Transcript for Quality & Population Health: Integrated Care for Kids (InCK) / Healthy Opportunity Pilots: Impacts to AMHs

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Presenters:

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Carol Stanley

It's 530 let's get started. Good evening, everyone. And thank you so much for participating in today's quality and Population Health Webinar, featuring healthy opportunities and Integrated Care for Kids also known as Inc. I'm Carol Stanley, North Carolina, AHEC's Medicaid transformation manager, and your host for tonight's webinar. The webinar is part of a series of informational sessions produced by NC Medicaid and NC AHEC to support providers across the state with Medicaid managed care. We have some great panelists tonight. From DHHS, we have Krystal Hilton, Associate Director for population health. From healthy opportunities. We have Amanda Van Vleet front who is the Associate Director of Innovation and from North Carolina Inc. We have Sara Allin, who is the Managing Director, Dr. Charlene Wong, Executive Director, Dr. Richard Chung, Director of population health and Nancy Madenyika lead integration consultant. Now I'll be brief with some reminders for the set successful viewing and listening experience for you. You can adjust the size of the slides on your screen by clicking on the gray bar just to the right of the slide and dragging it to either side so you can make it bigger or smaller and see the speaker as well. You can also adjust your video settings to hide people who aren't speaking. Click the View button on the top of your screen and select side by side with the speaker. everyone other than our presenters is already muted. Crystal Hilton will run through the agenda, but I'll go ahead and put it up just so you'll know what we are covering. We've learned in the past that the presenters will often address participant questions during their presentations. So please allow the topic to be covered before submitting your question in the q&a box. Please know that our goal is to respond to as many questions as possible during the webinar. tonight's webinar slides are on the A hit website and we'll put a link to them in the q&a box. Within a day or two. The recording and written transcript will be on the NC AHEC website. Krystal I'm turning this over to you now.

Dr. Charlene Wong

Thank you, Carol. Good evening, everyone. I am crystal Hilton as Carol shared, the Associate Director for population health at North Carolina Medicaid. And I wanted to quickly walk you through our agenda because we have a jam packed, action packed agenda for tonight. We are excited to have our speakers from the healthy opportunities pilot as well as the North Carolina integrated for kids project the ink project. We will not take a lot of time and share too much information extraneous because we really want you to be able to sit back focus and really enjoy the highlights of these programs. I will start by turning it over to Amanda Van Vleet to start with the hub the Opportunities Project.

Amanda Van Vleet

Right. Thanks crystal. I appreciate it. Hi, everyone. I'm Amanda VanVleet. I'm the Associate Director for innovation at North Carolina Medicaid, and I lead our healthy opportunities pilots. I'm excited to talk to you all tonight about them. We have been doing a lot of work around these pilots to launch them and the beginning of 2022 Sorry, I'm two years behind them at the beginning of 2022 I'm so excited to give you all an update tonight. Um, so as you all are probably aware that healthy opportunities pilots are a really unique opportunity that North Carolina Medicaid has been given. We've been given the authority by CMS to to spend up to $650 million on the healthy opportunities pilots for a while it will test the use of Medicaid funds to pay for services that are not traditionally paid for by Medicaid and are for priority, not non medical domains. Those are food transportation, housing and interpersonal violence or toxic stress. And we will test the use of those Medicaid funds for paying for those services on our enrollees, health outcomes and health care costs. So very unique opportunity. There are a lot of entities involved in the pilots. So the department is overseeing them but we're working in close collaboration with our health plans and with entities that we have recently procured that we're calling our healthy opportunities network leads. We previously referred to these entities as our lead pilot entities, but they're the same and are human service organizations that are community based organizations. And social service agencies like food pantries, homelessness shelters, and then of course, our provider community. So care management in particular is really central to the pilots. A big part of them is to ensure that individuals with both health and I should say medical and non medical needs, receive Whole Person Care Management. And so the care manager being a trusted person to be a trusted resource to the Medicaid enrollee is a really central part of our pilot. So I'll spend some extra time talking about care management in the pilots and the role of the care manager. Alright, let's go to the next slide. Thank you. Um, so just went through a little bit of this information. But again, these are our four priority domains. The services that we'll be providing through this pilot fall into one of these four domains of housing, food, transportation and interpersonal violence and the healthy opportunities network leads that we have procured much like the health plan forms a network of providers or network leads will be forming and managing a network of human service organizations or HS o's and then they'll really be connecting those HSOs to each of the health plans. So they'll really be bringing the network of HSOs and then doing think the fundamental job of having these organizations like food pantries, for example, really function more as Medicaid providers. And so this is obviously challenging for many reasons. So this is one of the balances that we're trying to strike is having them participate in the Medicaid program without over medicalizing the social services industry. So that's really the role of the network lead, and they will

again, they'll actually be contracting with each HSO in their network and then with each health plan as well, so they'll really be that central connector organization. Let's go to the next slide. Great, thank you. So in May the end of May we just awarded our three healthy opportunities network leads. There's one network lead in each of the three pilot regions which are highlighted on this slide. So we have access east we have community careful our Cape Fear and we have impact health, which is a subsidiary of dogwood Health Trust in western North Carolina.

