impairments

CMS requires award recipients to assess unmet needs for five aspects of functional impairments: self-care and functioning in the community, the family, social relationships, or

---

[fff] Z-codes are ICD-10 codes that clinicians, case managers, and other providers that interact with patients use to document social needs ranging from unemployment to housing. CMS first introduced Z codes in 2015; however, adoption and recording of them by providers has been slow.

[ggg] The Ohio Opportunity Index synthesizes over 34 variables measuring neighborhood conditions known to be associated with health and well-being across domains such as healthcare access, children's health, criminal justice, education, environment, family stability, housing, and infant health into a single index score. More information is available at: https://grc.osu.edu/Projects/OhioOpportunityIndex.

[hhh] The United States Department of Agriculture Economic Research Service develops food access indicators at the census-tract-level. More information is available at: https://www.ers.usda.gov/data/fooddesert.

[iii] Community level data, such as the Ohio Opportunity Index, provides an estimate of the level of food insecurity for an entire neighborhood or community. Assuming that all individuals in a neighborhood with higher levels of food insecurity are food insecure is a common form of bias known as ecological fallacy.

[jjj] The social deprivation index is a composite measure based on seven demographic characteristics collected in the American Community Survey and is calculated at the county, census tract, ZIP code, and primary care service area levels. The included measures are percent living in poverty, percent with less than 12 years of education, percent single-parent households, percent living in rented household units, percent living in overcrowded housing units, percent of households without a car, and percent of unemployed adults under 65.

at school/work/early learning settings. The needs identified in this domain are more difficult to directly tie to administrative or medical utilization data, and only one award recipient (BE-InCK NY) used administrative data for this CCS domain. BE-InCK NY assessed functional impairments using diagnosis, service, and procedure codes in Medicaid claims and clinical data.[kkk]

NC InCK found the medical utilization and programmatic eligibility data they identified to assess functional impairments overlapped with data reported in the CCS domains of behavioral health, special education, and early intervention. Further, NC InCK was unable to report functional impairment indicators obtained from other state agencies due to restrictions in their data use agreements. On November 10, 2022, CMS waived the requirement for NC InCK to separately report needs for beneficiaries in this domain.

Functional Symptoms

All award recipients, except NJ InCK, used, or plan to use, diagnoses reported in Medicaid claims or health records to assess at least one of the four aspects of functional symptoms: substance use, serious emotional disturbance, multiple chronic conditions, and complex medical conditions. AHHN, BE-InCK NY, and OH InCK relied on diagnosis, procedure, and service codes in claims and encounter data to assess functional symptoms. CT InCK Embrace New Haven also intends to use claims data to determine substance use needs. Three award recipients (AHHN, CT InCK Embrace New Haven, and Village InCK) selected the same claims-based algorithm to assess multiple chronic conditions and complex medical conditions as they did to assess physical health needs. CT InCK Embrace New Haven is planning to use diagnosis codes from the PMCA algorithm to identify beneficiaries with serious emotional disturbances and medically complex conditions. The 3M Clinical Risk Group (CRG) algorithm[lll,8] identifies healthy, significant acute, and seven chronic condition categories classified by severity, which can identify beneficiaries with multiple chronic conditions and complex medical conditions.

As with the functional impairments domain, NC InCK found the diagnosis codes they intended to use in this domain overlapped with those used to assess physical and behavioral health needs. On November 10, 2022, CMS waived the requirement for NC InCK to

---

[kkk] BE-InCK NY's process for identifying unmet needs in this domain is evolving. For example, a diagnosis code for dietary counseling and surveillance, intended to reflect a need for self-care, in practice reflects the occurrence of a conversation about diet, which does not make sense for the InCK Model Attributed Population. As a result, this diagnosis code was removed from the algorithm used to flag a self-care need.

[lll] The Clinical Risk Groups (CRG) algorithm uses administrative data to stratify children in nine health status groups—healthy, significant acute, and seven chronic condition categories which are then further classified by severity. The CRG system is used to classify children aged 0 – 18 into nine hierarchical categories which has been tested in adults and children in Medicare, Medicaid, and enrolled in private insurance.

separately report needs for beneficiaries in this domain. As of Q2 2022, NC InCK only reported assessments for medically complex conditions.

Housing Instability

BE-InCK NY and OH InCK used administrative data to assess housing instability. BE-InCK NY used Z-codes in claims and encounter data to assess housing instability.[mmm,117] OH InCK obtained beneficiaries' addresses from Medicaid data and assessed housing instability based on the number of changes in address within a certain set of time.

As with food insecurity, NC InCK plans to use screening data to assess housing instability, however, that data was unavailable as of Q2 2022. NC InCK used the social deprivation index[nnn,119] as a proxy for housing instability needs.

Maternal and Child Health

Three award recipients (BE-InCK NY, NC InCK, and OH InCK) developed unique methods for assessing maternal and child health (MCH) needs using administrative data. BE-InCK NY used claims and encounter data to examine diagnoses, services, and procedure codes: acute care visits, behavioral health screenings, and perinatal care/late entry to prenatal care. NC InCK executed a two-generational approach by linking Medicaid claims data for children and their mothers and assessed multiple dimensions of need. They limited their assessments to children aged five and under, resulting in MCH assessments for 31 percent of their attributed beneficiaries. Specifically, NC InCK reviewed:

- Beneficiaries' mothers' Medicaid claims to identify substance use during pregnancy and perinatal depression.

- Beneficiary Medicaid claims for under-utilization of preventive services or enrollment in NC Medicaid's Care Management for At-Risk Children program, which provides services to Medicaid enrollees aged five and under.

OH InCK used diagnosis codes within Medicaid claims to identify conditions that serve as an indicator of Women, Infants, and Children (WIC) or special education and early intervention

---

[mmm] Z-codes are ICD-10 codes that clinicians, case managers, and other providers that interact with patients use to document social needs ranging from unemployment to housing. CMS first introduced Z codes in 2015; however, adoption and recording of them by providers has been slow.

[nnn] The social deprivation index is a composite measure based on seven demographic characteristics collected in the American Community Survey and is calculated at the county, census tract, ZIP code, and primary care service area. The included measures are percent living in poverty, percent with less than 12 years of education, percent single-parent households, the percent living in rented household units, the percent living in overcrowded housing units, percent of households without a car, and percent of unemployed adults under 65.

program eligibility. OH InCK also intends to use the Ohio Opportunity Index[ooo,118] as a proxy for MCH needs.

Out-of-Home Placement

AHHN, BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and OH InCK identified administrative data sources to determine current or imminent risk of OOHP. Other than CT InCK Embrace New Haven, award recipients employed multiple types of administrative data to identify a current, or imminent risk of OOHP.

- AHHN used claims data to identify beneficiaries that participated in the Illinois Department of Children and Family Services programs. This administrative data is used to jointly identify child welfare involvement and OOHP. AHHN's service integration coordinators also assessed whether beneficiaries are at risk of OOHP, but this information was not reported in their SIL data submissions. AHHN also intends to use claims data to identify nursing home placements and prolonged hospitalizations. They intend to use the CRG algorithm to identify beneficiaries at risk of a clinical OOHP based on a high CRG score.

- CT InCK Embrace New Haven intends to use CT Department of Children and Families data to identify OOHP, but they did not report how this data will be used to identify OOHP separately from child welfare involvement.

