Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #:13

- ***Healthy Opportunities Pilots***
- ***NC Integrated Care for Kids (InCK)***

September 14, 2021

Agenda

1. Welcome and Roll Call (5 minutes)
2. Healthy Opportunities Pilots Overview (25 minutes)
3. NC InCK Overview (25 minutes)
4. Wrap-up and Next Steps (5 minutes)

AMH TAG Membership Introductions and Roll Call

Name	Organization	Stakeholder
C. Marston Crawford, MD, MBA	Pediatrician Coastal Children's Clinic – New Bern, Coastal Children's	Provider (Independent)
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
Rick Bunio, MD	Executive Clinical Director, Cherokee Indian Hospital	Provider
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Ruth Krystopolski, MBA	Senior Vice President of Population Health Atrium Health	Provider (CIN)
Amy Russell, MD	Medical Director Mission Health Partners	Provider (CIN)
Kristen Dubay, MPP	Director Carolina Medical Home Network	Provider (CIN)
Joy Key, MBA	Director of Provider Services Emtiro Health	Provider (CIN)
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer Duke Population Health Management Office	Provider (CIN)
George Cheely, MD, MBA	Chief Medical Officer AmeriHealth Caritas North Carolina, Inc.	Health Plan
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	Health Plan
Michelle Bucknor, MD, MBA	Chief Medical Officer UnitedHealthcare of North Carolina, Inc.	Health Plan
Eugenie M. Komives, MD	Chief Medical Officer WellCare of North Carolina, Inc.	Health Plan
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc.	Health Plan
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member

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Why Do We Need the Healthy Opportunities Pilots?

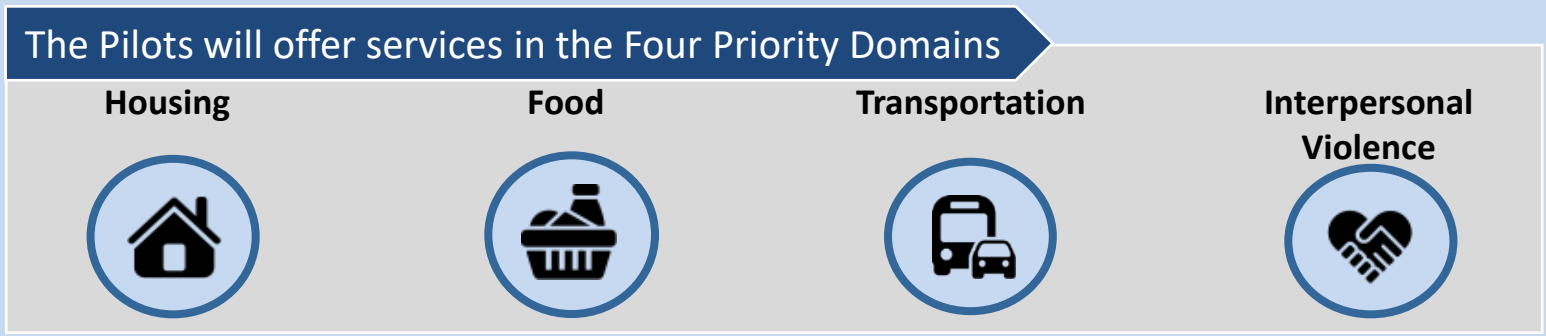
The Healthy Opportunities Pilots (the Pilots) present an unprecedented opportunity to provide selected evidence-based, non-medical interventions to Medicaid enrollees to address social needs within Medicaid managed care.

- Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.
- Pilot entities—including PHPs, Care Management Teams, Network Leads, and Human Service Organizations—will all play coordinated but distinct roles to provide "whole person care" to Pilot enrollees.
- The Pilots will test the impact of offering non-medical services on health outcomes and costs, with the ultimate goal of making them statewide offerings of the Medicaid managed care program
- Given their trusted relationships with members, care management teams play a unique role in identifying individuals who will benefit from Pilot services and connecting them to those services
    - Participating care management teams will be given resources, tools and infrastructure to execute their responsibilities (many of which they already do today!)

What Are the Healthy Opportunities Pilots?

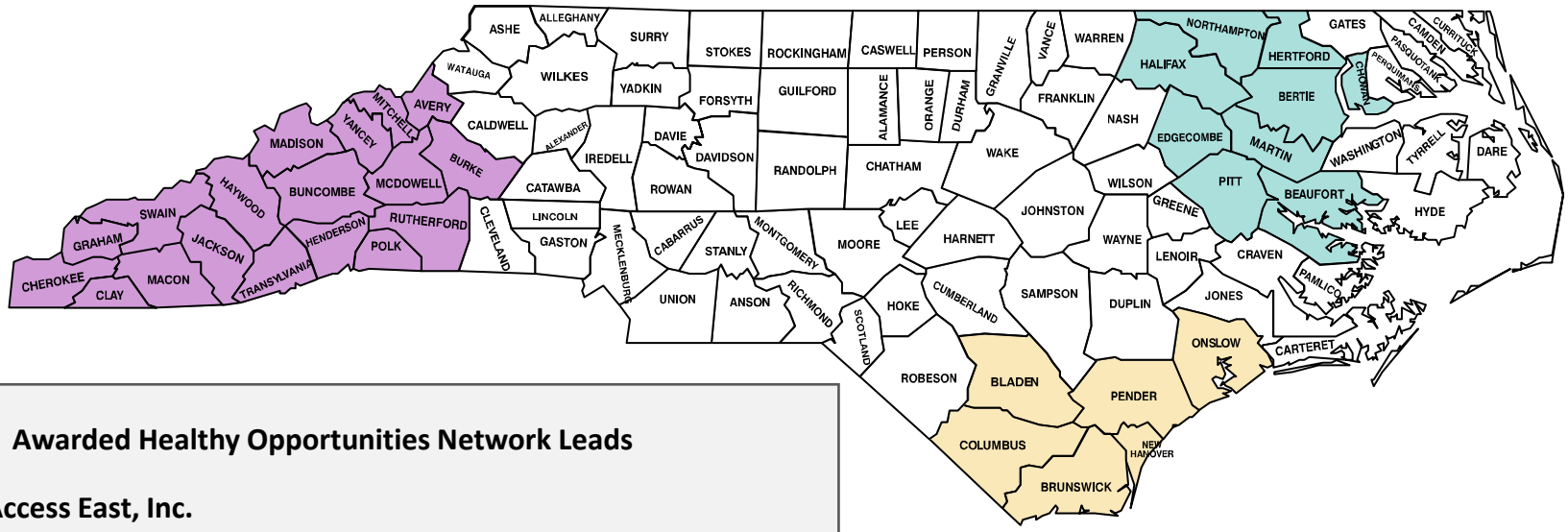
The federal government authorized up to $650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

- **PHPs will work with communities in three geographic areas of the state to implement the "Healthy Opportunities Pilots," as approved through North Carolina's 1115 waiver**
- **Pilot funds will be used over the demonstration period to:**
  - Support capacity building for "Healthy Opportunities Pilots Network Leads (NLs) and Human Service Organizations (HSOs), strengthening the ability of HSOs to deliver Pilot services
  - Cover the cost of federally-approved Pilot services, PHP and NL administration of the Pilots, payments to care managers for Pilot responsibilities, and value-based payments



Awarded Healthy Opportunities Network Leads and Regions

DHHS has procured Network Leads (NLs) with deep roots in their community that will facilitate collaboration across the healthcare and human service providers.



Awarded Healthy Opportunities Network Leads

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Impact Health

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must have:

At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children, ages 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

No Wrong Door—Entry Points into the Pilots

The Pilots utilize a “no wrong door” approach to identifying and enrolling individuals, ensuring that individuals who first show up at various “entry points” can efficiently undergo the Pilot eligibility through service delivery process.