So it's about 33 counties, so about just about a third of North Carolina's counties that are involved in the pilots. I think that they represent all fairly rural areas and a fairly diverse range of our Medicaid enrollees. So we're excited. We're excited for the possibilities that this that this brings to us through the pilots. Next slide. Great, thank you. As a quick reminder about who is eligible to receive these pilot services that are non traditional Medicaid benefits. To qualify to qualify for these services, an individual must be enrolled in Medicaid managed care, they must live in one of the three pilot regions that was on the last slide. And then they have to have at least one needs based criteria of at least one social risk factor. So the needs based criteria can be either a physical or behavioral health condition to qualify the member for the pilot and those qualifying conditions vary by age group. So an adult for example, could have two or more chronic conditions while a young child ages zero to three could be a NICU graduate and so those really vary by population. And then again, they'll also need to have at least one social risk factor in one of our four priority domains. So just to say that these are fairly complex individuals with complex needs, I should say, with really both physical behavioral health and social social risk factors. Let's go to them explain. Thank you. So we are we are attempting to create a new wrong door entry policy to the pilots. So whether and whether a Medicaid beneficiary is that their doctor's office, if they're with their care manager, or talking to their health plan if they show up at a food pantry. We're trying to provide enough information to entities in the pilot regions to be able to say you may be you may be eligible for the pilots and the messaging will be to connect that member to their care manager or if they don't have a care manager to their health plan and their health plan will connect them to a care manager. But the care manager is really the person that we want the individual to be routed to who will start the assessment process to see if the individual is eligible for the pilot services or not. So no wrong door entry, but all the entry points ideally will lead that individual to their care manager. Let's go to the next slide. Great, thanks. So these are examples of the pilot services that will be offered in the four priority domains. So we'll be offering services such as housing, navigation support moving moving support, first month's rent and security deposit for qualifying individuals. Short term post hospitalization housing. In the food domain, we will be offering home delivered meals medically tailored meals, fruit and vegetable prescriptions, certain nutritional and cooking educational classes. For transportation we will be reimbursing for both public and private transportation. And then for interpersonal violence and toxic stress. We will be reimbursing for evidence based parenting curriculums and some evidence based violence prevention or assessment programs. Thanks.

So this is a snapshot of each of the our key entities roles and the pilots. So as a quick overview to these are our health plans will have the job of really being responsible for managing this kept allocation of pilot funding that's available for the pilots. So with that they'll also be responsible for verifying that a member is eligible for the pilots and authorizing pilot services. And then of course, are ultimately

responsible for care management, whether that's provided by the health plan or whether that's delegated to a tier three major local health department or happens to a CIN. The care manager or a care management team, or I should say is really the member facing individual or team. So we want the members to continue to meet with their care managers, their doctors their health plans as they normally would. So the care manager will meet with the meet with the individual. They'll do an initial assessment to see if they think the member is eligible for the pilots and recommend pilot services that that member may be eligible for. And I'll walk through this process in a bit more detail. But that's their primary role. And then if they get approval from the health plan that the member is eligible and that the health plan is authorized. Services, then the care manager will refer that member to an HSA that can provide services that meet their needs. The HSO will deliver services to the member and the care management team will continue to provide care management track whether that individual did in fact get housing or transportation or food needs that they needed and continue to provide care management for that individual. Um, the network leads as I mentioned, we'll be developing this network of HSOs and providing a lot of technical assistance and support to those entities. And then our human service organizations are the frontline, non medical service providers that provide food and housing and transportation.

Next slide. Thanks. So I'll dig in a little bit more to the role of care management and the pilots. So again, I think North Carolina is obviously committed to local care management and so the the goal here is for the same individual or care team that is providing care management to a Medicaid member to also provide care management around the pilots are that member so we'd like the care managers to stay the same so that to keep with the idea of whole person care and one one central care management team, and so are trying to enable that to happen we will be offering additional resources to tier three AMHs that opts to provide care management for the pilots. There is an additional per member per month care management fee that will be that will be available to those tier three AMHS that decide to do pilot care management. And that really gives them additional support for conducting pilot eligibility assessments authorizing the services. Care Management Teams will also be just continuing to check up to make sure that the member is eligible so they will need to conduct reassessments every three and six months just to see if the service array is still appropriate for the member. And then it's six months to ensure that the member is still eligible for the pilots. So that's what the extra the additional care management fee will be on top of there on top of the current care management fees that that those entities are receiving. Um Let's go to the next slide. Great thank you. So this is a process flow that walks us through what I was verbally talking about earlier, but I'll walk through the process again. So so a member for example, let's say a member shows up at their food pantry and the food pantry says Are you a Medicaid member you may be eligible to have your food box paid for by Medicaid, call your care manager member calls their care manager and somehow routed and directed to their care manager.