- As with child welfare involvement, BE-InCK NY used Medicaid claims data to identify children in foster care. BE-InCK NY also examined medical utilization for clinical OOHP, such as prolonged hospitalizations, or stays in residential treatment, skilled nursing, or behavioral health residential care facilities.

- NC InCK assessed OOHP through current foster care enrollment identified in Medicaid eligibility data and through claims data indicating inpatient admissions and stays in a skilled nursing or residential treatment facility. While NC InCK had access to administrative child welfare and juvenile justice data, they were unable to report that data due to their data use agreements.

- OH InCK used state child welfare data to identify current or previous OOHP or sibling child welfare involvement. OH InCK also reviewed Medicaid data for aid involvement and medical utilization indicative of OOHP (e.g., prolonged inpatient stays, psychiatric inpatient, residential treatment, and skilled nursing stays).

[ooo] The Ohio Opportunity Index synthesizes over 34 variables measuring neighborhood conditions known to be associated with health and well-being across domains such as healthcare access, children's health, criminal justice, education, environment, family stability, housing, and infant health into a single index score. More information is available at: https://grc.osu.edu/Projects/OhioOpportunityIndex

Physical Health and Inpatient Admissions

Although all award recipients used Medicaid claims to assess physical health needs and inpatient admissions, assessment methods to identify needs varied. All award recipients, except BE-InCK NY, used, or plan to use, the CRG algorithm[ppp,8] or the PMCA[qqq,9] to assess physical health needs. While award recipients used these algorithms in other CCS domains, diagnoses codes from the PMCA algorithm can be restricted to those indicating a physical health need. AHHN used the same CRG assessments to determine needs in the physical health and the functional symptoms domains. Village InCK had not yet used claims data for the purposes of needs assessment, as of Q2 2022.

Rather than using a pre-existing algorithm, BE-InCK NY incorporated both claims data and health records to assess physical health needs based on diagnosis, procedure, and service codes, lab results, and clinical results. Examples of data elements BE-InCK NY used to indicate physical health needs include high body mass index measures, high Hgb A1c levels (measures blood sugar levels to assess for diabetes mellitus), and preventable emergency department visits or hospitalizations.

Some award recipients employed additional assessments to assess physical health needs, which are specific to subsets of their beneficiaries. For example:

- AHHN used Medicaid claims data to assess newborns for neonatal abstinence syndrome, a condition which results from exposure to opioids and other deleterious substances during gestational development.

- CT InCK Embrace New Haven's attributed population includes pregnant and postpartum beneficiaries for which they intend to assess physical health through the CareAnalyzer®, specifically designed to assess for physical health-related risks as a function of pregnancy and the postpartum period.[rrr]

[ppp] The Clinical Risk Groups (CRG) algorithm uses administrative data to stratify children in nine health status groups – healthy, significant acute, and seven chronic condition categories which are then further classified by severity. The CRG system is used to classify children, aged 0 – 18 in to nine hierarchical categories which has been tested in adults and children in Medicare, Medicaid and enrolled in private insurance.

[qqq] Washington MA initially designed the PCMA to identify individuals with complex health conditions, specifically children, and identify those who would benefit most from care coordination and other services. It has been validated in a variety of similar settings on populations similar to those served by the InCK Model.

[rrr] CareAnalyzer® provides risk score for pregnant and postpartum beneficiaries. Using the Johns Hopkins ACG® (Adjusted Clinical Group) Logic, CareAnalyzer® is an analytic approach to predictive modeling that uses ICD-10 codes from a one-year period of claims data and groups claims into five clinical categories: duration of the condition, severity of the condition, diagnostic certainty, etiology and expected need for specialty care. CareAnalyzer uses diagnostic codes to identify pregnant individuals and then identify those pregnant and postpartum individuals with higher levels of morbidity.

Special Education and Early Intervention

AHHN, BE-InCK NY, NC InCK, NJ InCK, and OH InCK used Medicaid data to identify special education and early intervention needs. AHHN reviewed claims data for the receipt of early intervention services and limited assessments to beneficiaries aged 4 and under. NC InCK also used Medicaid data to identify beneficiaries who are enrolled in early intervention programs, limiting assessments to beneficiaries aged 5 and under. BE-InCK NY used claims data and health records to identify beneficiaries with developmental screenings, individualized education plans, early periodic screening diagnosis and treatment screening exams and other diagnosis, and service and procedure codes indicative of a special educational or early intervention need.

NJ InCK and OH InCK did not specifically list sources for their special education and early intervention assessments in their documented needs assessment approach. However, both reported data in this domain in their Q1 and Q2 2022 SIL data submissions. NJ InCK reported special education and early intervention assessments from the PMCA algorithm, which includes codes for diagnoses such as developmental learning difficulties and intellectual disabilities. OH InCK reported assessments from claims data. In their documented needs assessment approach, OH InCK indicated that diagnosis codes within Medicaid claims would be used to identify conditions that serve as an indicator of special education and early intervention program eligibility.

Other Domains

NC InCK links children and guardian claims to determine two-generation guardian risks as a component of their SIL stratification process.

- Guardian Medicaid eligibility files for disability, behavioral health inpatient admissions, and enrollment in a tailored plan for behavioral health. NC InCK reported needs identified through guardian claims as an additional domain rather than incorporating it into their reporting of MCH needs.

APPENDIX I. DESCRIPTION OF AWARD RECIPIENTS' SCREEN-BASED ASSESSMENTS

All InCK Model Award Recipients are using screening tools conducted either in-person or telephonically to assess or verify needs in at least some Core Child Services (CCS) domains. Some are screening all beneficiaries, while others are focusing screening on those beneficiaries who they anticipate are most likely to be eligible for Service Integration Level (SIL) 2 or SIL 3. Some award recipients developed their own screening tools, relying heavily on validated instruments. For example, AHHN closely followed the National Survey of Children's Health[120] (NSCH) when developing their screening tool. Similarly, BE-InCK NY and Village InCK drew from the Accountable Health Communities Health-Related Social Needs Screening Tool (HRSN).[121] Village InCK also used the Ages and Stages Questionnaire-Social Emotional (ASQ-SE)[122] and Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)[123] to assess needs in multiple CCS domains. CT InCK Embrace New Haven, NJ InCK, and OH InCK selected a broader set of validated instruments for individual CCS domains. A detailed description of the screening tools for each domain follows.

Physical Health

Four award recipients (AHHN, BE-InCK NY, CT InCK Embrace New Haven, and Village InCK) identified screening tools they use to confirm physical health needs or identify additional needs not captured in Medicaid claims. For example, BE-InCK NY and Village InCK plan to use HRSN to identify additional physical health needs. Village InCK is also using the Adverse Childhood Experience Questionnaire (ACE-Q)[124] and the Pediatric Adverse Events and Related Life-events Screener (PEARLS).[125]

Behavioral Health

Five award recipients (AHHN, BE-InCK NY, CT InCK Embrace New Haven, NJ InCK, and Village InCK) used, or plan to use, screening data to supplement behavioral health needs identified through Medicaid claims. These award recipients created tailored screening tools by drawing from validated instruments, including the NSCH,[120] HRSN,[121] PEARLS,[125] the ACE-Q,[124] CRAFFT,[sss,ttt,126] the Pediatric Symptom Checklist (PSC-17),[127] and the Survey of Well-being of Young Children (SWYC).[128]

[sss]   CRAFFT is a mnemonic for the six domains including in the screening tool. Available at: https://www.ndbh.com/Docs/PCP/CRAFT-adolescents.pdf

[ttt]   CRAFFT is a validated substance use screening tool for adolescents 12 – 21 designed to identify substance use, substance-related riding/driving risk, and substance use disorder.