Provider Referral

Referral from Pilot Participating HSO

Referral from Non-Pilot Participating HSO

Self/Family Referral

PHP Identification

Care Management Team Assessment

PHPs must ensure there are multiple mechanisms for providers, HSOs and members/families to submit referrals for Pilot eligibility to the PHP

What Services Can Enrollees Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Examples include:

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals
- Medically tailored meal delivery

Transportation

- Linkages to existing transportation resources
- Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence (IPV)

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

Key Entities' Roles in the Pilots

Care Management Teams

- Frontline service providers located at Tier 3 AMHs, LHDs, and PHPs interacting with beneficiaries
- Assess beneficiary eligibility for Pilot, identify recommended pilot services, obtain member consent for participating in the pilots, and provide care management to members enrolled in the Pilots, coordinating access to Pilot services, in addition to managing physical and behavioral health needs
- Manage members' care plan, inclusive of Pilot services, and track enrollee progress over time

PHPs

- PHPs will maintain ultimate responsibility for all Pilot activities—even if they are delegated to a care management team
- Manage a Pilot budget and pay HSOs for the delivery of Pilot services
- Approve which of their enrollees qualify for Pilot services and which services they qualify to receive
- Ensure the provision of integrated care management to Pilot enrollees

Network Leads

- Competitively procured by DHHS
- Develop, manage, and oversee a network of HSOs
- Receive, track and validate invoices from HSOs and submit them to the PHP
- Provide support and technical assistance for HSO network
- Convene Pilot entities to share best practices

Human Service Organizations

- Frontline social service providers that contract with the NL to deliver authorized, cost-effective, evidence based Pilot services to Pilot enrollees
- Participate in the healthcare delivery system, including submitting invoices and receiving reimbursement for services delivered

Tier 3 AMHs/CINs may be best positioned to execute many member-facing Pilot eligibility through service delivery responsibilities due to strong relationships with Members

Pilot Care Management Embedded in Medicaid Care Management

North Carolina is committed to providing Medicaid members "whole person care" including through the provision of care management that occurs at the local level.

The Fundamental Role of Local Care Management

- Local care management teams located at Tier 3 AMHs/CINs, LHDs, and PHPs already have responsibilities related to addressing unmet resource needs (e.g., referrals to needed social services). The Pilots provide additional structure and resources to support care management teams in addressing the social needs of their patients.

- Individuals enrolled in the Pilots must receive comprehensive, integrated and intensive care management for their physical/behavioral needs in addition to their Pilot-related needs. Pilot-related care management should not be siloed or conducted separately from general care management.

- When a member enrolls in the Pilot who is not currently in care management, the PHP must ensure they begin receiving comprehensive care management services from an LHD, a Tier 3 AMH/CIN or the PHP itself.

Tier 3 AMHs will participate in Pilot-related onboarding and training prior to participating in the Pilots. Pilot-participating Tier 3 AMHs will receive an additional Pilot-specific care management PMPM for each member ***enrolled*** in the Pilots. This Pilot PMPM payment will be in addition to the Medical Home and Care Management payments received by Tier 3 AMHs.

Pilot Care Management Team Activities

Activity	Identifying Potentially Pilot Eligible Patients	Assessing Pilot Eligibility and Needed Services	Eligibility Determination & Service Authorization	Referral to Authorized Services	Review Service Mix and Reassess Pilot Eligibility
Summary of Essential Pilot Responsibilities	Supports identification of potentially Pilot-eligible patients (e.g. through regular patient interactions and screenings)	1. Assesses Pilot eligibility (physical/ behavioral and social needs) 2. Recommends Pilot services that are likely to meet patient needs 3. Obtains consent 4. Documents Pilot eligibility and service recs. in the Pilot eligibility and service assessment (PESA) in NCCARE360	***PHP Role:*** *The PHP reviews the PESA in NCCARE360 to determine eligibility, authorize services and document Pilot enrollment and notifies the care management team via NCCARE360*	Refers patient to authorized Pilot service using NCCARE360 and tracks progress	1. Reviews service mix every 3 months 2. Reassesses for Pilot eligibility every 6 months 3. Recommends additional or discontinued services and disenrollment if needed

Care Management Teams will provide support for transitions of Pilot enrollees between health plans and other practices

Note: Care Management Team members can expedite referral to a limited number or duration of pre-approved Pilot services (described further on subsequent slides)

Questions for Discussion

Questions for Discussion

- What (if any) feedback have you heard from AMHs/CINs regarding Pilot participation? Regarding NCCARE360 onboarding/use?
- To what extent will care managers have access to information on an individual's physical/behavioral health conditions in support of assessing for Pilot eligibility?
- Based on your knowledge of the Pilots, how aligned are Pilot responsibilities and how you currently address the non-medical needs of individuals receiving care management?

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NC InCK
NC INTEGRATED CARE FOR KIDS

NC Integrated Care for Kids (NC InCK)

An Innovative Model to Promote Child and Family Wellbeing in Central North Carolina

The project described is supported by Funding Opportunity Number CMS 2B2-20-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

What NC InCK Means for AMH Tier 3s

- New **child-focused stratification** will elevate children for integrated care support
- **"Family Navigators"** within AMHs will provide care management for a subset of NC InCK members with the support of NC InCK staff.
  - NC InCK Integration Consultants are available to support Family Navigators.
- AMHs will receive **actionable data on novel child-centered measures** for attributed NC InCK members
- AMHs may participate in the **NC InCK APM** that links payments to child-centered health and well-being measures

NC InCK NC INTEGRATED CARE FOR KIDS

Agenda

- **NC InCK Basics**

NC InCK NC INTEGRATED CARE FOR KIDS

CMS Integrated Care for Kids (InCK) Model Goals

Improve priority outcomes of child health and wellbeing

Reduce avoidable inpatient stays and out-of-home placements

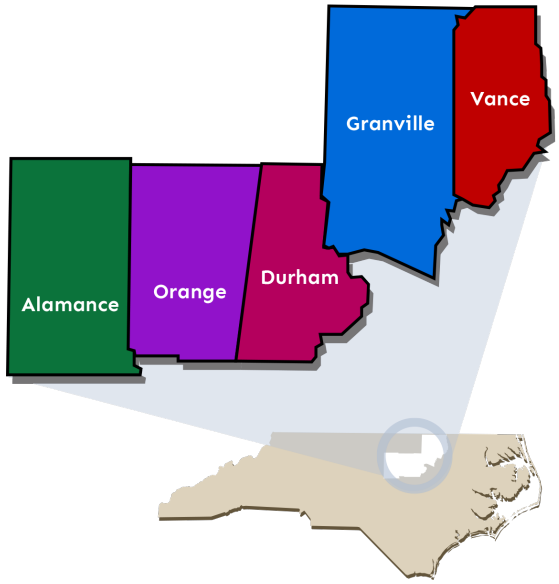
Create sustainable, alternative ways of paying for care

(Also called Alternative Payment Models)

NC InCK NC INTEGRATED CARE FOR KIDS

NC InCK: Brief Overview

- **Attributed population: All Medicaid and CHIP-insured children in this 5-county area**
  - Birth to age 20
  - Regardless of where they receive medical care
  - ~90,000 children



- **Funding: A 7-year, $16M grant from CMS to the following institutions:**

Duke UNIVERSITY

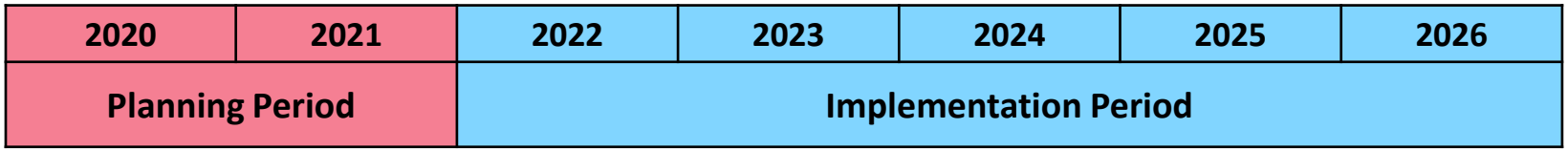
THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Model launches in January 2022

NC InCK NC INTEGRATED CARE FOR KIDS

NC InCK Timeline



July 2022: Launch of NC InCK APMs

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NC InCK is integrating care across these core child services