Care Manager knows gonna even let's say in this example care manager knows the number because they're already involved in care management. And they know that that's an adult with two or more chronic conditions and they have a food need. And so they say yeah, I think you would be eligible for these services. So they would fill out a standardized eligibility assessment. That's, I should say, it's not actually an additional assessment, but it's more of a documentation of how that member is eligible for

the pilots. So they would document their eligibility criteria, recommend services. So say, home delivered meals for the next three months, for example, and submit that information to the members health plan. The health plan would then confirm that the member is in fact eligible for the pilots and authorize the services send that authorization back to the care manager. Care Manager upon receiving authorization would make a referral through NC care 360 our statewide closed loop referral system to a food pantry in the members community on behalf of the member to get them the foods that they need, um, that that food pantry that is participating in the pilots would contact the member and coordinate delivering services to them. And then submit an invoice for reimbursement for providing that providing that those meals to to the members health plan and the health plan would then pay the age reimburse the HSO directly based on a pilot service fee schedule that we have developed that has a set rate for each of these services. So that's that's the general process. We are developing some extra functionality in NC care 360 to help support us. So the whole eligibility documentation with a standardized documentation tool and authorization functionality that will be built into NCCare 360 as well as the invoicing tool for HSOs to use. So the eligibility authorization referral and invoicing pieces will all be housed in the same platform. So entities that are participating in the pilots will need to be on unsecure 360s And so it's a central central tool to the program. But we are trying to limit the number of technology tools that participants will have to use so that it's all housed into one technology system. Let's go to the next slide. And that's it. So Krystal I believe I am passing it back to you.

Dr. Charlene Wong

Yes, thank you, Amanda. Now as we transition to our next speakers, and topic, I want to remind everyone that both programs speakers will be addressing questions at the end of the second set of presentations. Now I would like to welcome the team and now I'll turn it over to Dr. Charlene Wong.

Thanks so much Krystal is just trying to get on video and off me. Thanks for the opportunity to share more about the NC Integrated Care for Kids model. I think you will notice that a lot of the intention and the goals behind NC Integrated Care for Kids are certainly aligned with what Amanda was just describing for the healthy opportunities pilots and really thinking about how we can support more of this whole person and in the case of NC whole child and whole family health for children and families in North Carolina. Just as a disclaimer this project is funded by the Center for Medicare and Medicaid Services as described at that bottom disclaimer. And if we can go to the next slide, please. So just starting with the very basics sort of like Amanda describe the North Carolina Integrated Care for Kids model is also not all the way across the state for the children who will be served by NC and we're talking about all Medicaid and CHIP insured children who are in these in this five county area. So that is Alamance, Orange Durham and Granville advanced counties. And when we say children, we mean the full range of children from birth up to age 20. And it's regardless of where they receive medical care. It is any child who when they enroll in Medicaid has an address that is in one of these five counties. So we estimate this will be about 90,000 children who will be served in the North Carolina Integrated Care for Kids model. We have been working hard over the last two years two plus years planning the end designing this NC model which is going to launch in January of 2022. And we are so thrilled with a coalition of partners that has come together to design and implement the NC Inc. model. And with a un that's been working together to implement this with a seven year up to $16 million grant from the Center for Medicare and Medicaid

Services. There. As I mentioned, there's a large coalition of partners led by the following organizations. I am a pediatrician and the executive director of NC Inc, and I am at Duke University. I'm also the assistant secretary for children and families at the North Carolina Department of Health and Human Services, which is another one of the very key partners and then Duke and UNC in spite of our great sports rivalry have come together to do this model. So do u and C and the Park Department of Health and Human Services together are working on this model. Next slide.