Child Welfare

Four award recipients (AHHN, BE-InCK NY, NJ InCK, and Village InCK) identified unique screening resources for needs in the child welfare domain. BE-InCK NY adapted questions about child welfare engagement from the HRSN.[121] NJ InCK used questions from PSC-17[127] checklist and the SWYC.[128] Village InCK used the IM+ CANS.[123]

Out of Home Placement

Three award recipients (CT InCK Embrace New Haven, NJ InCK, and Village InCK) identified unique screening sources for child welfare involvement and out-of-home placement (OOHP). NJ InCK adapted questions from PEARLS;[125] while Village InCK adapted questions from PEARLS,[125] ACE-Q,[124] and Children's HealthWatch[129] to assess needs in these domains. CT InCK Embrace New Haven plans to include questions to assess needs in this domain in their tailored screening tool.

Food Insecurity

Five award recipients (AHHN, CT InCK Embrace New Haven, NJ InCK, NC InCK, and Village InCK) relied, or plan to rely on, data from the Children's HealthWatch Hunger Vital Sign[uuu,129] tool to assess food insecurity. BE-InCK NY and OH InCK plan to use questions adapted from the HRSN to assess food insecurity.

Housing Instability

Five award recipients (AHHN, CT InCK Embrace New Haven, NJ InCK, and Village InCK) relied, or plan to rely, on data from the Children's HealthWatch Housing Vital Sign.[vvv,130] NC InCK plans to use the Children's HealthWatch Hunger Vital Sign tool to assess food insecurity and the Protocol for Responding to and Assessing Patients Assets, Risks and Experience (PRAPARE)[www,131] to assess housing instability. BE-InCK NY and OH InCK used questions adapted from the HRSN to augment or confirm data from administrative data.

Functional Impairments

All award recipients, except NC InCK, used screening data to assess functional impairments. BE-InCK NY and Village InCK integrated screening data with administrative data following a sequential approach. Currently, NC InCK does not plan to separately report data about

---

[uuu] The Children's HealthWatch Hunger Vital Sign is a screening tool for identifying households at risk of food insecurity.

[vvv] The Children's HealthWatch Housing Stability Vital Signs tool screens for housing-related risks – such as the ability to pay for housing, homelessness, and frequent moves in the last 12 months.

[www] PRAPARE is a standardized patient risk assessment tool to assess social drivers of health including domains related to personal characteristics, money and resources, family and home life, and social and emotional health.

functional impairment. Award recipients use a mix of screening tools to assess the needs that define this domain[xxx] including the HRSN, ACE-Q, NSCH, the PSQ-17, and the SWYC.

Functional Symptoms

Five award recipients (AHHN, BE-InCK NY, NC InCK, NJ InCK, and Village InCK) used, or plan to use screening data to identify functional symptoms. Five award recipients (AHHN, BE-InCK NY, CT InCK Embrace New Haven, NC InCK, and NJ InCK) used both administrative data and screening to assess needs in these domains. Only Village InCK plans to use screening data alone and incorporate questions from PEARLS, ACE-Q, and the HRSN into their tailored screening tool.

Maternal and Child Health

AHHN, CT InCK Embrace New Haven, and NJ InCK plan to rely on screening data alone to assess maternal and child health needs. BE-InCK NY plans to use screening data to verify needs identified in administrative data. A variety of validated tools were identified by award recipients in this domain, including: ACE-Q (Village InCK), HRSN (BE-InCK NY and Village InCK), NSCH (AHHN); PEARLS (Village InCK), PHQ-2 (CT InCK Embrace New Haven), [yyy,132] PSC-17 (NJ InCK), and SWYC (NJ InCK).

Special Education and Early Intervention

All award recipients, except NC InCK, used, or plan to use, screening data to assess needs in the domains of early intervention and special education. Most award recipients (CT InCK Embrace New Haven, NJ InCK, and OH InCK) that used screening to assess educational needs relied on questions from the SWYC tool; however, it is unclear how CT InCK Embrace New Haven and NJ InCK plan to assess special education needs for children over five years of age, given this tools is for children 5 years and younger. Alternatively, Village InCK adapted questions from the PEARLS for this domain.

[xxx] CT InCK Embrace New Haven is using the Functioning Scale of the Ohio Mental Health Consumer Outcomes System. NJ InCK is using the PSC-17. Ohio is using a combination of the Pediatric Quality of Life Inventory, the 12-item short form survey, the SWBYC and their own Medicaid Health Risk Assessment. Village InCK is using a combination of ACE-Q, PEARLs, and the AHC HRSN screening tool.

[yyy] The Patient Health Questionnaire (PHQ-2) screens for depression as a "first step" approach. Patients who screen positive are then confirmatory screened.

APPENDIX J: EVALUATION NEXT STEPS

This appendix describes the InCK Model Evaluation's planned data collection, analysis, and reporting activities for Model Year 4 (January 1, 2023 – December 31, 2023). The evaluation draws on multiple data sources and each data source provides information to answer multiple research questions, as shown in Exhibit J.1. As part of the Implementation Study, the evaluation team will acquire and analyze data to investigate award recipients' implementation activities on key model components, as well as the local context in which each InCK Model is operating. As part of the Impact Study, the evaluation team will assess the quality of administrative data, review model performance measure specifications, and revise those, as needed. It will also examine the differences in outcome trends between the attributed and comparison populations. Award recipients will continue to be a critical partner in all evaluation activities. Specifically, the team relies on award recipients to understand the accuracy, comprehensiveness, and appropriateness of the evaluation activities. Award recipients will participate in site visits and interviews, submit Service Integration Level (SIL) data, as well as program documents, which we use to further refine the details of model implementation to ultimately provide insight to the causality of the model on a priori impact measures.

The team will address evaluation research questions for the implementation period and how various data sources contribute to the research questions (Exhibit J.1).

Exhibit J.1. The Evaluation Team Will Use a Mix of Qualitative and Quantitative Data Sources to Answer the Evaluation Research Questions.

Research Question	Type of Analysis	Data Sources
1. How was the InCK Model implemented by each award recipient?		• Annual Retrospective Attribution File (RAF) • Annual Retrospective Comparison File (RCF) • Service integration level (SIL) data • Medicaid claims, encounter, demographic, and eligibilty data (Medicaid data) • Program documents submitted by award recipients (Program Documents) • Interviews with Lead Organization staff, Partnership Council Members, Providers, Service Integration Coordinators (SICs), and caregivers/beneficiaries (Interviews)
2. How has the InCK Model impacted children and families in the following domains:		
Navigation/care coordination?		• Program Documents • Interviews
Utilization/expenditure (health and Core Child Services (CCS))?		• RAF • RCF • SIL data • Medicaid data • Core Child Services (CCS) utiliization administrative data
Quality of care?		• Medicaid data • CCS utiliization administrative data • Interviews
Beneficiary experience of care?		• Interviews
3. What was the role of service disruption in the InCK Model?		• CCS utiliization administrative data • SIL data • Medicaid data • Program documents • Interviews

Research Question	Type of Analysis	Data Sources
4. What is the return on investment of the InCK Model?		• SIL data • CCS utiliization administrative data • Medicaid data • Interviews
5. To what extent do the impacts of the InCK Model vary?		• RAF • RCF • SIL data • Medicaid data • CCS utiliization administrative data • Program documents • Interviews

Key:

Qualitative Data   Quantitative Data

Quantitative Data Sources

In this section, we describe the quantitative data that we will acquire and analyze in Model Year 4 (2023), how we will obtain the data, its role in the evaluation, and a summary of our planned approach to data processing and analysis for each data type.