1. Schools
2. Early Care and Education
3. Food – SNAP, WIC, Food banks
4. Housing
5. Physical and Behavioral Healthcare
6. Public Health Services – Title V
7. Social Services – Child Welfare
8. Mobile Crisis Response
9. Juvenile Justice
10. Legal Aid

Three Key Strategies to Integrate Care for Children in NC InCK

1 UNDERSTAND NEEDS

More holistically understand the needs of children and youth

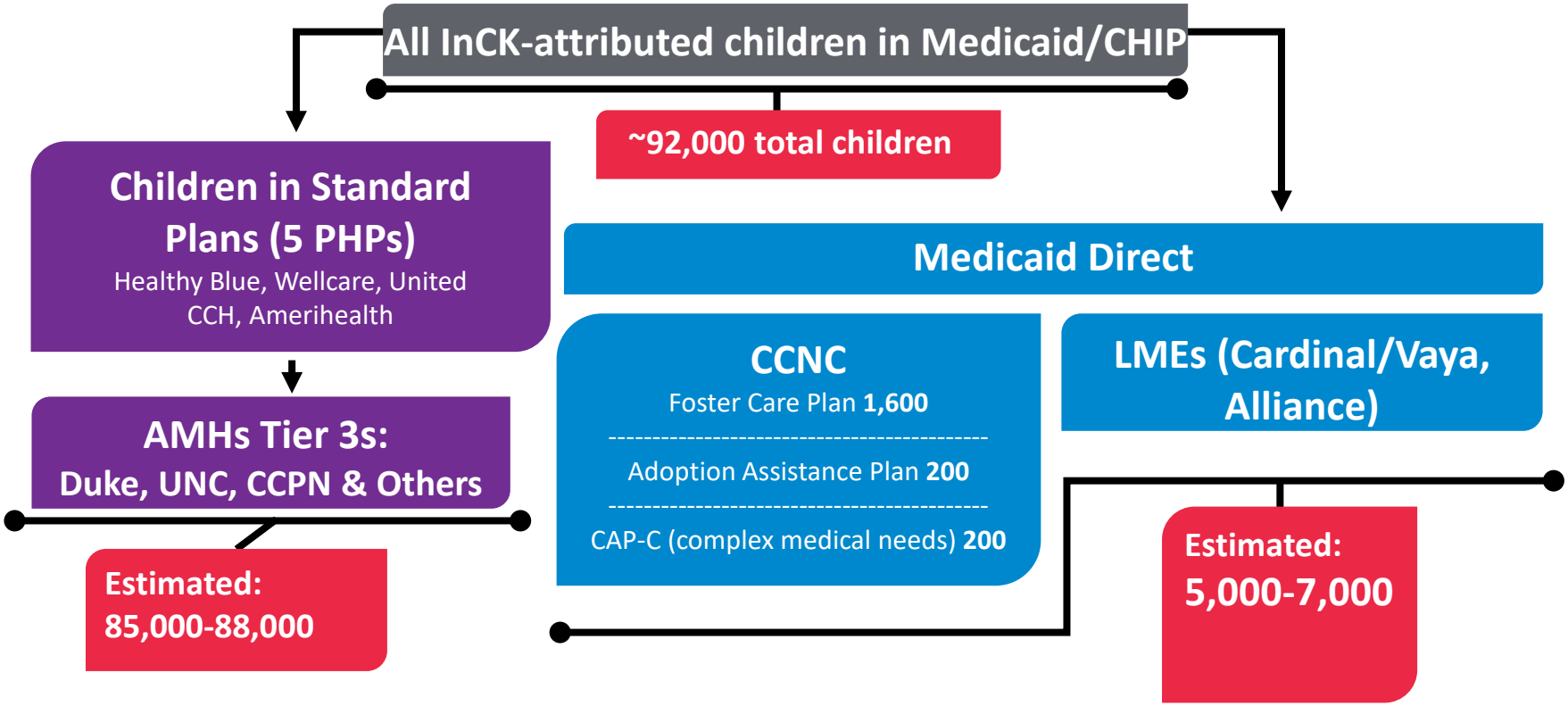
2 SUPPORT AND BRIDGE SERVICES

Integrate services across sectors for children and youth who could benefit from additional support

3 FOCUS HEALTH CARE INVESTMENTS

Find ways to invest resources into what matters most for children, youth, and families

NC InCK and Care Management Responsibilities at Launch



Estimates from DHB data from early 2021

NC InCK
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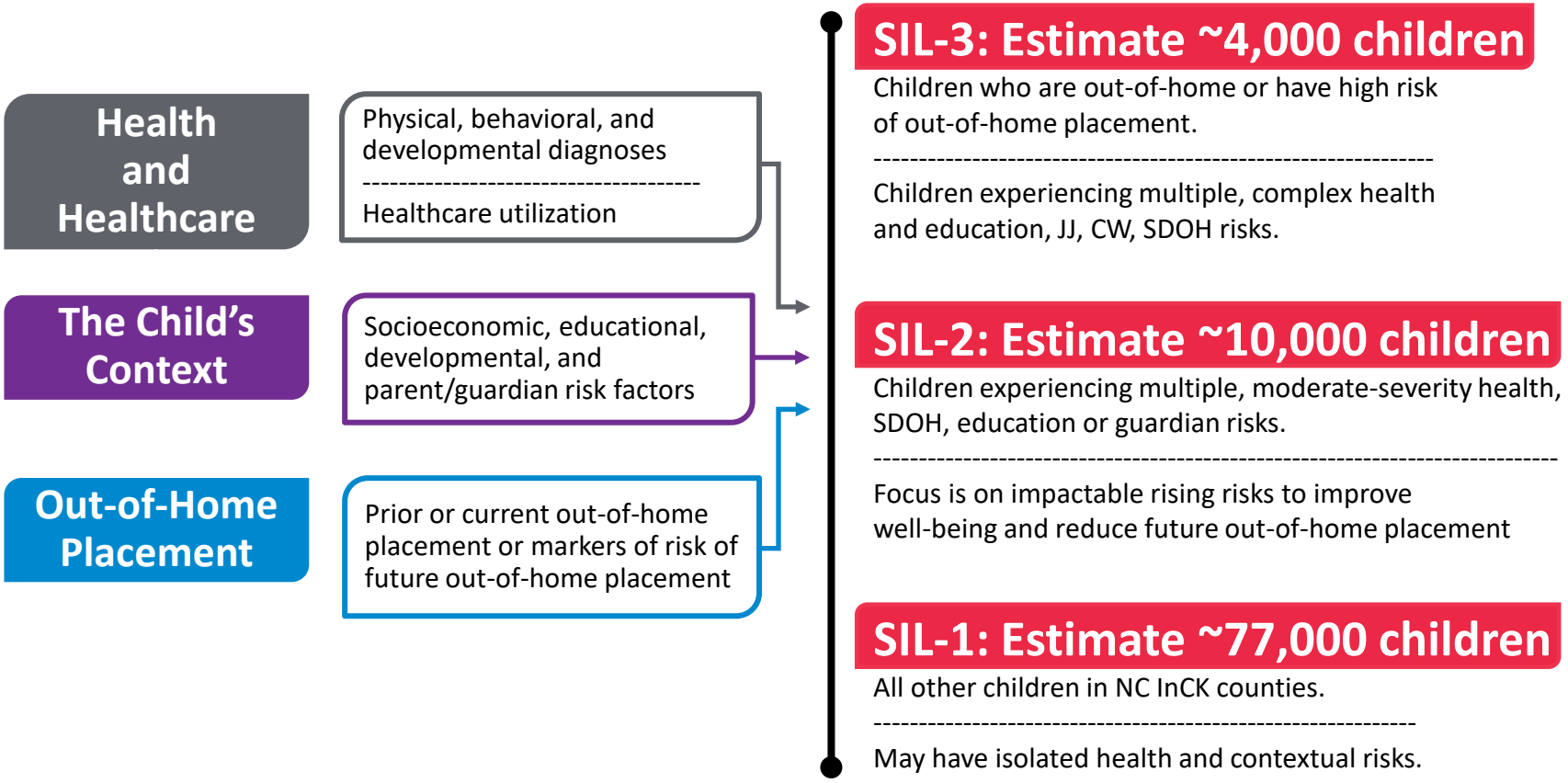
Overview: InCK's Service Integration Levels



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Merging New Data to Stratify Children in InCK

Value: NC InCK will integrate statewide data beyond administrative healthcare in a pediatric-focused risk model.

