



Healthy Opportunities in Medicaid Managed Care

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Why Focus on Healthy Opportunities?

“Healthy Opportunities,” commonly referred to as the social determinants of health, are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- 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.
- Addressing the factors that directly impact health is a key component of meeting DHHS’s mission to improve the health, safety and well-being of all North Carolinians while being good stewards of resources.

North Carolina’s Healthy Opportunities Priority Domains

Housing



Food



Transportation



Interpersonal
Violence



North Carolina's Strategies to Embed Healthy Opportunities into Statewide Medicaid Managed Care

Promoting “Healthy Opportunities” is a core focus of North Carolina’s transformation to Medicaid Managed Care—for both Standard Plan (SPs) and Behavioral Health and Intellectual and Developmental Disability Tailored Plans (BH I/DD TPs)*

Key Healthy Opportunities Initiatives



Care Management



NCCARE360



Quality Strategy



Value-Based Payment Strategies



Value-Added Services/In-Lieu of Services



Voluntary PHP Contributions to Health-Related Resources



Healthy Opportunities Pilots

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Addressing Social Needs Through Care Management

The care management model requires PHPs and care managers to take steps to address beneficiaries' unmet resource needs.

Addressing Unmet Resource Needs through Care Management

- The State's care management model drives a focus on addressing beneficiaries' unmet resources needs.
- PHPs identify a broad range of individuals from rising risk to high-risk (including those with social needs) and provide care management or delegate care management to qualified local entities—e.g., Tier 3 Advanced Medical Homes, Care Management Agencies, and Local Health Departments
- **Care managers and other members of the multi-disciplinary care team will play a significant role in addressing the non-medical drivers of health.**

Addressing Social Needs Through Care Management (cont'd)

- **PHPs must identify and provide care management to beneficiaries with “high unmet resources needs.”** PHPs will identify such individuals through a combination of methods, including:
 - Use of State-standardized SDOH screening
 - Analysis of claims, encounters and other available data;
 - Provider, patient and family referral.
- **Care managers will conduct a comprehensive assessment** with identified beneficiaries that addresses physical, behavioral, pharmacy, long term services and supports, and social areas of need.
- **PHPs are accountable for addressing identified needs**, including by:
 - Providing in-person assistance with select human service applications (e.g., TANF & Food and Nutrition Services);
 - Connecting beneficiaries to needed social resources and tracking outcomes using NCCARE360;
 - Having a housing specialist;
 - Providing access to medical-legal partnerships for legal issues adversely affecting health.

High Unmet Resource Needs

PHPs must define high unmet resource needs to include beneficiaries who are:

- Homeless;
- Experiencing or witnessing domestic violence or lack of personal safety; and;
- Showing unmet needs in three or more SDOH domains (e.g. food, transportation and housing)

Care Management Deep Dive: Standardized SDOH Screening

Screening Tool

- PHPs will use DHHS' standardized SDOH screening questions as part of an initial Care Needs Screening to identify individuals eligible for care management due to high unmet resource needs.
- PHPs must ask these standardized SDOH screening questions across the four priority domains to every beneficiary within 90 days of enrollment.

Providers are encouraged but not required to use these standardized screening questions as part of their intake processes.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		




NCCARE360 Overview

NCCARE360 is a statewide resource and referral platform that allows key stakeholders to connect individuals with needed community resources.

- **NCCARE360 (NC Resource Platform) is a telephonic, online and interfaced IT platform, providing:**
 - A robust **statewide resource repository** of community-based programs and services at community-based organizations, social service agencies and other organizations.
 - A **referral platform** that allows health care providers, insurers and human service providers to connect people to resources in their communities. It supports “closed-loop referrals,” giving them the ability to track whether individuals accessed the community-based services to which they were referred.
- **PHPs will, at minimum, use NCCARE360 to:**
 - Identify community organizations to meet a beneficiary’s needs
 - Make a referral on behalf of the beneficiary, and
 - Track closed-loop referrals.