Exhibit J.2   The Evaluation Team Will Use a Variety of Quantitative Data Sources to Inform Evaluation Activities.

Quantitative Data Source	Details	Method of Acquisition
Medicaid data	Individual-level data for beneficiaries residing in the attributed and comparison regions from the Transformed Medicaid Statistical Information System (T-MSIS) on healthcare utilization, enrollment, and eligibility categories.	Obtained by the evaluation team via Data Use Agreement.
Retrospective Attribution File (RAF)	Individual-level identifiers for all Medicaid and CHIP (if applicable) beneficiaries residing in the attributed region in the previous calendar year and who had coverage for at least one month.	Submitted by award recipients annually.
Retrospective Comparison File (RCF)	Individual-level identifiers for all Medicaid and CHIP (if applicable) beneficiaries residing in the comparison region in the previous calendar year and who had coverage for at least one month.	Submitted by award recipients annually.
Core child services (CCS) Utilization Administrative data: SNAP, WIC[a]	Individual-level data for both attributed and comparison beneficiaries about their engagement and receipt of nutritional services from SNAP and WIC.	Submitted by award recipients annually starting in 2023.
CCS Utilization Administrative data: Child welfare[a]	Individual-level data for the attributed and comparison beneficiaries about their engagement in the child welfare system.	Submitted by award recipients annually starting in 2023.
Service Integration Level (SIL) data	Individual-level data for attributed beneficiaries on their SIL assignment and needs assessment results.	Submitted by award recipients quarterly.
CCS Utilization Administrative data: HUD	Individual-level data for the attributed and comparison beneficiaries about participation in federal subsidized housing programs from the Tenet Rental Assistance Certification System (TRACs) and the Inventory Management System/Public and Indian Housing Information Center Data from the United States Department of Housing and Urban Development (HUD).	Obtained by the evaluation team via Data Use Agreement starting in 2022.

Quantitative Data Source	Details	Method of Acquisition
Administrative data: Foster Care Data	Individual-level data for the attributed and comparison beneficiaries about children in foster care and reports of child abuse and neglect from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) maintained by the National Data Archive on Child Abuse and Neglect (NDACAN).	Obtained by the evaluation team via Data Use Agreement in 2021.
US Census/ American Community Survey[b,120]	Data for the attributed and comparison region populations on various social, economic, housing, and demographic characteristics at the census tract and other geographic levels.	Publicly available data obtained by the evaluation team.
Area Health Resource File[133]	Data for the attributed and comparison region populations to characterize the demographics, healthcare professions, health facilities, hospital utilization, and environment across regions.[c]	Publicly available data obtained by the evaluation team.

Notes:

a. This data will include administrative data files from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP).
b. In addition to publicly available data from the US Census and Area Health Resource File, the evaluation team will use community-level information provided in other publicly available databases as needed.
c. The Area Health Resource File was developed by the Health Services Research Administration.

Qualitative Data Sources

The evaluation team will collect and analyze two types of qualitative data: award recipient-submitted program data and data obtained through site visits. Both data sources provide insight into the evaluation's five research questions.

Exhibit J.3. The Evaluation Team Uses a Variety of Qualitative Data Sources to Inform Evaluation Activities.

Qualitative Data Sources	Details	Method of Acquisition
Annual Model Operational Plans	Operational plans outline award recipients intended activities for each upcoming 12-month budget period and a timeline for meeting milestones.	Submitted annually by award recipients.
Progress Reports	Progress reports include details on award recipients' progress toward implementation on key model elements.	Submitted both quarterly and annually by award recipients.

Qualitative Data Sources	Details	Method of Acquisition
Needs Assessment and Stratification Standard Operating Procedures (SOPs)	SOPs outline award recipients' planned approaches to needs assessment and Service Integration Level (SIL) assignment.	Initially submitted by award recipients in 2021. Periodically updated.
Service Integration SOPs	SOPs outline award recipients' planned approach to service integration and identifying a single point of contact for families and beneficiaries.	Initially submitted by award recipients in 2021. Periodically updated.
Lead Organization Interviews	Interviews with Lead Organization staff include details on progress toward model implementation including their approach to needs assessment and SIL assignment, and service integration.	In-person site visits conducted in spring 2023.
Partnership Council Member Interviews	Interviews with Partnership Council members include details on the role of Partnership Council in the implementation period, the role in ongoing model activities, and the needs of the attributed population.	In-person site visits conducted in spring 2023.
Medical and Core Child Service (CCS) provider Interviews	Interviews with medical and CCS providers include details on needs of the attributed population, the local service context, and anticipated impacts of the InCK Model.	In-person site visits conducted in spring 2023.
Service Integration Coordinator (SIC) Interviews	Interviews with SICs and local equivalents include details on award recipients' planned approaches to needs assessment, SIL assignment, and service integration; their progress toward implementation; strategies for beneficiary outreach and engagement; and needs of the attributed population.	In-person site visits conducted in Spring 2023.
Beneficiary and Caregiver Interviews and Focus Groups	Interviews with beneficiaries and caregivers include details on the local service context, needs of the attributed population, and the role of families and caregivers in the design of the local InCK Model.	In-person site visits conducted in Spring 2023.

Reporting Evaluation Activities and InCK Model Implementation Status

Throughout the InCK Model Implementation Period, the evaluation team will produce communications materials that include case study briefs, special study results, memorandums, other reports for the Centers for Medicare & Medicaid Services, and public-facing materials, such as annual reports, manuscripts, and presentations. In Model Year 4 (2023), we will report on the evaluation's research questions through Model Year 4, as shown in Exhibit J.4. Timing of evaluation results depends on the availability of clean, complete, and accurate data.

Exhibit J.4. Reporting on InCK Model Evaluation Questions in Model Year 4 Will Begin to Identify Preliminary Trends.