Category	Examples of Data used to Assess Needs
SDOH Needs	• Food, housing, transportation needs from Care Needs Screen • Social Deprivation Index for member address
Education	• # of school absences and suspensions
Juvenile Justice	• Placement in detention or development center • Probation status
Child Welfare	• Current foster care placement • Recently returned home from foster placement
Guardian	• Casehead substance use during pregnancy • Casehead qualifies for Tailored Plan
Medical Complexity	• Pediatric Medical Complexity Algorithm, Level 3

The NC InCK Service Integration Levels & AMHs

- Children in **SIL 2 and 3** will be distributed across Standard Plans and Medicaid Direct in January 2022
- Each PHP and CCNC will receive a file monthly (**modified Patient Risk List**) from NC Medicaid with InCK members' Service Integration Levels (SIL).
- PHPs and CCNC will share the SIL assignment with the associated AMHs

Children in SIL 2 and 3 will be prioritized for care management starting Jan 1, 2022

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Key Roles in InCK Model

INTEGRATION CONSULTANT
Team of 15 InCK clinical staff available for consultation support to Family Navigators

FAMILY
InCK members in SIL 2 or 3 and their guardians and caregivers will work with a Family Navigator

CARE TEAM
Existing staff within PHPs, CCNC, AMHs and LHDs who support care management who are assigned to InCK SIL 2 and SIL 3 members

FAMILY NAVIGATOR
Existing staff within PHPs, CCNC, AMHs and LHDs who support care management who are assigned to InCK SIL 2 and SIL 3 members

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Family Navigator: A family's primary contact

Engaged InCK Members assigned to SIL 2 and SIL 3 will receive integrated care support from a Family Navigator

Who: Existing PHP, CCNC or AMH staff serving as family's primary contact.

Role: The Family Navigator is an existing PHP/CCNC/AMH staff member who works directly with the family and care team to meet the member's health, social, and educational goals.

Components of Family Navigator Role:

1. Serve as consistent Point of Contact for family
2. Foster long-term support of member and family
   - 1 year for engaged members with at least quarterly check ins for assessment of needs and support
3. Convene and communicate with care team as defined by family (e.g. schools, early childcare, child welfare)
4. Support member's care needs across InCK's 10 core child service areas
5. Support completion of Shared Action Plan and InCK Consent (for applicable members)

AMHs have flexibility on assignment and staffing of the InCK Family Navigator Role.

Examples: Care Manager, Community Health Worker, RN, BSW, Population Health Specialist, MSW

Integration Consultant Support of Family Navigators

Integration Consultants are **available to all Family Navigators** (in PHPs, CCNC or AMHs) who provide integrated care to InCK members in SIL 2 and SIL 3.

Capacity building includes **one-on-one consultation, group trainings & convenings, & written guides**.

Consultation and education for Family Navigators within the 10 NC InCK core child service areas

Training for family-centered completion of **Shared Action Plan**

Best practices guides & ongoing support for creating a **cross-sector care team** with representatives from core child services critical to a child's success

Beneficiary Transition Support: Health plan changes; coverage lapses; aging out

Support for InCK Operations: VirtualHealth + Consent

Monthly integrated care rounds focused on a core child service area and capacity building topics for pediatric care management

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Developing the Shared Action Plan (SAP): Our process

Goal: Create Shared Action Plan for improved **family-centered, whole-child** service coordination

Identify range of care plans across health and child service agencies → Analyze strengths and weaknesses of existing care plans → Develop, test, and revise Shared Action Plan for NC InCK children

DESIGN PRINCIPLES BASED ON DEVELOPMENT PROCESS:

- **Simple and strengths focused** → 3-page document is easy to navigate
- **Completed by family** in collaboration with Family Navigator → Alignment with family's priorities
- **Perspective of family** prioritized in care team development → Those who know family best across systems are engaged in care
- **Accessible to family** and shareable → Reduce burden on family of relaying key information and decrease likelihood of information gaps

NC InCK NC INTEGRATED CARE FOR KIDS

Shared Action Plan Basics

- **Completed** for subset of children in SIL 2 and SIL 3 who could benefit from increased care integration and are at-risk of future out of home placement
  - SIL 2: 10% of eligible children
  - SIL 3: 30% of eligible children
  - **Shared Action Plan Completion is incentivized** as a component of NC InCK's Alternative Payment Model

- **Shared by Family Navigator** with guardian, listed care team members, & member's Integration Consultant.
  - **Flexibility on platform used to share:** e.g., EHR, PHP, or AMH care management platform
  - Also uploaded to **VirtualHealth**, InCK's integrated care platform, by Family Navigator or Integration Consultant

- **Key Uses**
  - **Care team:** identify and share emerging or current care needs.
  - **Family:** set and track goals; inform other providers on services, care team members, and key supports and goals.

InCK VIRTUALHEALTH Integrated Care Platform

Uses of Virtual Health

Integration Consultant

- **Identification of NC InCK-attributed children** in SIL 2 & SIL 3
- **Viewing InCK Child Profile** with basic data on children in SIL 2 & SIL 3
- **Integrated care panel management** & notes for members in SIL 2 & SIL 3
- Storage and sharing of InCK **Shared Action Plan** and **Consent**
- **Role Based Access** for care teams wishing to use the platform

Family Navigator

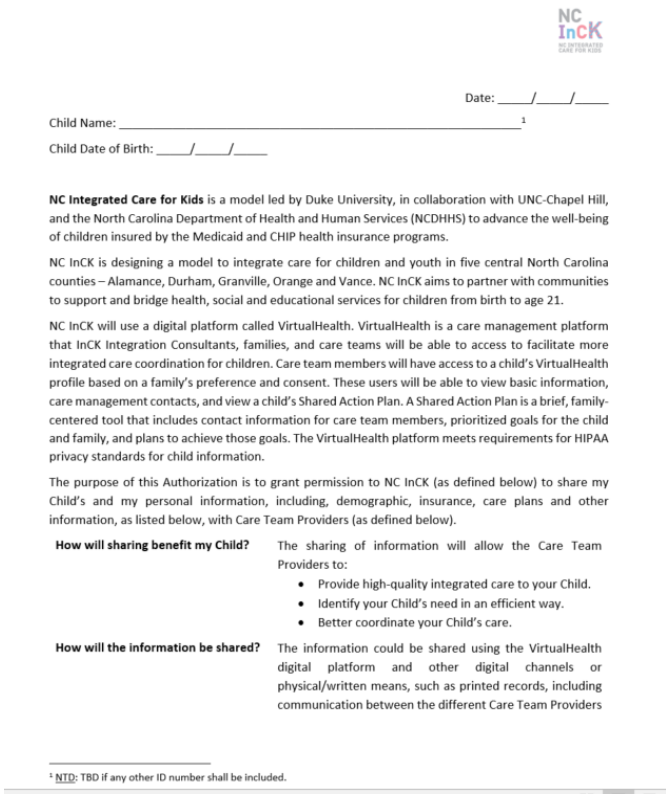
Care Team

Family

Note: All optional and based on guardian completion of InCK consent

- **Access to InCK Child Profile, Shared Action Plan**, and **Consent**
- **Document sharing** with healthcare and non-healthcare care team members (e.g., schools, early childhood, natural supports)
- Ability to **send secure messages** to care team members and guardian

NC InCK Consent Overview



NC InCK

Date: ____/____/____

Child Name: _____[1]

Child Date of Birth: ____/____/____

NC Integrated Care for Kids is a model led by Duke University, in collaboration with UNC-Chapel Hill, and the North Carolina Department of Health and Human Services (NCDHHS) to advance the well-being of children insured by the Medicaid and CHIP health insurance programs.

