Healthy Opportunities Pilots

Presented by:

Andrea Price-Stogsdill

Program Manager,
NC Medicaid, Strategy Office:
Healthy Opportunities Pilots Program

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

NC HOP
Medicaid Healthy Opportunities

Healthy Opportunities Pilots Pass One Year Mark

Across 33 counties the Healthy Opportunities Pilots have delivered over 61,000 services to more than 8,500 NC Medicaid members since March 2022.

ADA compliant shower

Large Food Box

From a recent HOP enrollee:

"Since I have been receiving healthy food [through the HOP program], I have lost 66 pounds and I feel so much healthier. I am beyond elated with this program. [....] I THANK every individual who has made this program available to me. I am assisting others in my community here to also receive this assistance. Since we no longer receive the COVID allotment with our SNAP benefits, many of us here are struggling with purchasing groceries."

NC HOP
Medicaid Healthy Opportunities

Healthy Opportunities Pilots Update

Who's involved?

- DHHS, PHPs, CMs, NLs, HSOs, NCCARE360, and you!

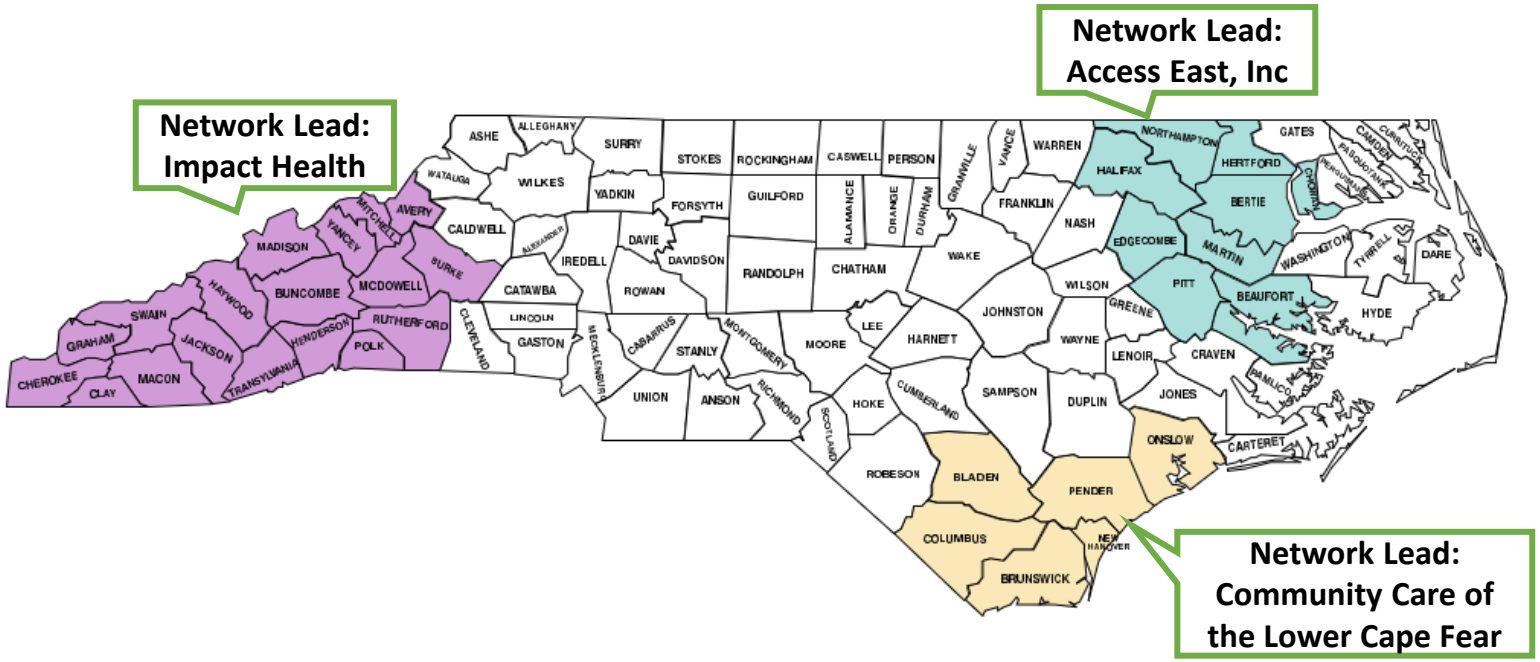
Service Domains

- **Food** (Ex. Healthy Food Boxes/Meals, Fruit and Vegetable Prescription)
- **Housing** (Ex. Housing Navigation, Home Remediation Services, Move-In Support)
- **Transportation** (Ex. Reimbursement for Health-Related Private Transportation)
- **Toxic Stress/Interpersonal Violence** (Ex. Violence Intervention Services, Home Visiting)
- **Cross-Domain** (Ex. Medical Respite)