And when we say integrated care NC Inc is working to integrate care across the following core Child Services for Children and Families. I'm really excited about working with schools and early care and education. Thinking about food, just as Amanda was just talking about and thinking about programs like SNAP and WIC and food banks. And we like to help the opportunities. Pilots are also focused on housing, physical and behavioral health care, of course is critical for child service. We're also working with our public health service programs like Title Five, and social services and especially child welfare. There's also a huge emphasis on behavioral health. Care and the systems that can support behavioral health for our children and families. So that includes mobile crisis response, as well as the juvenile justice system and Legal Aid. Next slide. So we know that we have a lot of providers who are on the call today and we want to just sort of highlight what NC InCK means for health care providers. We are really working to enhance how whole child care for children who are insured by Medicaid in these five central counties can happen more often by optimizing multi system integrated care and resources for improved health outcomes. And of course, this is in support of what we as healthcare providers do. I'm actually sitting in my clinic right now. We also more of our child patients are our pediatric patients because of NC InCK which I'll describe in a second how this will work will be newly elevated for care management, but our prepaid health plans, the health systems who are advanced medical homes will offer and that will support us as health care providers and improving child well being. Part of it will be having more care teams that are convened around patients who have higher needs across different systems. And we as healthcare providers will have the opportunity to participate in those four meanings if we want and will also have access to something I'll describe in more detail or we'll describe in more detail is called a shared action plan. For the families top goals and care team members are listed. And finally we as providers will also receive regular actionable data on novel child centered measures such as such as rates of kindergarten readiness, which is something that you know, we certainly don't receive now in our practices for children who are in our practices that are served by the NC InCK model. Next slide.

So when we think about the ecosystem of health care providers and payers and care management entities that will be involved in NC InCK again, this is regardless of where children get care. So when we look at all attributed children who are insured by Medicaid or CHIP in those five counties, that's about 92,000 kids birth up to age 21. The vast majority of those children will be in one of the five PHPs or standard plans, most of whom are going to be receiving care management and that EMH tier three, the three big ones that are serving these five counties are Duke, UNC and CCPN. So in total about 85 to 88,000 children in in will be in the standard plans mostly served in a MH tier threes in January 2022. When the model launches, we also will have a smaller group of children who will remain in Medicaid direct. Most of those will be cared for by the LME MCOs as we were waiting to launch of tailored plans in July of 2022. And for these counties that would be Cardinal via as far as Alliance and in their smaller

numbers of children who will be eligible for the specialty care for children who are involved in foster care, the adoption Assistance Plan and CapC for our children with complex medical needs, then this ecosystem will change as additional plans like the tailored plans and the specialty plan for children in foster care launching subsequent years. Next slide.

And so at the very highest level and we're gonna dive into each of the strands of this braid, which is our symbol for NC InCK there are three main strategies that we are using to integrate care for children and NC InCK. The first pink strand is that we want to more holistically understand the needs of children and youth by bringing more data together, either that already exists in different systems or that we're asking children and families so we can better understand who might benefit from additional support in integrated care, then for children that we have identified could benefit from that additional support, integrating services across sectors to support and bridge those services. So really doing that integrated care model. And then also very exciting sort of like what Amanda was talking about with healthy opportunities pilots. The third strand of the braid is focusing our healthcare investments and we also like healthy opportunities have the authority and the mandate to include new types of payment models called Alternative Payment Models, where we'll be investing resources linked to more meaningful measures of child health. Next slide. And so for the first section, which is understanding a child's needs, we have the following if you can go. We have the child's needs and we look at three different types of data. The first are the stuff that we often look at now which are health and healthcare data, different diagnoses, how much are they using care? The purple box the next box down is the child's context. So looking at different socio economic, educational, developmental, as well as risk factors for the child's parent or guardian. And then very importantly, we're also looking at metrics of our measures and predictors of out of home placement. Because that's something that we know that we want to prevent bringing those data together on the left will then assign a trial to what is called a service integration level, which is really a tier one, two or three, one being our largest bucket and fortunately, most of the children will fall into this bucket, which is where they have you know, some needs, but that as we go into the higher tiers, we see increasing needs across health, health care, the child's context as well as risks of out of home placement. So si l to our children who are experiencing multiple of needs across those different areas. And that'll be about 10,000 children, and then that's fine. All three are service integration. Level three is the highest tier, and that's about 4000 children. And in particular, these are children who are already out of home or who are very high risk of being placed out of home and out of home settings might be places like being in foster care, being in prolonged inpatient residential stays, or being homeless. Next slide.

Dr. Charlene Wong

Next slide. And so these are some of the data that we have been working very hard on over the last two years to be able to bring together beyond just administrative healthcare data to have this child focused risk model. So we will be using data from the care needs screen or social determinants of health needs. around and like Amanda was talking about food, housing and transportation. We're also using a measure of social deprivation using member addresses. We've been working very closely with the Department of Public Instruction in North Carolina to bring those data together with Medicaid. So we'll be looking at number of school absences and suspensions. We've also been working with the Department of Public Safety and juvenile justice to bring those data together so that we can look at

variables like children who have been in a detention or Youth Development Center or probation status. We'll be looking at metrics related to child welfare like kids who are currently in foster care placement. Looking at risk factors related to the guardian or parent, as well as medical complexity and a specific algorithm that is on children specifically looking at Children's Medical complexity. Next slide. And so now I'd like to turn it over to my colleague Nancy Madenyika to review some of the key roles in NC Integrated Care for Kids.