NC InCK is designing a model to integrate care for children and youth in five central North Carolina counties – Alamance, Durham, Granville, Orange and Vance. NC InCK aims to partner with communities to support and bridge health, social and educational services for children from birth to age 21.

NC InCK will use a digital platform called VirtualHealth. VirtualHealth is a care management platform that InCK Integration Consultants, families, and care teams will be able to access to facilitate more integrated care coordination for children. Care team members will have access to a child's VirtualHealth profile based on a family's preference and consent. These users will be able to view basic information, care management contacts, and view a child's Shared Action Plan. A Shared Action Plan is a brief, family-centered tool that includes contact information for care team members, prioritized goals for the child and family, and plans to achieve those goals. The VirtualHealth platform meets requirements for HIPAA privacy standards for child information.

The purpose of this Authorization is to grant permission to NC InCK (as defined below) to share my Child's and my personal information, including, demographic, insurance, care plans and other information, as listed below, with Care Team Providers (as defined below).

How will sharing benefit my Child? The sharing of information will allow the Care Team Providers to:

- Provide high-quality integrated care to your Child.
- Identify your Child's need in an efficient way.
- Better coordinate your Child's care.

How will the information be shared? The information could be shared using the VirtualHealth digital platform and other digital channels or physical/written means, such as printed records, including communication between the different Care Team Providers

[1] NTD: TBD if any other ID number shall be included.

Family Navigators will collect consent to support InCK's model of integrated care

InCK has created a guardian-centered consent form to enable Family Navigator's to deliver integrated care:

- **Regular interactions** between care team members and guardians
- **Integration Consultant consultation** on service needs & referrals
- **Role-based access to InCK's VirtualHealth** integrated care platform for all care team members
- Creation and sharing of the **Shared Action Plan** with care team members within and outside of healthcare

Input Needed: InCK wants to ensure the form supports integrated care teams in outreach and communication with Integration Consultants. **We are requesting input from legal teams of PHPs, AMHs & CCNC on edits.**

Investing in Health: NC InCK's Alternative Payment Model

- NC InCK is working with the PHPs and health systems to design a payment model that **links incentive payments to more meaningful measures of child well-being**
- **Goal**: Increasing funding and investments for child well-being
- Two tiers reflect a **glidepath to more advanced payment models** and different levels of readiness to take on risk

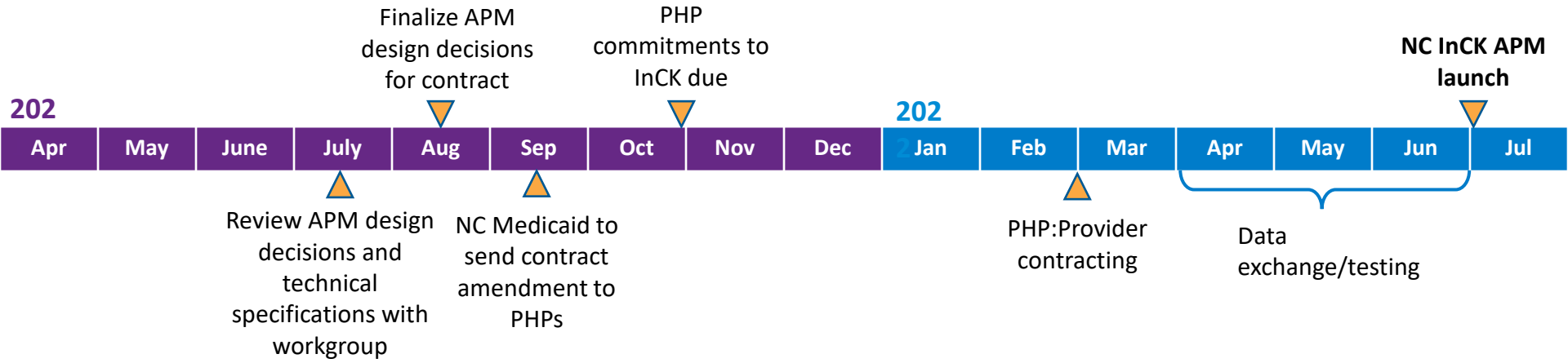
	NC InCK APM Performance Measures
Cross-sector child well-being metrics	Kindergarten Readiness
	Food Security
	Housing Stability
Health care utilization metrics	Shared Action Plan
	Screening for Clinical Depression & Follow-Up
	Rate of Emergency Dept Visits
	Equity: Reduction in disparity in 15mo WCC
	Total Cost of Care

The NC InCK APM has been designed over the last 2 years by a Working Group with leadership representation from Medicaid, CINs, and all 5 PHPs

NC InCK NC INTEGRATED CARE FOR KIDS

NC InCK APM Timeline

Understand a child's needs | Integrate services | Invest in what matters most



Implementation – Key Dates:

- **July 2022:** Launch of NC InCK APMs
- **Jan 2025:** If participating since July 2022, provider organization transitions to InCK Advanced
- **December 31, 2026**: CMS-funded program ends

NC InCK NC INTEGRATED CARE FOR KIDS

Summary: What NC InCK Means for AMH Tier 3s

- New **child-focused stratification** will elevate children for integrated care support
- **"Family Navigators"** within AMHs will provide care management for a subset of NC InCK members with the support of NC InCK staff.
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NC InCK NC INTEGRATED CARE FOR KIDS

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Next Steps on Pilots

- DHB/HO Team/PHPs will directly engage affected AMHs (HO Pilots)
- DHB/InCk Team/PHPs will directly engage affected AMHs (InCk Pilots)
  - *Tailored Plans will support InCk beginning in July 2022

COVID Vaccinations

- Please continue to encourage vaccination in ALL care management encounters
- ***DHB is preparing data on unvaccinated members to share with PHPs and AMHs (mid-end of October)***
- PHPs are developing COVID vaccination member incentive programs (stay tuned)

AMH Opportunities

- Standardized PCP Change Form (coming very soon!)
  - AMH Homepage DHB
- AHEC Managed Care Webinars
  - Webinars: Quality & Population Health Series (like this)
- Managed Care Quality Forum, October 12

  Registration: https://www.ncahec.net/medicaid-managed-care/
- Tailored Care Management (TCM) Webinars (October-December)

Healthy Opportunities Pilots Overview - Appendix

Pilot Service Fee Schedule (1 of 3)

The Pilots represent the first time Medicaid funding will systematically pay for health-related social services for a broad subset of Medicaid enrollees. The CMS-approved fee schedule, based on the Department's 1115 waiver, defines and prices Pilot services. All Pilots will adhere to the fee schedule's rates in their payment practices.

	Service Name	Fee Schedule Rate
Housing Services	Housing Navigation, Support and Sustaining Services	$373.66 PMPM
	Inspection for Housing Safety and Quality	$250 per inspection*
	Housing Move-In Support	1-5+ BR: $900- $1,250*
	Essential Utility Set-Up	$500 for utility deposits, arrears or reinstatement*
	Home Remediation Services	$5,000 per year*
	Home Accessibility and Safety Modifications	$10,000 per lifetime of waiver demonstration*
	Healthy Home Goods	$2,500 per year*
	One-Time Payment for Security Deposit and First Month's Rent	• First Month's Rent: 110% Fair Market Rent (FMR)* • Security deposit: 110% FMR x2*
	Short-Term Post Hospitalization Housing	• First Month's Rent: 110% Fair Market Rent (FMR)* • Security deposit: 110% FMR x2*

* Indicates cost-based reimbursement up to the fee schedule cap

The Pilot Service Fee Schedule provides more detail on each Pilot service, including a service description, anticipated frequency and duration, setting of service delivery, and minimum eligibility criteria to be approved for the service.