Research Question	Level of Analysis
1. How was the InCK Model implemented by each award recipient?	🟢
2. How has the InCK Model impacted children and families in the following domains:	
Navigation/care coordination?	🟢
Utilization/expenditure (health and Core Child Services)?	🔵
Quality of care?	🟢 🔵
Beneficiary 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 impacts of the InCK Model vary?	🟢 🔵

Implementation Study: ◐= Descriptive; 🟢 = Preliminary trends; ● = Summative results

Impact Study: ◐= Descriptive; 🔵 = Preliminary trends; ● = Impact estimates

References

REFERENCES

[1] Salas, J., Hinyard, L., Cappellari, A., Sniffen, K., Jacobs, C., Karius, N., Grucza, R. A., & Scherrer, J. F. (2022). Infant, pediatric and adult well visit trends before and during the COVID-19 pandemic: a retrospective cohort study. *BMC Health Services Research*, *22*(1), 328. https://doi.org/10.1186/s12913-022-07719-7

[2] Kujawski, S. A., Yao, L., Wang, H. E., Carias, C., & Chen, Y.-T. (2022). Impact of the COVID-19 pandemic on pediatric and adolescent vaccinations and well child visits in the United States: A database analysis. *Vaccine*, *40*(5), 706-713. https://doi.org/10.1016/j.vaccine.2021.12.064

[3] Chaiyachati, B. H., Agawu, A., Zorc, J. J., & Balamuth, F. (2020). Trends in pediatric emergency department utilization after institution of Coronavirus Disease-19 mandatory social distancing. *The Journal of Pediatrics*, *226*, 274. https://doi.org/10.1016/j.jpeds.2020.07.048

[4] Heist, T., Schwartz, K., & Butler, S. (2021, February 18). *Trends in overall and non-COVID-19 hospital admissions*. KFF. https://www.kff.org/health-costs/issue-brief/trends-in-overall-and-non-covid-19-hospital-admissions/

[5] Quality Payment Program. (2023). *APMs Overview*. https://qpp.cms.gov/apms/overview

[6] Allen, C. W., Diamond-Myrsten, S., & Rollins, L. K. (2018). School Absenteeism in Children and Adolescents. *American family physician*, *98*(12), 738-744. https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=mdc&AN=30525360&site=eds-live&scope=site&authtype=sso&custid=s1139472

[7] Weinstein, E. J., Ritchey, M. E., & Lo Re, V., 3rd. (2023). Core concepts in pharmacoepidemiology: Validation of health outcomes of interest within real-world healthcare databases. *Pharmacoepidemiology and Drug Safety*, *32*(1), 1-8. https://doi.org/10.1002/pds.5537

[8] Neff, J. M., Sharp, V. L., Muldoon, J., Graham, J., Popalisky, J., & Gay, J. C. (2002). Identifying and classifying children with chronic conditions using administrative data with the clinical risk group classification system. *Ambulatory Pediatrics*, *2*(1), 71-79. https://doi.org/10.1367/1539-4409(2002)002<0071:iaccwc>2.0.co;2

[9] Simon, T. D., Cawthon, M. L., Stanford, S., Popalisky, J., Lyons, D., Woodcox, P., Hood, M., Chen, A. Y., & Mangione-Smith, R. (2014). Pediatric medical complexity algorithm: a new method to stratify children by medical complexity. *Pediatrics*, *133*(6), e1647-e1654. https://doi.org/10.1542/peds.2013-3875

[10] SS&C. *S&C® CareAnalyzer*. https://www.ssctech.com/products/careanalyzer

[11] Department of Health and Human Services Centers for Medicare & Medicaid Services. (2019). *Integrated Care for Kids (InCK)* [Grant]. https://www.grants.gov/web/grants/view-opportunity.html?oppId=312759

[12] Title 42 of the CFR § 438.6 Special contract provisions related to payment. https://www.ecfr.gov/current/title-42/section-438.6

[13] Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream: How interventions that address the social determinants of health can improve health and reduce disparities. *Journal of Public Health Management & Practice*, *14*, S8-S17. https://doi.org/10.1097/01.PHH.0000338382.36695.42

[14] Ettinger de Cuba, S. A., Bovell-Ammon, A. R., Cook, J. T., Coleman, S. M., Black, M. M., Chilton, M. M., Casey, P. H., Cutts, D. B., Heeren, T. C., Sandel, M. T., Sheward, R., & Frank, D. A. (2019). SNAP, young children's health, and family food security and healthcare access. *American Journal of Preventive Medicine*, *57*(4), 525-532. https://doi.org/10.1016/j.amepre.2019.04.027

[15] Caulfield, L. E., Bennett, W. L., Gross, S. M., Hurley, K. M., Ogunwole, S. M., Venkataramani, M., Lerman, J. L., Zhang, A., Sharma, R., & Bass, E. B. (2022). *Maternal and child outcomes*

associated with the special supplemental nutrition program for women, infants, and children (WIC). Agency for Healthcare Research and Quality (US). https://doi.org/10.23970/ahrqepccer253

[16] Kaiser, L. (2008). Why do low-income women not use food stamps? Findings from the California Women's Health Survey. *Public Health Nutrition*, *11*(12), 1288-1295. https://doi.org/10.1017/s1368980008002528

[17] Shrivastava, A., & Patel, U. (2023, May 1). *Research reinforces: Providing cash to families in poverty reduces risk of family involvement in child welfare*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/income-security/research-reinforces-providing-cash-to-families-in-poverty-reduces-risk-of

[18] Health Resources and Services Administration. *HPSA find*. https://data.hrsa.gov/tools/shortage-area/hpsa-find

[19] Internal Revenue Service. (2023). *Earned Income Tax Credit (EITC)*. https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit-eitc

[20] Congressional Research Service. (2022, March 31). *The Temporary Assistance for Needy Families (TANF) block grant: Responses to frequently asked questions*. https://sgp.fas.org/crs/misc/RL32760.pdf

[21] Knowles, S., Dehry, I., Shantz, K., & Minton, S. (2022). *Graphical overview of state TANF policies as of July 2020* (OPRE Report 2021-160). https://www.acf.hhs.gov/sites/default/files/documents/opre/wrd-2020-databook-companion-piece-feb2022.pdf

[22] Shrivastava, A., & Thompson, G. A. (2022, February 18). *TANF cash assistance should reach millions more families to lessen hardship: Access to TANF hits lowest point amid precarious economic conditions*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/income-security/tanf-cash-assistance-should-reach-millions-more-families-to-lessen

[23] USDA Economic Research Service. (2021, October 18). *Food security and nutrition assistance*. https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/food-security-and-nutrition-assistance/#:~:text=In%202021%2C%2032.1%20percent%20of,and%20very%20low%20food%20security

[24] USDA Food and Nutrition Service. (2021, October 1). *SNAP eligibility*. https://www.fns.usda.gov/snap/recipient/eligibility

[25] Center on Budget and Policy Priorities. (2023, March 3). *A quick guide to SNAP eligibility and benefits*. https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits

[26] Aussenberg, R. A., & Falk, G. (2022). *The Supplemental Nutrition Assistance Program (SNAP): Categorical eligibility* (R42054). Congressional Research Service. https://crsreports.congress.gov/product/pdf/R/R42054

[27] United States Department of Agriculture Food and Nutrition Services. *SNAP participation rates by state, all eligible people (FY2018)*. https://www.fns.usda.gov/usamap#

[28] USDA Food and Nutrition Service. (2023, January 9). *National and state level estimates of WIC eligibility and program reach in 2020*. https://www.fns.usda.gov/wic/eligibility-and-program-reach-estimates-2020

[29] University of Wisconsin Population Health Institute. (2021). *Comprehensive housing affordability strategy data, 2013-2017 through University of Wisconsin Population Health Institute*. https://www.countyhealthrankings.org/

[30] United Health Foundation. *America's health rankings analysis of U.S. Department of Housing and Urban Development, comprehensive housing affordability strategy*. America's Health Rankings. AmericasHealthRankings.org

[31] Office of Policy Development and Research. (2022). *Public housing authorities*. U.S Department of Housing and Urban Development. https://hudgis-hud.opendata.arcgis.com/datasets/public-housing-authorities-1/explore?location=19.147155%2C-82.195653%2C3.60