Nancy Madenyika

Thank you, Charlene. Good evening, everyone. So I'm going to walk through some key roles within the ink model. And how they work together. Okay, so, children si l two and three will be elevated for care management. And these children will be distributed across standard plans and Medicaid direct starting in January of 2020. To receive integrated care support for my family navigator, so the same type of support that we're talking about here. Children will be elevated to receive this support. The next role is a family navigator. So the family navigator and I'll talk in a little bit more detail on the next slide, but this is an existing staff member within the prepaid health plans or within CCNC or their past medical homes who serves as the family's primary contact. So they're the ones spearheading and facilitating the coordination of all of their needs. A critical role of the family Navigator is helping identify other service providers and natural supports, and bring those people together to form our care team. And these people collectively will assist in integrating all of the supports that a child in a family needs. The integration consultant such as myself is an InCK staff. And the integration consultants role is to provide any type of monitoring and surveillance of all Inc engaging members and ensuring that they have a family navigator connected to them and providing support to the family navigator to ensure that they are able to provide the integrated care supports that children need on the next slide, more detail about the family navigators so again, a family navigators assigned to children in SI oh two and three. So this person is serving as a consistent point of contact for the family and there are several components of this role that will provide guidance to for those that are serving as a family navigator for children in SIO two or three. So the goal really is to ensure that families have access to a long term support and you'll see the five components listed out here, ensuring that they have a long term support and this is done through a level of quarterly check ins at a minimum. So the check ins are really based on need. But the family navigators maintaining this ongoing communication with the family, and they're checking in and having regular check ins to make sure that any needs that the member has are being addressed. And any service referrals are being made as needed. This, the family navigator will also lead and convene the care team with help from the family. So we're really focusing on the people that the family feels the most imperative to their success and meeting their goals. Those are professional and national supports. They come together and form this care team. So the family Navigator is leading that and then also for eligible members. They will also develop a tool called a shared action plan which we'll develop shortly. So you hear us talking mentioning care manager a lot but the plans do. entities and plans do have flexibility in determining who serves in this family navigator role. So it doesn't necessarily have to be a person that has a care manager role, title, but there's someone that supports care management within their entity and be able to fulfill these components of the family navigator role.

On the next slide, we talk about the support that the integration consultant will provide to the family navigator. So some of that support will include one on one consultations. We're also providing some written guides for the family navigators to use and referrals. We're providing training for completing the shared action plan as well. We're also providing in addition to those same guides they're really helping the family navigators understand what are the best practices to provide this cross sector collaboration and engagement with families. We're also helping them when our beneficiaries are going through some type of support. So there's a health plan change if they're moving out of the service area. If they're aging out, we'll provide them with some level of medium type support to assist with those transitions. And then just general ank operations so there'll be completing a consent form there'll be certain like administrative tasks that they may be completing. So integration consultants will also be available to assist with that as well. And then another additional support that will be provided will be what we're calling monthly care integrated rounds. So this is more of a capacity building opportunity that we'll be meeting with family navigators to provide

On the next slide here we talk more about our shared action plan. So a subset of children in SIO two and three who really could benefit from some increased care integration, and are likely at risk for out of home placement will be eligible for a tool called a shared action plan. This tool was designed to be brief, simple, but impactful, and that is really capturing what's most important to the family is family lead shareable is accessible across the care team. So the families have access to it and they're able to share it at their discretion. And although there's flexibility on the platform, so we'll offer space on virtual health to upload the plan there so the family the family navigator, any care team members can access it. But family navigators can also want to the family to keep it on a platform that's most convenient for the family and the care team. So in terms of the process for developing these tools, this is something that we're really excited about to share out for children that would benefit from this we spent a great deal of time reviewing in excess of 100 care plans across the country, just learning about what gaps are in the majority of care plans that are being used today. And then we've also gone through a round of usability testing of our plan and going through another round now. So we really want to make sure that this plan is something that will be beneficial. It's been family informed. We've gotten a lot of feedback from family members, who've told us what they feel has been missing from their entire process, not just a part of writing down a plan and writing down answers but the entire engagement piece with the care team. So we're really hoping that this is a tool that would be beneficial across the board for a subset of children in ink. And on the next slide again, we as integration consultants will be using virtual health. So we're really using this platform for panel management meaning this is where we see our enrolled members their basic information and care management information like their service integration level if they ever shared Action Plan uploaded. So we will also be able to give guardians and care team members access again if they would like to have access to the platform. In addition to that, we're also encouraging the use of NC care 360 as a statewide platforms and boats specifically within our five counties and for English limited children. So we just want to make sure we're not in a silo in this one platform, but we're also using the platform that the majority of people are using as well. So from here, I'll pass it to Richard.