Pilot Service Fee Schedule (2 of 3)

	Service Name	Fee Schedule Rate
Food Services	Food and Nutrition Access Case Management Services	15-minute interaction: $12.51
	Evidence-Based Group Nutrition Class	One class: $21.60
	Diabetes Prevention Program	Phase 1 (16-class program): $264.12 Phase 2 (16-class program): $99.04
	Fruit and Vegetable Prescription	$200 per month*
	Healthy Food Box (For Pick-Up)	Small box: $85.04 Large box: $136.06
	Healthy Food Box (Delivered)	Small box: $90.04 Large box: $141.06
	Healthy Meal (For Pick-Up)	$4.14 per meal
	Healthy Meal (Home Delivered)	$4.87 per meal
	Medically Tailored Home Delivered Meal	$5.05 per meal

* Indicates cost-based reimbursement up to the fee schedule cap

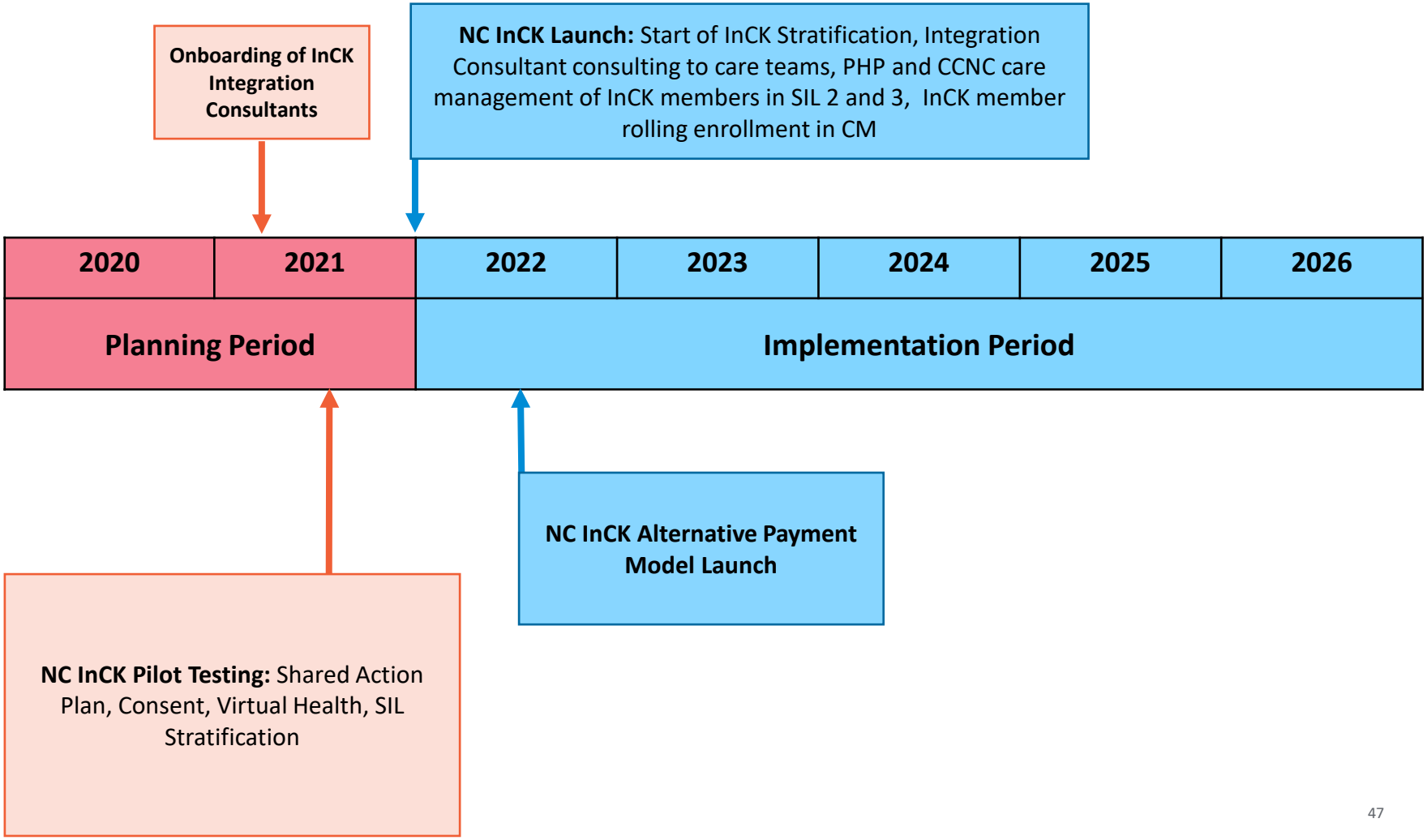
Pilot Service Fee Schedule (3 of 3)

	Service Name	Fee Schedule Rate
Interpersonal Violence (IPV) Services	IPV Case Management Services	$209.37 PMPM
	Violence Intervention Services	$152.44 PMPM
	Evidence-Based Parenting Curriculum	One class: $21.50
	Home Visiting Services	One home visit: $63.43
	Dyadic Therapy	$68.18 per occurrence
Transportation Services	Reimbursement for Health-Related Public Transportation	$102 per month*
	Reimbursement for Health-Related Private Transportation	$204 per month*
	Transportation PMPM Add-On for Case Management Services	$71.30 PMPM
Cross-Domain Services	Holistic High Intensity Enhanced Case Management	$470.23 PMPM
	Medical Respite	$206.98 per diem
	Linkages to Health-Related Legal Supports	15-minute interaction: $23.83

* Indicates cost-based reimbursement up to the fee schedule cap

NC InCK Overview - Appendix

NC InCK Timeline



InCK Awardees

State	Awardee Name
Connecticut	Clifford W. Beers Guidance Clinic
Illinois	Ann & Robert Lurie Children's Hospital
Illinois	Egyptian Health
New Jersey	Hackensack Meridian Health Hospital
New York	New York Department of Health
North Carolina	**Duke Health in partnership with NCDHHS, UNC**
Ohio	Ohio Department of Medicaid
Oregon	Oregon Health Authority

How NC InCK Plans to Achieve Integrated Care

More holistically understand the needs of children

- **Data Driven Needs Assessment** to assign a child to 1 of 3 Service Integration Levels
- **Use of cross-sector data** from state child welfare, juvenile justice, school attendance & suspensions
- Identify children and youth who could benefit from care management support

Integrate services for children who could benefit from additional support

- **InCK Integration Consultant** to support care managers in resource navigation
- Identify a **Family Navigator** for long-term support of children and families
- **Shared Action Plan** for families and care team members
- Access to **InCK VirtualHealth platform** to support care team collaboration

Invest resources in what matters for children and families

- Develop **Alternative Payment Models (APMs)** that link payments to meaningful measures of child well-being
- Identify, advocate for, and reward interventions which address **health inequities**

Area 1: Holistically Understand Needs of Children

Summary

- Overview: InCK's Service Integration Levels (SILs)
- Merging new cross-sector data to stratify children in InCK
- NC InCK SILs and PHPs/AMHs

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Data Used to Stratify Children into SILs

Current Out-of-Home Placement Flag*

- Juvenile Justice residential placement (current)
- Foster Care plan eligible (current)

Out-of-Home Placement Risk Flag

- Prior foster care plan eligibility (within past year)
- Adoption assistance plan enrollee (entry within past year)
- Juvenile Justice engagement (higher severity)
- ≥ 3 hospitalizations within past year
- ≥ 30 inpatient days within past year
- Residential treatment within past year
- Skilled nursing facility treatment within past year
- Psychiatric inpatient admission within past year

Health Designation Flag: one or more of

- Care Management for At-risk Children (CMARC) enrollee
- Community Alternatives Program for Children (CAP/C) enrollee
- Pediatric Medical Complexity Algorithm (PMCA) level 3
- Tailored Plan eligible

Healthcare Utilization Flag: one or more of

- Antipsychotic Rx within past year
- In-home mental health services within past year
- Mobile crisis response use within past year
- ≥ 4 ER visits within past year
- Medicaid paid cost > $5,000 within past year
- < 5 years old without any claims within past 2 years despite continuous enrollment

Socioeconomic Flag: one or more of

- Healthy Opportunities Screen (≥ 2 positive): Food, Housing, Transportation, Violence
- Temporary Assistance for Needy Families (TANF) eligible
- High Social Deprivation Index (SDI) score
- Juvenile Justice engagement (lower severity)

Education Flag: one or more of

- Chronic school absences within past year (2019-2020)
- Frequent short-term suspensions within past year (2019-2020)
- Expulsion within past year (2019-2020)
- Early intervention - infant-toddler program enrollment within past year

Guardian Flag: one or more of

- Guardian Tailored Plan eligible
- Guardian psychiatric admission within past year
- Guardian Medicaid eligible due to disability
- Guardian substance use during pregnancy or perinatal depression within past 2 years

Stakeholder Escalation Flag

- Child flagged by family or other stakeholder for case review due to perceived risk

***Out-of-Home Placement:** Currently resides or is at risk for out-of-home placement **OR** prolonged or multiple inpatient admissions. This refers to placement in a psychiatric hospital, residential care center, skilled nursing facility, correctional facility, foster care (including kinship care), or juvenile detention.