[32] U.S Department of Housing and Urban Development. (2023, February). *PIT and HIC data since 2007 : 2007-2021 Point-in-Time estimates by CoC*. https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/

[33] Stoltzfus, E. (2023). *Child welfare: Purposes, federal programs, and funding*. Congressional Research Service. https://sgp.fas.org/crs/misc/IF10590.pdf

[34] Casey Family Programs. (2019). *The Child Abuse Prevention and Treatment Act: Keeping children safe and strengthening families in communities*. https://caseyfamilypro.wpenginepowered.com/media/CAPTA-Paper_web.pdf

[35] Administration for Children and Families. Children's Bureau. (2022, January 19). *Child maltreatment 2020*. U.S. Department of Health & Human Services. https://www.acf.hhs.gov/cb/about/our-organization

[36] Child Welfare Information Gateway. (2022). *Definitions of child abuse and neglect*. U.S. Department of Health and Human Services, Administration for Children and Families, & Children's Bureau. https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/

[37] Child Trends. (2023). *Child Welfare Agency spending in Illinois in SFY 2020*. https://cms.childtrends.org/wp-content/uploads/2023/05/Illinois_SFY2020CWFS_ChildTrends_May2023.pdf

[38] Children's Bureau. (2023, September 15). *Title IV-E programs expenditure and caseload data*. https://www.acf.hhs.gov/cb/report/title-iv-e-programs-expenditure-and-caseload-data

[39] Vaughan, J. M., & Griffith, B. (2023, July 11). *Map: Sanctuary cities, counties, and states*. Center for Immigration Studies. https://cis.org/Map-Sanctuary-Cities-Counties-and-States

[40] City of Chicago. *The welcoming city*. https://www.chicago.gov/city/en/sites/texas-new-arrivals/home.html

[41] Joseph, K. S., Boutin, A., Lisonkova, S., Muraca, G. M., Razaz, N., John, S., Mehrabadi, A., Sabr, Y., Ananth, C. V., & Schisterman, E. (2021). Maternal mortality in the United States: Recent trends, current status, and future considerations. *Obstetric Anesthesia Digest*, *41*(3), 110-110. https://doi.org/10.1097/01.aoa.0000765988.46176.ac

[42] Mehra, R., Keene, D. E., Kershaw, T. S., Ickovics, J. R., & Warren, J. L. (2019). Racial and ethnic disparities in adverse birth outcomes: Differences by racial residential segregation. *SSM - Population Health*, *8*. https://doi.org/10.1016/j.ssmph.2019.100417

[43] New York State Office of Temporary and Disability Assistance. *Supplemental Nutrition Assistance Program (SNAP)*. https://otda.ny.gov/programs/snap/

[44] Farson Gray, K., Balch-Crystal, E., Giannarelli, L., & Johnson, P. (2022). *WIC 2019 eligibility and coverage rates*. U.S. Department of Agriculture Food and Nutrition Service. https://www.fns.usda.gov/wic/2019-eligibility-coverage-rates#5

[45] Child Trends. (2021). *Child Welfare Agency spending in New York in SFY 2018*. https://cms.childtrends.org/wp-content/uploads/2021/01/New-York_SFY2018-CWFS_03.03.2021.pdf

[46] Children's Bureau. (2023, September 15). *Title IV-E programs expenditure and caseload data 2022*. https://www.acf.hhs.gov/cb/report/programs-expenditure-caseload-data-2022

[47] Saunders, H., Guth, M., & Eckart, G. (2023, January 10). *A look at strategies to address behavioral health workforce shortages: Findings from a survey of state Medicaid programs*. KFF. https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/

[48] Saldanha, I. J., Adam, G. P., Kanaan, G., Zahradnik, M. L., Steele, D. W., Chen, K. K., Peahl, A. F., Danilack-Fekete, V. A., Stuebe, A. M., & Balk, E. M. (2023). Health insurance coverage and postpartum outcomes in the US: A systematic review. *JAMA Network Open*, *6*(6), e2316536-e2316536. https://doi.org/10.1001/jamanetworkopen.2023.16536

[49] Eliason, E. L. (2020). Adoption of Medicaid expansion is associated with lower maternal mortality. *Women's Health Issues*, *30*(3), 147-152. https://doi.org/10.1016/j.whi.2020.01.005

[50] Admon, L. K., Zivin, K., & Kozhimannil, K. B. (2021). Perinatal insurance coverage and behavioural health-related maternal mortality. *International Review of Psychiatry*, *33*(6), 553-556. https://doi.org/10.1080/09540261.2021.1903843

[51] Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on healthy birth outcomes. *The Journal of Perinatal Education*, *22*(1), 49-58. https://doi.org/10.1891/1058-1243.22.1.49

[52] Scott, K. D., Klaus, P. H., & Klaus, M. H. (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Women's Health & Gender-Based Medicine*, *8*(10), 1257-1264. https://doi.org/10.1089/jwh.1.1999.8.1257

[53] National Health Law Program. *Doula Medicaid Project*. https://healthlaw.org/doulamedicaidproject/

[54] U.S Department of Health and Human Services. (2022, June 25). *Know your rights: Reproductive health care*. https://www.hhs.gov/about/news/2022/06/25/know-your-rights-reproductive-health-care.html

[55] Guttmacher Institute. (2023, August 23). *Interactive map: US abortion policies and access after Roe*. Retrieved January 9, 2023 from https://states.guttmacher.org/policies/new-york/abortion-policies

[56] Center for Reproductive Rights. *After Roe fell: Abortion laws by state*. https://reproductiverights.org/maps/abortion-laws-by-state

[57] Guttmacher Institute. (2023). *Minors' access to contraceptive services, state policies in brief*. Retrieved January 30, 2023 from https://www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services

[58] Centers for Medicare & Medicaid Services. *Transformed Medicaid Statistical Information System (T-MSIS)*. https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html

[59] State of Connecticut. (2020). *Temporary Assistance for Needy Families (TANF) state plan*. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Economic-Security/CtTANFPlan.pdf

[60] Department of Social Services. *Supplemental Nutrition Assistance Program – SNAP: Eligibility*. Connecticut State Department of Public Health. https://portal.ct.gov/DSS/SNAP/Supplemental-Nutrition-Assistance-Program---SNAP/Eligibility

[61] 211 of Connecticut. *Housing*. https://www.211ct.org/topic_pages/housing

[62] Statewide Legal Services of Connecticut. *Self-help: Homes and apartments*. https://ctlawhelp.org/self-help-guides/housing

[63] Rosinsky, K., Fischer, M., & Haas, M. (2023). *Child Welfare Agency spending in Connecticut in SFY 2020*. https://cms.childtrends.org/wp-content/uploads/2023/05/Connecticut_SFY2020CWFS_ChildTrends_May2023.pdf

[64] Governor Lamont announces Connecticut expands maternal health coverage through HUSKY from 60 days to twelve months after pregnancy. (2022). In: State of Connecticut.