Richard Chung

Great, thank you, Nancy. To round out the content regarding the income model. We'll talk a little bit about the braid thread of investing in what matters most specifically talking about NC InCK alternative payment model. So the APM has been designed painstakingly over the past close to two years by a partnership of leaders from Medicaid, the CINs and as well as the PHPs and other entities to really draw in a lot of nuance and insight into driving investment in a really meaningful fashion. The idea here is to link investment incentive payments to more meaningful measures of child wellbeing. increasing funding and investments in those threads of work on behalf of teams of ever caring for these kids. There are two tiers involved in the APM, reflecting a glide path to more advanced payment models over time as participants mature and their infrastructure and involvement the first at the start of the APM will be something called Ink foundation and that will then move forward to something called Think advanced. Here you see a brief rendering of the key measures within the APM. There are certainly a lot more details under the hood, but briefly there is a set of cross sector Child Wellbeing metrics related to reporting and percentages of kindergarten readiness in a particular catchment area. Also reporting and rates of food security and housing stability as well. There are other measures related to health care utilization, specifically one related to shared Action Plan utilization, as Nancy was referring to a common measure related to screening and follow up for clinical depression rates of emergency department visits. A specific measure that's been really called out in the spirit of health equity, which is reducing disparities in 15 months while child check as well as expanding eventually to 30 month well child check rates, and then a measure related to total costs of care. And so welcome additional conversation around some of the details and some of these measures but again, this was designed over a course of close to two years in close partnership with all of our key stakeholders. Next slide.

Now the overall calendar of the APM so we are into late 2021. The model goes live in 2022 and there's sort of a staggered start in which the APM will launch in July 2020 to January 2025 is the target for advancement into Inc advanced for a provider organizations that have been participating since the inception of the APM and then the model ends at the end of calendar year 2026. Next slide. Another key aspect of our current work is related to health care provider engagement. So the ink model has been in the works for close to two years at this point and we are including this evening working to socialize some of the concepts and plans that will go live in January. So through the fall, we've been working through the ink orientation phase working with individual clinics in our five counties that have high numbers of Medicaid beneficiaries that will be served by the InCK model, and then presenting in broader forums, such as this evening's conversation we're also moving into a phase of engaging in Champions these are individuals and local practices who are close collaborators with the entire team and will be sort of on the ground partners in helping practices as ink goes live. This will also involve dissemination of information through provider newsletters, as well as other mechanisms of communication that ongoing conversation with CIN leadership and other key entities in our catchment area into the first half of 2022. There will be intensive efforts around supporting practices as the model goes live, and then also partner and PHPs. As we move towards launching the APM in mid calendar year 2022. And then beyond the midpoint of next year, there will be a slew of trainings and technical assistance related to aspects of the InCK model in particular supporting participants in the APM. Next slide.

And then finally, beneficiary engagement so we are in the process of creating content, including flyers and FAQs around what it means to be a part of the income model for families, and children. This will be shared with children's health care providers, care managers, Medicaid enrollment staff and PHP outreach teams. We're also developing web content for easy accessibility of the same content for families and the teams that care for them. Focusing on an overview of InCK as well as specific details related to integrated peer support and some connectivity with other core Child Services. Excellent. So again, this is the overall timeline. It's really a privilege for our team to be able to share some of the details with you tonight, given that we are moving quickly toward launch at the model. There's certainly much more under the hood in terms of all of the details that we share, and we welcome that further engagement and conversation as as we have that opportunity. I will say as a provider as Charlene mentioned in sitting down in clinic downstairs actually we are really excited about this because we feel that this is such a privileged opportunity to pursue work that we feel like providers long have wanted for kids and their families the idea of drawing together data elements across sectors to have a broader and more holistic view of the kid in front of you to be able to really integrate services not sort of limited at the water's edge and medical care or even behavioral health care but really beyond that, including these other sectors that are so critical, including schools and other entities. And then finally, moving towards evolving payment mechanisms so that resources can be really directed towards things that had highest impact and that are most of its family. So we are excited about this. And we hope that some of the content that we shared have spurred interest and excitement as well for you. So we'll pause there and I'll hand it off to the to the program, folks.