Area 2: Support and Bridge Services

Summary

- Integrating care across services
- Integration Consultant Role and support offered to PHPs, AMHs, and CCNC
- Assignments of Integration Consultants to Care Teams
- Family Navigator Role Overview
- InCK Shared Action Plan Overview
- Additional InCK Tools: VirtualHealth Platform and Consent

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Resources Available to PCPs in NC InCK

- **Capacity building** on core child service areas through group trainings, convenings, and resource guides
- **Technical assistance** for assessing and addressing non-clinical needs:
  - What to do when a child is experiencing food insecurity or housing instability
  - How to support a child to promote Kindergarten readiness
  - How to utilize new codes/modifiers for non-clinical interventions
- **Facilitated communication and collaboration** across practices and sectors to share promising interventions for children

InCK Integration Consultant

Lead Consultant UNC

Integration Consultant Leadership Team

Lead Consultant Nancy Madenyika, Duke

Local Health Department	DSS-Child Welfare	PHP's	Cardinal	Alliance	Head Start	Dept of Public Safety (JJ)	Title V (School Nurse)
Granville Vance Health	Orange DSS	Wellcare: Missy Burrell					
Orange Co Health	Local DSS	United: Tami Hilton					
		CCH: LaShawnda Massey					
		Healthy Blue: Diana Vandergrift					
		Amerihealth Caritas: Amy Davis					

Integration Consultant Support of PHPs, CCNC and AMHs

Integration Consultants are experienced clinicians (social work, nursing) focused on supporting care teams in implementing pediatric integrated care

Integration Consultants are embedded across key child service areas to improve integrated care and offer cross sector consulting to PHP, CCNC and AMHs serving InCK members

PHP-based Integration Consultants currently advise InCK leadership on key components of InCK model design

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Assignment of Integration Consultants to SIL 2 and 3 Members

Order	Criteria	Consultant Assigned
1.	Juvenile Justice engagement 12 months from today's date	Juvenile Justice
2.	Currently enrolled in Medicaid Direct Foster Care or Adoption Plan	Orange County DSS
3.	Child in foster care placement within 12 months from today's date	Orange County DSS
4.	Current enrollment in CAP-C	School Nurse Consultant
5.	CMARC enrollment	Granville Vance Health Dept and Orange Health Dept
6.	Meets future criteria for Tailored Plan enrollment	Alliance and Cardinal
7.	Attributed to Duke-affiliated AMH	Duke and Head Start
8.	Attributed to UNC-affiliated AMH	UNC and School Nurse
9.	Enrolled in Standard Plans, Not at UNC or Duke	
	+ enrolled in Amerihealth	Amerihealth
	+ enrolled in CCH	CCH
	+ enrolled in Healthy Blue	Healthy Blue
	+ enrolled in United	United
	+ enrolled in Wellcare	Wellcare

Consultant Assignment to care teams will be based on identifiable characteristics of the InCK member

Care Team members embedded in PHPs will connect with their PHP's Integration Consultant

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Developing the Shared Action Plan (SAP): Our process

Goal: Create Shared Action Plan for improved **family-centered, whole-child** service coordination

Identify range of care plans across health and child service agencies → Analyze strengths and weaknesses of existing care plans → Develop, test and revise Shared Action Plan for NC InCK children

1. **National review of over 120 existing care plans** across various core child service areas
2. **Interviewed frontline care managers in health and child service agencies to learn:** who develops care plans and based on what assessments, where are they stored, how they are shared, how their effectiveness is evaluated
3. **Hosted focus groups with families** to learn about their experiences with the development and use of care plans for their children
4. **Co-designed the Shared Action Plan based on analysis** in collaboration with families, physicians, care managers, DSS and Juvenile Justice representatives
5. **Usability Testing** on the Shared Action Plan from July to October
   - United and Amerihealth both participated in feedback

Components of the SAP

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SHARED ACTION PLAN
FOR:

CHILD & FAMILY BACKGROUND

Please fill in the child & family background. Current caregivers may include birth parent(s), foster parent(s), or other family members. If applicable, natural supports may include essential family members, friends, or neighbors who play an important role in supporting the child's health and well-being.

First Name: ____ Last Name: ____ Preferred Name: ____

DOB: ____ (mm/dd/yyyy) County: ____

Preferred written & spoken language: ____ Preferred Pronouns: ____

Primary Caregiver: ____ Legal Guardian

Relationship to Child: ____ Phone Number: ____ Other Phone Number: ____

Email: ____

Other Caregiver/Natural Support Name: ____

Relationship to Child: ____ Phone Number: ____ Other Phone Number: ____

Email: ____

Family Navigator: ____ Date completed: ____ (mm/dd/yyyy)

Your family's concerns and priorities related to your child's health and wellbeing are the focus of your Shared Action Plan. The information you choose to provide is helpful as we all work together to achieve your desired outcomes for your child and family.

Child's & Family's Strengths, Interests, and Activities

Family's Area of Concern: What are you most worried about? What challenges does your child and/or family face every day? What challenges do not happen often, but are of concern?

CURRENT ENGAGEMENT WITH HEALTH AND SOCIAL SERVICES & PLANS OF CARE

Who*	Agency	Name	Phone and Email	Other way to contact
Guardian/ Legally Responsible Person				
Family Contact 1				
Primary Care Provider				
Family Navigator				

ACTION PLAN

GOAL	WHO	IS DOING WHAT	BY WHEN	PROGRESS
Start date / Check in date / Completion date			Date	Date; Met goal; Satisfactory Progress; Needs more time/assistance; Goal needs modification
Start date / Check in date / Completion date			Date	Date; Met goal; Satisfactory Progress; Needs more time/assistance; Goal needs modification
Start date / Check in date / Completion date			Date	Date; Met goal; Satisfactory Progress; Needs more time/assistance; Goal needs modification
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Start date / Check in date / Completion date			Date	Date; Met goal; Satisfactory Progress; Needs more time/assistance; Goal needs modification