[65] Haley, J., & Johnson, E. M. (2021). *Closing gaps in maternal health coverage: Assessing the potential of a postpartum Medicaid/CHIP extension*. https://www.commonwealthfund.org/publications/issue-briefs/2021/jan/closing-gaps-maternal-health-postpartum-medicaid-chip

[66] Robles-Fradet, A., & Greenwald, M. (2022, August 8). *Doula Care Improves Health Outcomes, Reduces Racial Disparities and Cuts Cost*. National Health Law Program. https://healthlaw.org/doula-care-improves-health-outcomes-reduces-racial-disparities-and-cuts-cost/#:~:text=Doula%20Care%20Improves%20Health%20Outcomes%2C%20Reduces%20Racial%20Disparities,reduces%20overall%20perinatal%20spending%20...%204%20Conclusion%20

[67] Guzmán, L. (2022, August 8). *CT Medicaid to cover doulas, breastfeeding*. RJ Media Group. https://www.myrecordjournal.com/News/State/doula_medicaid.html

[68] State of Connecticut. (2023). *HUSKY Maternity Bundle*. https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle

[69] State of Connecticut. (2023). *Abortion access in Connecticut*. Retrieved July 10, 2023 from https://portal.ct.gov/reproductiverights/Legal-Assistance?language=en_US

[70] Center on Budget and Policy Priorities. (2023). *North Carolina Food and Nutrition Services*. https://www.cbpp.org/sites/default/files/atoms/files/snap_factsheet_north_carolina.pdf

[71] Child Trends. *State-level data for understanding child welfare in the United States - Child maltreatment*. https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states

[72] North Carolina Department of Health and Human Services. (2021). *2022 annual progress and services report for the North Carolina Child and Family Services Plan*. https://www.ncdhhs.gov/2022-apsr-revised-section-3/download?attachment

[73] Child Trends. (2021). *Child Welfare Agency Spending in New Jersey in SFY 2018*. https://cms.childtrends.org/wp-content/uploads/2021/01/New-Jersey_SFY2018-CWFS_03.03.2021.pdf

[74] North Carolina Department of Health and Human Services. *Healthy Opportunities Pilots*. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

[75] The State of North Carolina. (2023, March 23). *Governor Cooper signs Medicaid expansion into law* [Press Release]. https://governor.nc.gov/news/press-releases/2023/03/27/governor-cooper-signs-medicaid-expansion-law

[76] Vidrine, S. (2020, September). *How NC Medicaid managed care implementation will affect kids*. NC Child. https://ncchild.org/medicaid-transformation-update/

[77] Allen, E. H., Johnston, E., Courtot, B., Alvarez Caraveo, C., Gonzalez, D., & Long, J. (2022). *North Carolina Medicaid's Transition to Risk-Based Managed Care*. https://www.u

[78] NJ One App. *Online instructions for TANF application*. https://oneapp.dhs.state.nj.us/Forms/SignIn/frmStart.aspx

[79] Legal Services of New Jersey. SNAP—Am I eligible? https://www.lsnjlaw.org/legal-topics/government-aid-services/food-hunger-nutrition/food-stamps/pages/snap-nj-food-stamp-program-aspx

[80] New Jersey 211. *About 211*. https://www.nj211.org/about-211

[81] New Jersey Department of Children and Families. (2022). *2022 annual progress and services report (APSR)*. https://www.nj.gov/dcf/childdata/njfederal/2022.APSR.pdf

[82] Hackensack Meridian Health. *About Hackensack Meridian Health*. Retrieved May 17, 2023 from https://www.hackensackmeridianhealth.org/en/about-us

[83] Ohio Department of Job and Family Services. (2022). *Ohio Works First: Fact Sheet*. https://jfs.ohio.gov/factsheets/owf.pdf

[84] Benefits.gov. *Ohio Supplemental Nutrition Assistance Program*. https://www.benefits.gov/benefit/1588

[85] Children's Defense Fund. (2020). *The State of America's Children® 2020 - Table 27: Child Abuse and Neglect, 2018*. https://www.childrensdefense.org/policy/resources/soac-2020-child-welfare-tables/

[86] Child Trends. (2021). *Child Welfare Agency spending in Ohio in SFY 2018*. https://cms.childtrends.org/wp-content/uploads/2021/01/Ohio_SFY2018-CWFS_03.03.2021.pdf

[87] Ohio Department of Job and Family Services. (2019). *2020 - 2024 child and family services plan*. https://jfs.ohio.gov/static/ocf/CFSP2020-2024.pdf

[88] Centers for Medicare & Medicaid Services. (2022, October 20). *Ex Parte renewal: Strategies to maximize automation, increase renewal Rates, and support unwinding efforts* [Powerpoint Presentation]. https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf

[89] Tolbert, J., & Ammula, M. (2023, February 22). *10 things to know about the unwinding of the Medicaid continuous enrollment provision*. KFF. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/

[90] American Hospital Association. (2021). *Mitigating Medicaid coverage loss at the end of the public health emergency* [Webinar]. https://www.aha.org/system/files/media/file/2022/03/AHA%20PHE%20Unwinding%20Medicaid%20June%2C%202021.pdf

[91] *Unwinding the Medicaid continuous enrollment provision: Projected enrollment effects and policy approaches*. (Issue Brief No. HP-2022-20). (August 19, 2022). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation & U.S. Department of Health and Human Services

[92] Brooks, T., & Gardner, A. (2021). *Continuous coverage in Medicaid and CHIP*. Georgetown University Health Policy Institute. https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf

[93] Brooks, T., & Lewit, E. (2016). *Making Medicaid work better: Lessons from states on implementing Ex Parte renewals*. Georgetown University Health Policy Institute and Robert Wood Johnson Foundation. https://ccf.georgetown.edu/wp-content/uploads/2016/04/20160407_Medicaid_Work_Better_Ex_Parte_Renewals.pdf#:~:text=Based%20on%20a%20current%20working%20definition%20from%20the,renewals%20is%20that%20it%20happens%20without%20beneficiary%20involvement.6

[94] Center for Medicaid and CHIP Services. (2021, August 6). *Express lane eligibility for Medicaid and CHIP coverage*. https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicaid-and-chip-coverage/index.html

[95] Morrow, B., & Artiga, S. (2010). *Building an express lane eligibility initiative: a roadmap of key decisions for states*. Kaiser Commission on Medicaid and the Uninsured and The Children's Partnership. https://www.kff.org/wp-content/uploads/2013/01/8043.pdf

[96] Medicaid and CHIP Learning Collaborative. (2021, January 13). *Coverage learning collaborative: Medicaid and CHIP renewals and redeterminations* [Powerpoint Presentation]. https://www.medicaid.gov/resources-for-states/downloads/renewals-redeterminations.pdf

[97] Medicaid. (2023). *Anticipated 2023 state timelines for initiating unwinding-related renewals as of February 24, 2023*. https://www.medicaid.gov/sites/default/files/2023-03/ant-2023-time-init-unwin-reltd-ren-02242023.pdf

[98] Centers for Medicare & Medicaid Services. (2022). *Eligibility & enrollment processing for Medicaid, CHIP, and BHP during COVID-19 public health emergency unwinding key requirements for compliance* [Powerpoint Presentation]. https://www.medicaid.gov/resources-for-states/downloads/eligibility-enrollment-rules.pdf

[99] King, R. (2023). *Managed care plans, states can now text Medicaid beneficiaries to warn of enrollment changes*. Fierce Healthcare. https://www.fiercehealthcare.com/payers/managed-care-plans-states-can-now-text-medicaid-beneficiaries-warn-enrollment-changes

[100] Department of Health and Human Services, & Centers for Medicare & Medicaid Services. (2023, January 25). Medicaid and CHIP continuous enrollment unwinding: What to know and how to prepare. In *Partner Education Monthly Series*. Virtual.