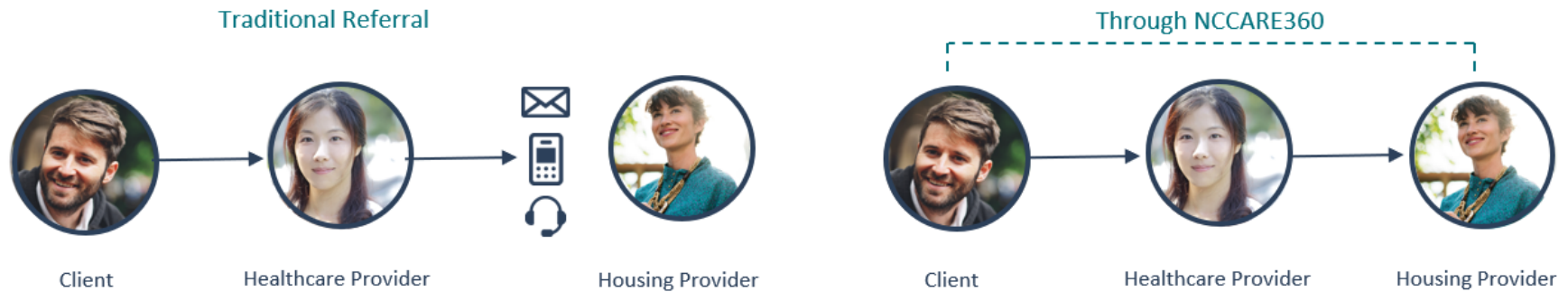
Providers are encouraged but not required to onboard onto and use NCCARE360.

NCCARE360 Functionalities

	Functionality	Partner	Timeline
Resource Directory & Call Center	Directory of statewide resources that will include a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.		Phased update 2019 – Spring 2020 * Currently has verified resources across all counties and all domains
Resource Repository	APIs integrate NCCARE360 directory with resource directories across the state to share resource data in one repository.	 Expound	Phased Approach
Referral & Outcomes Platform	An intake and referral platform to connect people to community resources and allow for a feedback loop.		Rolled out by county January 2019 – December 2020
Hands on, in-person technical assistance and training to on-board providers and community organizations.			

Coordination Platform at Work

Improving coordination efficiency and accuracy



- ✗ Service provider cannot always exchange PII or PHI via a secure method
- ✗ Limited prescreening for eligibility, capacity, or geography
- ✗ Onus is usually on the client to reach the organization to which he/she was referred
- ✗ Service providers have limited insight or feedback loop
- ✗ Client data is siloed & transactional data is not tracked

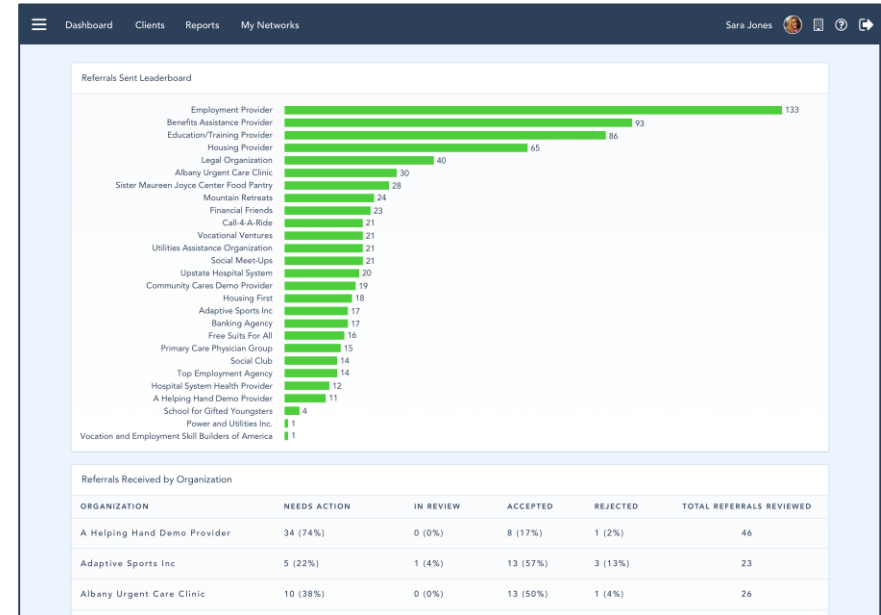
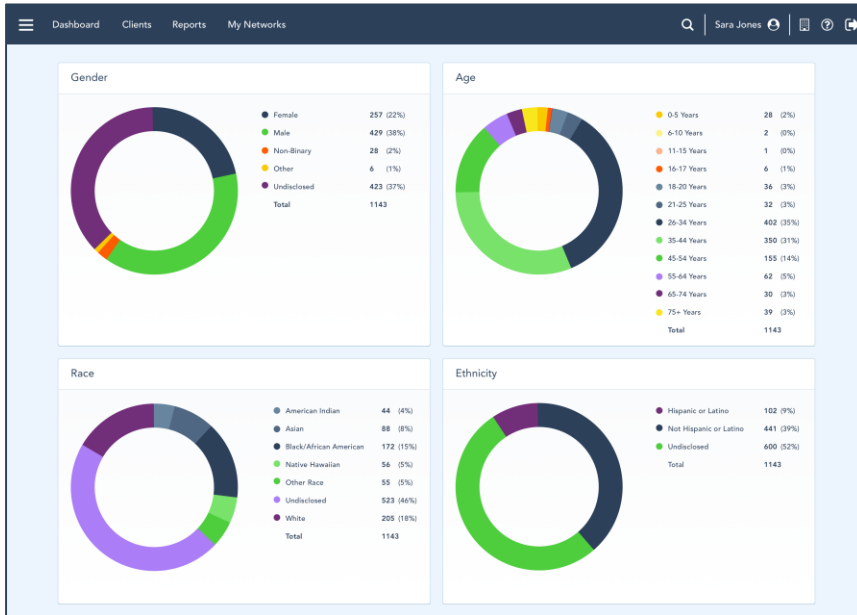
- ✓ All information is stored and transferred on HIPAA compliant platform
- ✓ Client is matched with the provider for which he/she qualifies
- ✓ Client's information is captured once and shared on his/her behalf
- ✓ Service providers have insight into the entire client journey
- ✓ Longitudinal data is tracked to allow for informed decision making by community care teams