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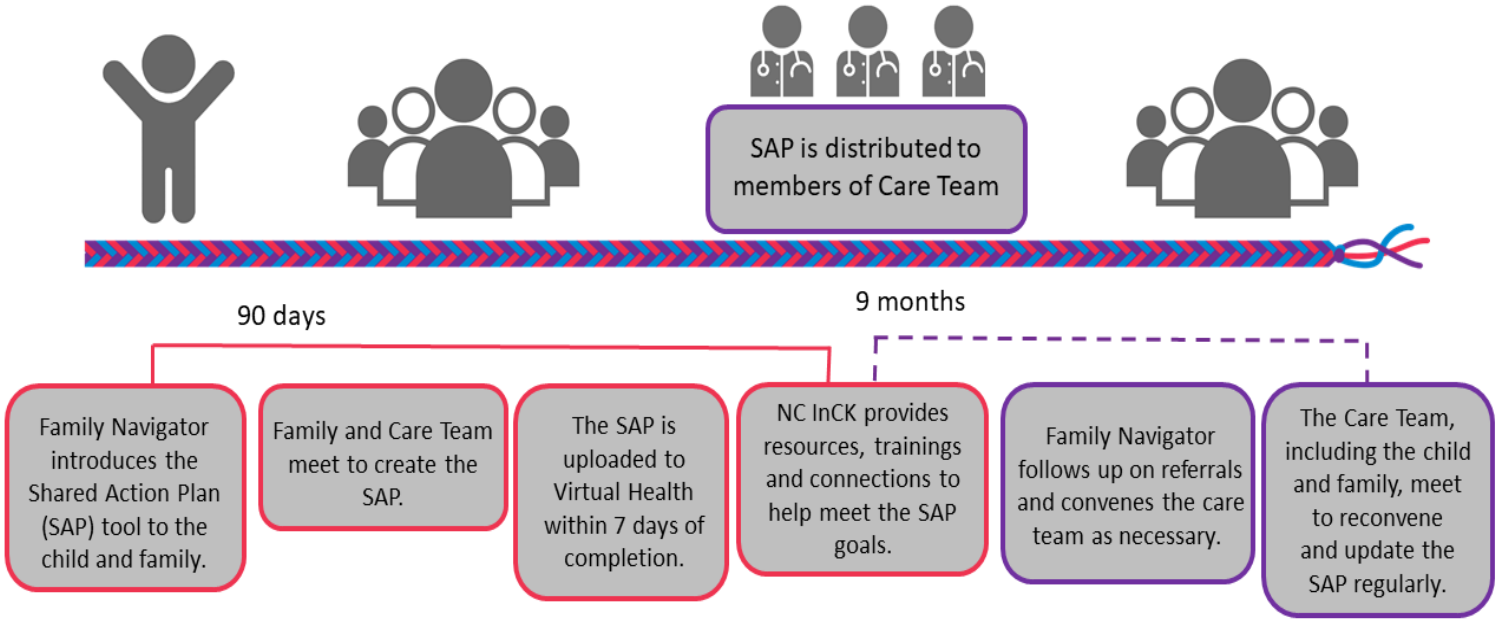
Draft Timeline: NC InCK Shared Action Plan (SAP)

Start: Family engages in Care Management



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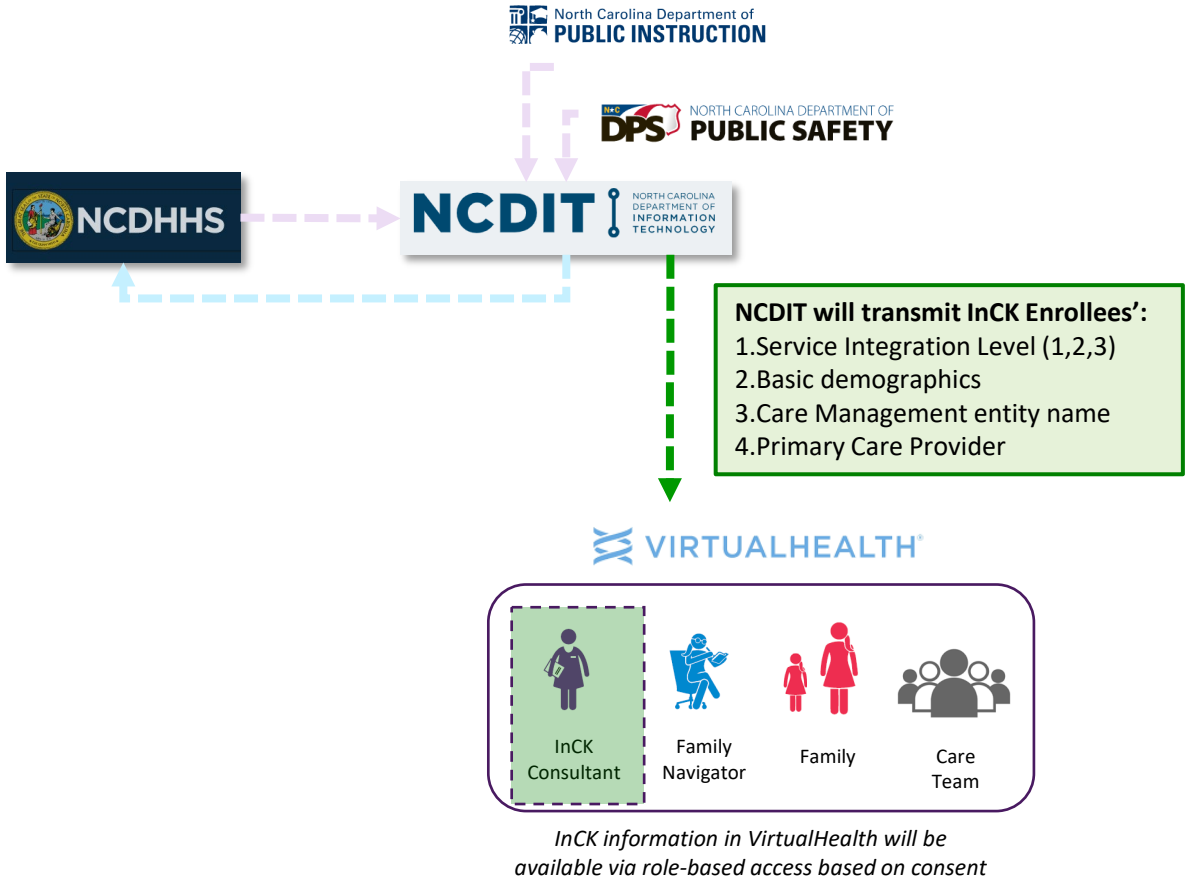
VirtualHealth & Duke BAAs/DSAs

Why BAAs/DSAs Are Needed:

- Consultants will do NC InCK panel management on Virtual Health
- Access to PHI on InCK members and records on interactions and services

- **Each PHP has been asked to sign Duke's BAA and Data Security Agreement by Sept 15, 2021**
- NC InCK and Duke will hold open office hours on **August 24 at 9am for questions on the BAA and DSA documentation.**



Area 3: Focus Healthcare Investments (APM)

Summary

- NC InCK is working with the PHPs and health systems to design a payment model that **links incentive payments to more meaningful measures of child well-being**
- These Alternative Payment Models (APMs) will change how money flows between Medicaid, the PHPs, and our practices
- **Goal**: Increasing funding and investments for child well-being

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NC InCK APM Structure

Understand a child's needs | Integrate services | Invest in what matters most

- NC InCK APM will be a **5-year, targeted incentive program** in the 5 NC InCK counties, beginning July 2022 through Dec 2026. Eligible beneficiaries will be Medicaid/CHIP-insured individuals birth to age 20 in Standard Plans.
- Two tiers reflect a **glidepath to more advanced payment models** and different levels of readiness to take on risk
- The default option for participation is the **InCK Foundation**, built on pay-4-reporting and pay-4-performance as providers build capacity and infrastructure. Provider organizations participating in InCK must transition to **InCK Advanced** from InCK Foundation after 2 years, which includes shared savings/losses.

	InCK Foundation	InCK Advanced
Primary Care Kindergarten Readiness Bundle	**Pay-4-Reporting** for documenting Kindergarten Readiness Bundle	**Shared Savings/Losses** for improving Kinder. Readiness rate
Screening for Housing Instability	**Pay-4-Reporting** for screening & addressing + screens	**Shared Savings/Losses** tied to housing instability rate benchmark
Screening for Food Insecurity	**Pay-4-Reporting** for screening & addressing + screens	**Shared Savings/Losses** tied to food insecurity rate benchmark
Shared Action Plan for children in SIL-2 and SIL-3	**Pay-4-Reporting**	**Shared Savings/Losses** tied to completion rate benchmark
Screening for Clinical Depression & Follow-Up Plan	**Pay-4-Performance**	**Shared Savings/Losses** tied to measure benchmarks
Ambulatory Care: ED Visits	**Pay-4-Performance**	
Equity: Well-Child Visits in first 30 months of life	**Pay-4-Performance**	
Total Cost of Care	**Aware**	**Shared Savings/Losses** tied to TCOC benchmarks