[101] Musumeci, M., Haldar, S., Childress, E., Artiga, S., & Tolbert, J. (2022). *A 50-state review of access to state Medicaid program information for people with limited English proficiency and/or disabilities ahead of the PHE unwinding*. KFF. https://www.kff.org/report-section/a-50-state-review-of-access-to-state-medicaid-program-information-for-people-with-limited-english-proficiency-and-or-disabilities-ahead-of-the-phe-unwinding-appendix/

[102] Hinton, E. (2022, March 22). *Medicaid managed care plans can help enrollees maintain coverage as the public health emergency unwinds*. KFF. https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-plans-can-help-enrollees-maintain-coverage-as-the-public-health-emergency-unwinds/

[103] Manatt Health. (2022). Leveraging managed care plans to support Medicaid continuous coverage unwinding toolkit In: State Health & Value Strategies.

[104] Center for Medicare and Medicaid Services. (2022). *Supporting seamless coverage transitions for children moving between Medicaid and CHIP in separate CHIP states* [Webinar], https://www.medicaid.gov/resources-for-states/downloads/supporting-medicaid-chip-transitions.pdf

[105] Medicaid and Chip Payment and Access Commission. (2022). *Transitions between Medicaid, CHIP, and Exchange coverage*. https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf

[106] Lotven, A. (2022, November 1). *CMS lays plan to move those losing Medicaid to marketplace*. Inside Health Policy. https://insidehealthpolicy.com/daily-news/cms-lays-plan-move-those-losing-medicaid-marketplace

[107] Institute of Medicine and National Research Council, Institute of Medicine, & Committee on Children Health Insurance and Access to Care. (1998). *America's children : Health insurance and access to care* (M. J. Coye & M. Edmunds, Eds.) [Book]. National Academies Press.

[108] Nguyen, Q. C. (2016). *Health insurance churn: The basics*. Community Catalyst. https://www.communitycatalyst.org/wp-content/uploads/2022/11/Health-Insurance-Churn-November-2016_FINAL.pdf

[109] Frost, R. (2020). *Are Americans stuck in place? Declining residential mobility in the US*. Joint Center for Housing Studies of Harvard University. https://www.jchs.harvard.edu/sites/default/files/media/imp/harvard_jchs_are_americans_stuck_in_place_frost_2020.pdf

[110] Office of Management and Budget. (1997). *Revisions to the standards for the classification of federal data on race and ethnicity*. The White House.

[111] Office of the Assistant Secretary for Planning and Evaluation. (2011). *HHS implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status*. ASPE.

112 Corallo, B., & Moreno, S. (2023, April 4). *Analysis of recent national trends in Medicaid and CHIP enrollment*. KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/

113 Tsai, D., & Center for Medicaid and CHIP Services. (2023). Key dates related to the Medicaid continuous enrollment condition provisions in the Consolidated Appropriations Act, 2023. *CMCS Informational Bulletin*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf#:~:text=On%20Thursday%2C%20December%2029%2C%202022%2C%20the%20Consolidated%20Appropriations,the%20temporary%20FMAP%20increase%2C%20and%20the%20unwinding%20process

114 Tsai, D. (2022). *Re: Promoting continuity of coverage and distributing eligibility and enrollment workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) upon conclusion of the COVID-19 public health emergency*. (SHO #22-001). Centers for Medicare & Medicaid Services Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf

115 Brooks, T., & Center for Children and Families. (2022, August 22). *An estimated 3.8 million eligible children could lose Medicaid due to administrative churn during the unwinding*. Georgetown University Health Policy Institute. https://ccf.georgetown.edu/2022/08/22/millions-of-eligible-children-could-lose-medicaid-due-to-administrative-churn-during-the-unwinding/#:~:text=That%20means%20about%206.8%20million,losing%20Medicaid%20will%20remain%20eligible!

116 Corallo, B., Garfield, R., Tolbert, J., & Rudowitz, R. (2021, December 14). *Medicaid enrollment churn and implications for continuous coverage policies*. KFF. https://www.kff.org/report-section/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies-issue-brief/

117 CMS Office of Minority Health. (2022). *Using Z Codes: The Social Determinants of Health (SDOH) data journey to better outcomes*. https://www.cms.gov/files/document/zcodes-infographic.pdf

118 Ranbom, L., & Doogan, N. *Ohio Opportunity Index*. Ohio Colleges of Medicine Government Resource Center. https://grc.osu.edu/Projects/OhioOpportunityIndex

119 Robert Graham Center. (2018, November 5). *Social Deprivation Index (SDI)*. American Academy of Family Physicians. https://www.graham-center.org/maps-data-tools/social-deprivation-index.html

120 Health Resources and Services Administration. (2023, March 31). *National Survey of Children's Health (NSCH)*. U.S. Census Bureau. https://www.census.gov/programs-surveys/nsch.html

121 Centers for Medicare & Medicaid Services. *The accountable health communities health-related social needs screening tool*. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

122 American Academy of Pediatrics. *Ages and Stages Questionnaire: Social-Emotional (ASQ-SE-2)*. https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/ages-and-stages-questionnaire-social-emotional-asq-se-2/

123 Illinois Department of Healthcare and Family Services. *IM+CANS Provider Portal*. https://hfs.illinois.gov/medicalproviders/behavioral/communitymentalhealthcenter/imcansproviderportal.html

124 Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., Chambers, R. A., & Schumacher, U. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, *6*(1), 1-9. https://doi.org/10.1080/2331205X.2019.1581447

125 Center for Youth Wellness and UCSF Benioff Children's Hospital. *Pediatric ACEs and Related Life Events Screener (PEARLS)*. ACEs Aware. https://www.acesaware.org/pdf_wrapper/pearls-tool-child-parent-caregiver-report-de-identified-english/

126 CRAFFT. *About the CRAFFT*. https://crafft.org/about-the-crafft/

127 Gardner, W., Murphy, M., Childs, G., Kelleher, K., Pagano, M., Jellinek, M., McInerny, T. K., Wasserman, R. C., Nutting, P., & Chiappetta, L. (1999). The PSC-17: a brief pediatric symptom checklist with psychosocial problem subscales. A report from PROS and ASPN. *Ambulatory Child Health*, 5(3), 225.

128 Tufts Medical Center. (2010). *The survey of well-being of young children*. https://pediatrics.tuftsmedicalcenter.org/The-Survey-of-Wellbeing-of-Young-Children/Parts-of-the-SWYC

129 *The Hunger Vital Sign™*. Children's HealthWatch. https://childrenshealthwatch.org/public-policy/hunger-vital-sign/

130 Children's HealthWatch, & Boston Medical Center. (2019). *Children's Health Watch Housing Stability Vital Signs*. LOINC. https://loinc.org/98975-6/

131 National Association of Community Health Centers Inc., & Association of Asian Pacific Community Health Organizations. (2022). *What is PRAPARE?* https://prapare.org/what-is-prapare/

132 National HIV Curriculum. *Patient Health Questionnaire-2 (PHQ-2)*. https://www.hiv.uw.edu/page/mental-health-screening/phq-2

133 HRSA Data Warehouse. (2022, July 31). *Area Health Resources Files*. https://data.hrsa.gov/topics/health-workforce/ahrf