Carol Stanley

Excellent information. Thank you all so much. It's really is exciting to have so much innovation and child centered care going on and ramping up for this. And we do have some questions, both for healthy opportunities and for the ink team. I think we'll go ahead and start with ink. Some questions that have come in since the team just finished up. One of the questions is that we have downgraded to AMH tier two and left our CIN. So the PHPs will handle our care management are we still eligible for ink if we if we are in the geographic coverage area?

Dr. Charlene Wong

We sure are any any am each provider would be eligible for participation and we'll be covering again lives for children who are in NC InCK and bottle some of the requirements and sort of how that would be structured will look different for ages that are tier two or one versus tier three. But if they want to reach out, we had our email up on the screen and please feel free to reach out to us so we can provide more details.

Carol Stanley

Okay, excellent. Thanks so much. The next question is please clarify the economic model of how the PCP is compensated for participating in the Inc program.

Dr. Charlene Wong

So get us started this you know really the InCK program is a we are building and sort of as Nancy and Dr. Cheung were describing and I was describing, it's really a supportive infrastructure underneath what we're already doing already. And so really, it is just meant to help us do what we are trying to do which is to support children's health care, via behavioral health, social and educational needs, you know, more often. And so really the InCK model and the APM that Dr. Cheung described is sort of built all aligned with and sometimes a little bit on top of what's already happening in Medicaid transformation and so as an example, if a practice was participating in the NC InCK alternative payment model, there's the opportunity for additional incentives linked to some of these more novel measures of child well being, which we will hope we hope will give practices more flexibility and resources that they would be able to use to help do things like get more children can support more children and getting kindergarten ready and addressing food insecurity and housing instability.

Carol Stanley

Those sound like great outcomes. I'm going to jump up here to healthy opportunities and ask a question that came in. This individual says that they left their CIN and downgraded to an AMH tier 2, PHPs will do the care management does this mean our practices not position to participate?

Amanda Van Vleet

Yeah, thanks for the question. So, your practice is still able of course to be an NC care 360 and refer refer members to community based resources that can meet their needs actually inside or outside of NC care 360. But the health plan would be the entity that would be taking on all of those care management responsibilities around documenting eligibility, recommending services having them authorized by the care plan for the specific set of about 29 pilot services that we have that are reimbursed by Medicaid.

Carol Stanley

Very good. Thank you. And we still have time for some more questions. So I would invite the listeners and viewers. If you do have a question, please add it into the q&a box. It looks like a chat box at the bottom of your screen. And if you click that you are able to submit a question.

Dr. Charlene Wong

I'm Carol, do you mind if I respond to I see one comment in there that I can just respond to I think sort of similar to the other question of bad practice being in AMH tier two that we recognize there and we actually know the practices that are either in CINS or not in CIN that are serving children in the ink region. And again, we are looking to engage in there are opportunities to participate in any NC AHEC for any types of primary care practices.

Carol Stanley

Thank you and this question just came in when will InCK be available in other areas once the pilot is up and running it running in the five counties?

Dr. Charlene Wong

So we are the NC InCK model will launch in January of 2022 and run through 2026 We hope that we demonstrate that we are wildly successful and supporting this concept of whole child and family health for children. And really the goal for all of these CMS models and I'm sure Amanda would say the same thing for the healthy opportunities to show wild success and then scale across the state. I think Already we are seeing that some of the efforts that are underway that Nancy describing Dr. Chung described there already. There's already interest and the ability to scale. So for example, some of the data linkages that Dr. Chung has really been helping lead the way on, we're building those in a way that we can very easily turn that on for the whole state. So you know, we're testing it first in these five counties.

Carol Stanley

That's wonderful. And we do have an another question. You mentioned the six month reassessment for the pilot related care management. Would you expand a little more on what that process would look like?

Amanda Van Vleet

Sure, no problem. So I'll talk about both. So one type of reassessment is needed every once every three months and that's a an an assessment of the service mix. That the member is getting. So we don't have particular guidelines for that. We kind of leave it up to the care management team. But the the intent there is just to make sure that the member still in fact needs the services that they're getting if they need any other services that they're not currently getting just to make sure that they're really receiving the right services for their current needs. And then every six months is an eligibility reassessment where the care manager would just make sure that the member still meets all of the eligibility criteria for the pilot and for some services that have service level eligibility. So for example for I think our housing navigations or housing move in support. The members also also needs to be getting housing case management. And so for example, if the member is no longer getting housing case management, they might not be able to continue to get the other service or for example, if a member has moved to a different county, that is not a pilot County, they could be factors that may impact the members eligibility. So the care manager would just need to reconfirm that the number is still eligible every six months.