No Wrong Door Approach



Configurable & Structured Data

Real-time reporting of outcomes, performance & efficiency



Patient Level Coordination & Tracking

Patient Demographics, Access Points, Service Delivery History, Outcomes

Network Level Transparency & Accountability

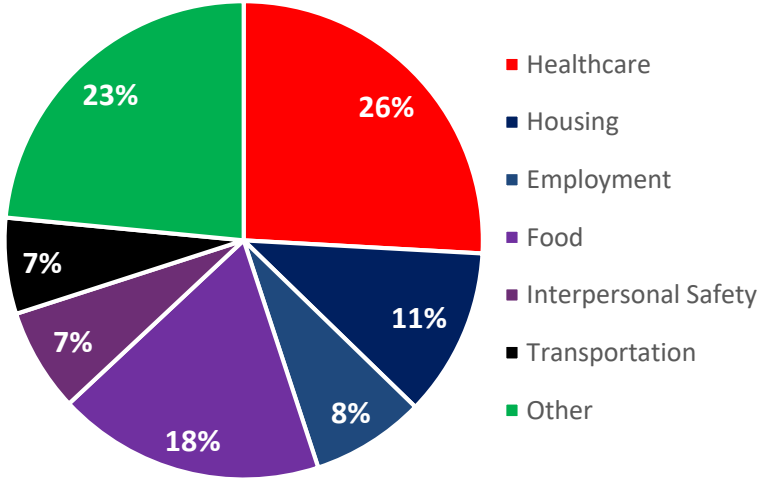
Service Episode history, Referrals Created, Structured Patient Outcomes

Status Update (as of 11/11/19)

NCCARE360 Implementation Status Update	
21	Counties launched (Alamance, Beaufort, Bertie, Brunswick, Chowan, Durham, Edgecombe, Franklin, Guilford, Granville, Hertford, Johnston, Martin, New Hanover, Pender, Person, Pitt, Rockingham, Vance, Wake and Warren)
29	Counties started on implementation
1,859	Organizations engaged in socialization process
425	Organizations with NCCARE360 licenses
1,762	Active Users
1,333	Referrals Sent
630	People helped

NCCARE360 Resource Repository	
2,655	Organizations verified
8,231	Programs verified