Eligibility Criteria

- Enrolled in Medicaid Managed Care
- Live in a Pilot region
- Have at least one qualifying physical/behavioral condition and one qualifying social risk factor
- Note: There are no age restrictions for eligibility!

A whole family can access HOP services through one Medicaid member!



➢ **No Wrong Door referral pathway in NCCARE360:** Create a "Benefits Eligibility Screening" referral in NCCARE360 to refer a member you think may be eligible for HOP to their health plan. The health plan will assess the member's eligibility and enroll them in HOP, if eligible.

Source: UniteUs Insights Dashboard, Payments Activity Overview, Data as of April 30, 2023. For Additional Information Visit: Healthy Opportunities Pilots | NCDHHS

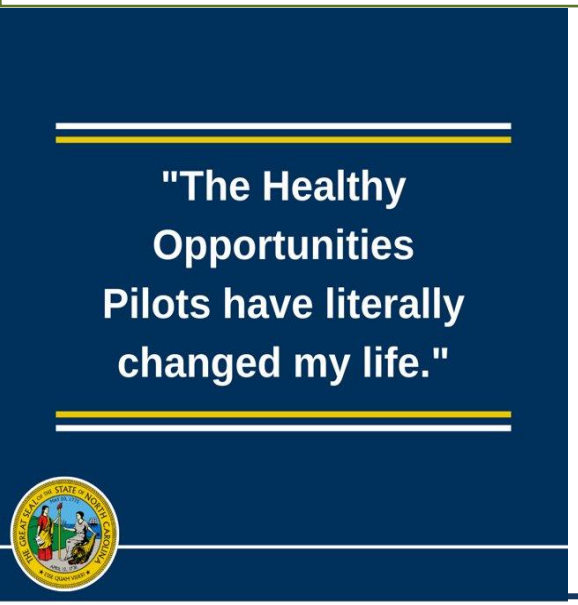
Healthy Opportunities Pilots Update - Continued

Upcoming Engagements

- Community Partners Webinar – September

Where to learn more

- For more information, please visit the Healthy Opportunities Pilots webpage or the Healthy Opportunities Frequently Asked Questions
- Visit Healthy Opportunities Pilots at Work webpage for key Pilot metrics and success stories
- Like our posts on the DHHS Facebook, Twitter, and Instagram accounts!



No Wrong Door Approach to Enrollment

Potentially Pilot eligible individuals may be connected to HOP via one of the other pathways:

- provider referral,
- referral from pilot participating Human Service Organizations (HSOs), referral from *non*-pilot participating HSOs,
- self/family referral, or
- referred by their care management teams.

Members can be referred to their Medicaid care manager or health plan via phone/email, NCCARE360, or by calling the health plan's member services number.

In addition to being proactively identified by a health plan, potentially HOP eligible members may also be identified by providers. After identifying physical or behavioral health conditions that may qualify someone for the Pilots, providers can help patients call their health plan's Member Services line, refer the member via NCCARE360, or call the health plan to request the member be assessed for Pilot services. Providers play an essential role in helping to identify member who may benefit from HOP!

Health Plans' Member Services Numbers:

AmeriHealth Caritas: 855-375-8811 (TTY 1-866-209-6421)
Carolina Complete Health: 833-552-3876
Healthy Blue: 844-594-5070 (TTY 711)
United Healthcare: 800-349-1855
WellCare: 866-799-5318

Contact

For more information, call the NC Medicaid Contact Center: 888-245-0179

Behavioral Health Statewide Central Availability Navigator

(BH SCAN)

June 9, 2023

GOAL for BH SCAN

- **Emergency departments are often the first line of defense for those facing BH challenges. ED staff are often unequipped to safely and adequately manage acute crises**
- **Moving patients quickly from the ED to an appropriate level of care allows hospitals to ease overcrowding and reduce the likelihood of preventable readmissions**
- **Inpatient case managers are using an outdated, time consuming process which reduces efficiency and has the potential to affect health outcomes**
- **BH SCAN is an online centralized bed registry, the current system allows for emergency departments and hospitals to search for appropriate and available beds. Future system functioning will allow for near “real time” bed automated bed availability, and in system referrals and communication**