Carol Stanley

Thank you, Amanda. We still have a little more time for questions. I'll go ahead and ask a question with for the ink team. There's there's some other states involved in this initiative. Can you tell us a little bit about are are the models very similar and how they're being implemented in the other state or are there many differences in the design for each state.

Dr. Charlene Wong

So to answer my call on you if you're available, or Dr. Chung so I'll just say that there are seven other models across the country. We are the only one in the southeast. And so I know Nancy, in particular has been communicating with a lot of the staff that are leading and some of the other CCNC Do you want to comment a little bit on that?

Nancy Madenyika

Yes, sure. So we all have certain guidelines that we have to follow for CMS, so all of the sites will follow those and then there's flexibility to change a few things based on what works best in your area. So there are some slight differences based on their staffing like our staffing is a little bit different in terms of we work more as consultants, whereas some states, their integration consultants are actually providing the direct support to families. So those are like some of the differences between the sides.

Carol Stanley

Very good. Thank you.

Dr. Charlene Wong

And the parallel to see what other big difference we have is we are the only state that are the only state in sight where we are also going through Medicaid transformation at the same time. A little bit of extra fun and yeah, and it was very involved in the initial design of the model and that also means is that we get to align and leverage so many of the amazing tools that are being built as part of transformation like NC care 360 and I will say I will tell you because we talk with the other awardees all time, they are so jealous. Statewide, you know, the statewide focus the fact that all of our Medicaid beneficiaries get screened with a candidate screen. I mean, it's like really amazing. Yeah, and we're about to chime in on something too.

Richard Chung

I was just gonna say that if anything sort of comparing and contrasting across the state awardees is just shown how privileged we are actually in North Carolina, sort of the avid partnership with the Medicaid agency you know, despite all the challenges that we always face every day as clinicians, I think it's just important to recognize that we have something special here in North Carolina. It's complicated, and it's

not easy, but it is special in particular in comparison to other state beneficiary recipients who face their own challenges.

Carol Stanley

Yeah, for sure. And it we'll certainly be able to benefit from lessons learned from those other states as well as they will from us too. So we have a few more minutes. I'll just pause here for

Dr. Charlene Wong

So Carol. I'm actually seeing several questions that I see coming up in the q&a. So okay, there's a question that says are the two programs funded from the same source so there they are both from the Center for Medicare and Medicaid Services, but they are but it is it is two different it's two different awards to two different mechanisms.

Carol Stanley

Okay, excellent. Thanks. Yeah, I do see these extra questions. This other one, these are innovative pilots. We have participated in pilots before to see them and that Medicaid managed care go live and this is talking question about funding but it sounds like you're going through 2026 so that, that I'm not sure what the question is here.

Dr. Charlene Wong

Sustainability I can see. I don't know if you can speak for healthy opportunities. I think for NC InCK we are we are building this in, for example, the alternative payment models that Dr. Chung described, we are not building those in a vacuum. These have been co designed by a work group, as he mentioned that has leadership from all of the PHPs and all the major CINS so that you know we are really trying to do this together and again, chef that we hopefully show that we have wild success, that there is a sustainability mechanism in place beyond this five year pilot.

Carol Stanley

Yeah, sure.

Amanda Van Vleet

Yeah, thanks, Charlene. I completely agree. We've also been trying to engage Well, we did engage our HSOs is a lot and the design of our fee schedule and are engaging our health plans and their roles and responsibilities. So agreed, trying to foster those relationships to outlast the pilots. But also with

funding. So this is funded through our Medicaid waiver. And our agreement with CMS is also that hopefully these pilots will be really successful and if we are if they are successful that then the goal would be that we would also get the authority to make them more permanent Medicaid benefits so that then they could be offered statewide and over a longer of time. Okay, excellent.

Carol Stanley

And this other question, it looks like Nancy is typing an answer into I'll jump to this other one. Other than transportation. What are the other services that could be covered by the pilot via NCs 1115 waiver?

Amanda Van Vleet

Yeah, so transportation food, housing and interpersonal violence or toxic stress. So, for food things like actual meals, home delivered meals, fruit and vegetable prescriptions, dietary and nutrition classes or housing we have housing navigation, we have moved in support we have cleaning services like carpet cleaning, mold remediation, first month's rent and security deposit. And then for interpersonal violence and toxic stress. We're offering evidence based parenting curriculums and some evidence based violence prevention services. Okay, great.

Carol Stanley

Thanks so much, Amanda. And I'm gonna I just want to thank all of the presenters for today. You all were excellent and very inspiring and looking forward to all of this coming to fruition very, very soon and can't wait to see things in motion. So I want to thank everyone for joining us this evening. And hope you have a good evening. Take care now.