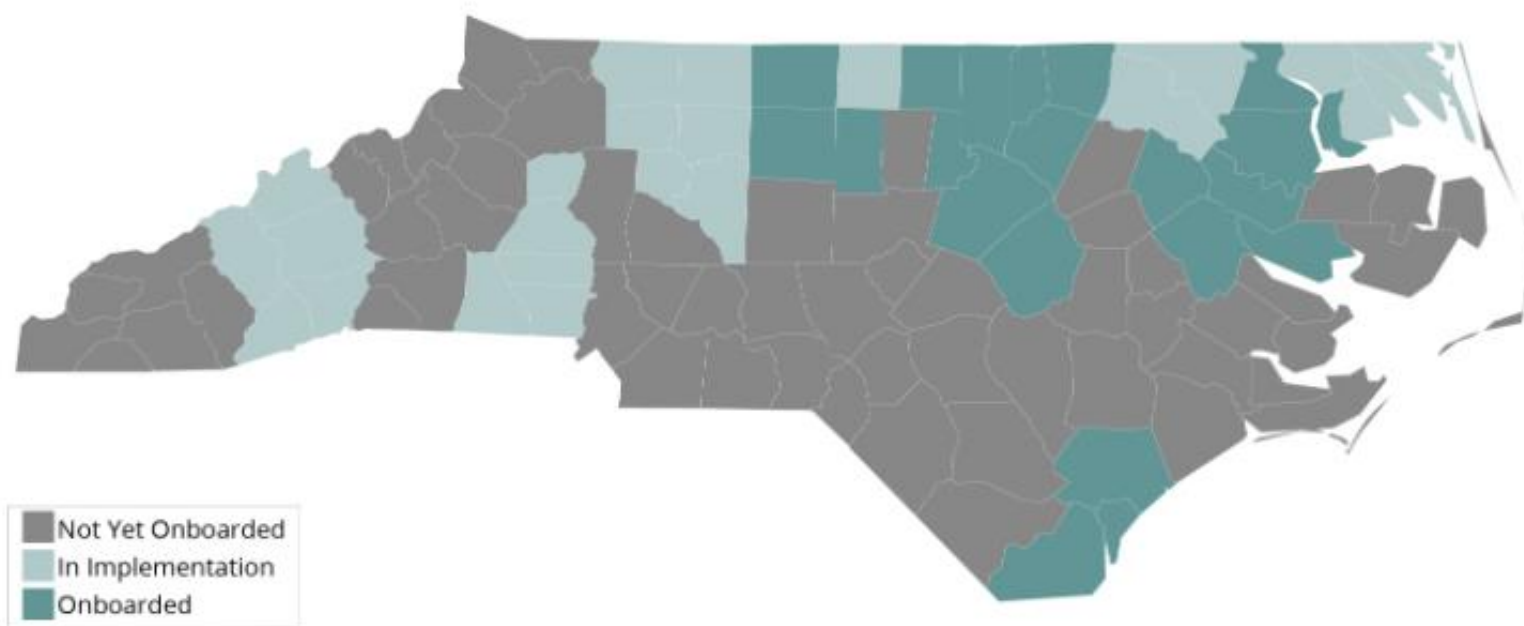
Engaged Organizations by Service Type



NCCARE360 will be implemented statewide by end of 2020

State Coverage

Began rollout January 2019, statewide by December 2020



Using the Quality Strategy to Promote Healthy Opportunities




North Carolina's Quality Strategy details how PHPs are held accountable for achieving desired outcomes, including those linked to Healthy Opportunities.

- Addressing unmet resource needs is a critical component of the NC's Quality Strategy and approach to improving population health.
- PHPs must conduct at least one non-clinical Performance Improvement Project annually.
- PHPs will work with communities to improve population health, and promote the aim of healthier people and healthier communities within North Carolina.
- PHPs will report on rates of completed SDOH screenings in Year one of managed care. PHPs may be asked to report on referrals to services to address identified needs in future years.

Incorporating Healthy Opportunities into Value-Based Payment Strategies

VBP Overview

- Value-based payments give providers flexibility to decide how best to use payments, including by paying for health-related social supports that may be more cost-effective than traditional medical care.
- The State's VBP strategy will encourage PHPs and other providers to consider how they can incorporate and promote healthy opportunities into their VBP contracts.

			
CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION - BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Leveraging In-Lieu of (ILOS) and Value Added (VAS) services to Promote Healthy Opportunities

PHPs are encouraged to use ILOS to finance services that improve health through connecting members with social resources to address unmet resource needs, and other supports upon receipt of approval from DHHS.

PHPs are also encouraged to offer value-added services that address unmet resource needs.

What are ILOS?

PHPs may use ILOS to deliver a service or utilize a setting not covered in North Carolina's State Plan or its managed care contract. The State must determine the service to be both medically appropriate and a cost-effective substitute for a state plan service.

- **Example:** Offering medically tailored meals *in lieu of* a hiring a contracted home health aide

Encouraging Voluntary PHP Contributions to Health-Related Resources

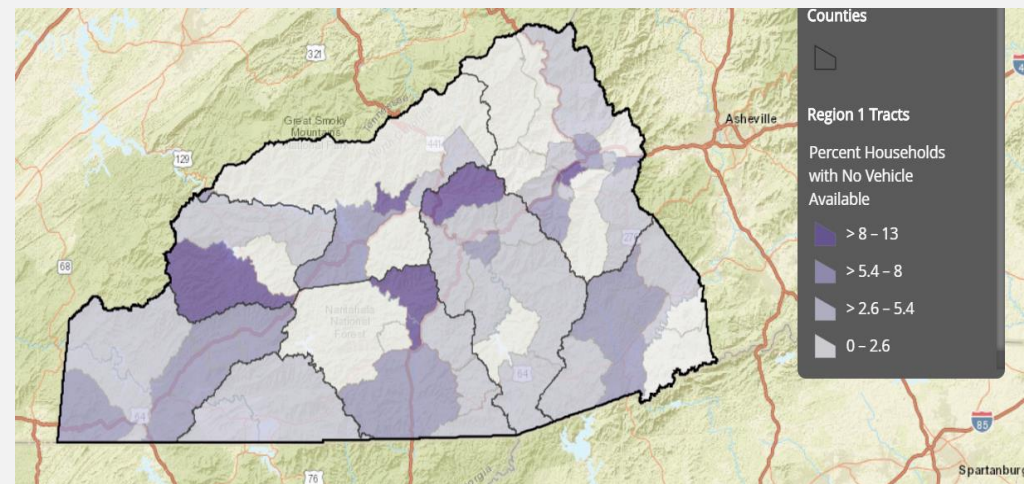
PHPs are encouraged to make contributions to health-related resources that help to address members' and communities' unmet health-related needs.

Contributions to Health-Related Resources

- PHPs are encouraged to contribute to health-related resources that improve health outcomes and cost-effective delivery of care in the communities they serve.
- PHPs that voluntarily contribute to health-related resources may count the contributions in the numerator of their MLR.
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a region to health-related resources may be awarded a **preference in auto-assignment** to promote enrollment in each region in which the PHP contributes.

Providers may wish to give input to PHPs on how to direct their contributions in their communities.

Percent of Households Without Access to a Vehicle in Region 1



The NC "Hot Spot" Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state **and can strategically guide contributions to health-related resources.**

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 in two to four geographic areas of the state will work with their communities to implement the “Healthy Opportunities Pilots,” as approved through North Carolina’s 1115 waiver
- Pilot funds will be used over the five-year demonstration period to:
 - Cover the cost of federally-approved Pilot services
 - Support capacity building to establish “Lead Pilot Entities” that will develop and manage a network of human service organizations (HSOs), and strengthen the ability of HSOs to deliver Pilot services
 - *DHHS will procure Lead Pilot Entities with deep roots in their community that can facilitate collaboration across the healthcare and human service providers.*

The Pilots will offer services in the Four Priority Domains

Housing



Food



Transportation



Interpersonal
Violence



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

What Services Can Enrollees Receive Through the Pilots?

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



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

PHPs (*SPs and BH I/DD TPs*)

- Manage a Pilot budget
- 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
- Prevent duplication of services

Care Managers

- Frontline service providers predominantly located at Tier 3 AMHs, CMAs, LHDs and PHPs interacting with beneficiaries
- Assess beneficiary eligibility for Pilot, identify recommended pilot services, and manage coordination of pilot services, in addition to managing physical and behavioral health needs
- Ensure individuals are enrolled in other federal/state programs if eligible (e.g. SNAP and TANF)
- Track enrollee progress over time

Lead Pilot Entities

- Competitively procured by DHHS
- Develop, manage, pay and oversee a network of HSOs
- 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 LPE 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

Care Managers will play a critical role in operationalizing the Pilots. Other providers may be helpful in identifying Medicaid enrollees who may be eligible for the Pilots

Additional Healthy Opportunities Resources

Resources

1. **Healthy Opportunities Website:** <https://www.ncdhhs.gov/about/departments/initiatives/healthy-opportunities>
2. **Healthy Opportunities Pilots Policy Paper:** https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf
3. **Draft Healthy Opportunities Pilots Service Definitions and Pricing Methodology:** <https://files.nc.gov/ncdhhs/documents/Public-Feedback-Pilot-Service-Definitions-and-Pricing-Inputs-FULL-PACKAGE-FINAL.pdf>

Watch the Healthy Opportunities Website for updates regarding the Pilot Fee Schedule and LPE RFP.

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