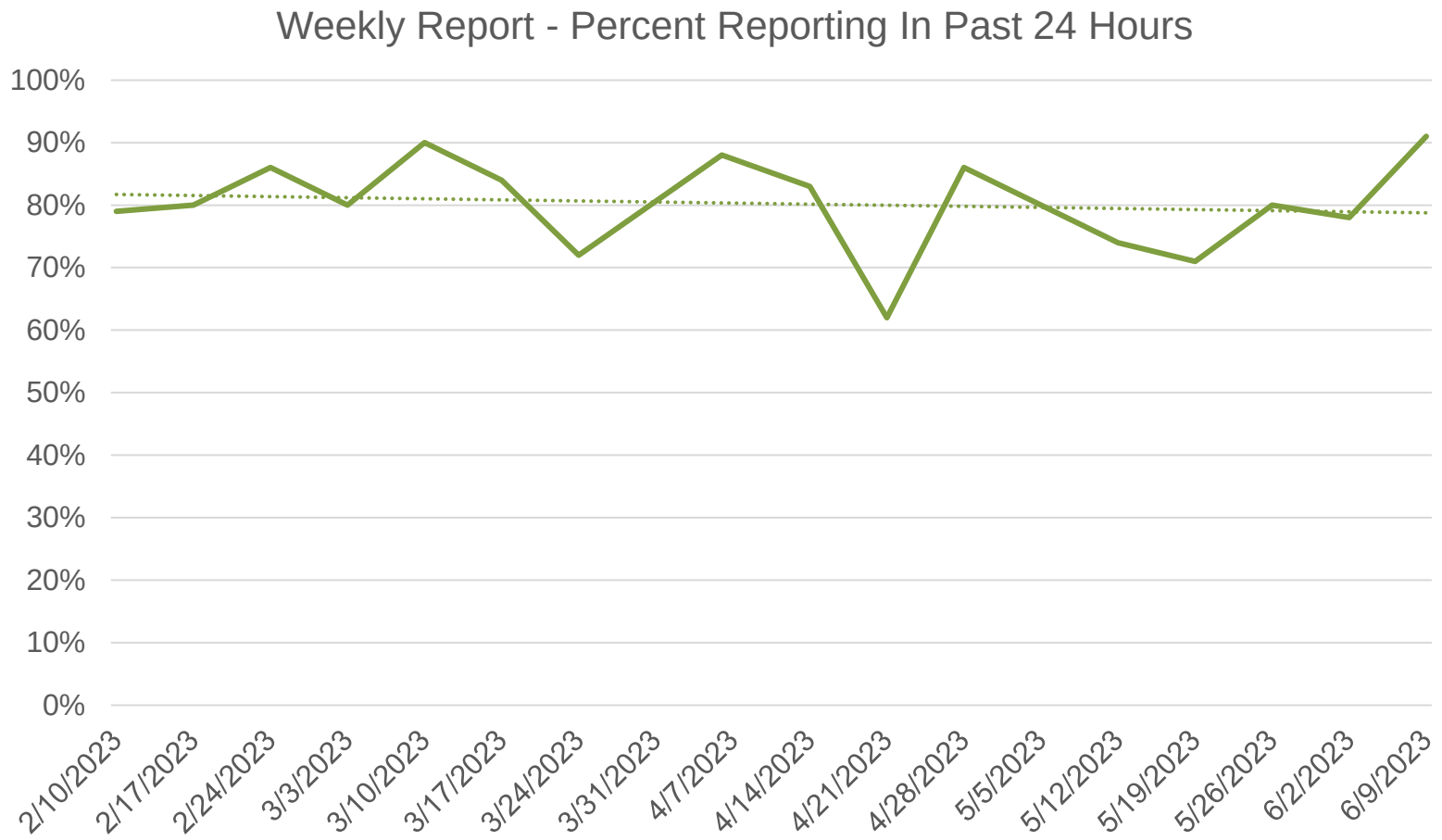
Participating Facilities/Units

Current system provider types included:

- **Emergency Departments (currently, 83 referring sites)**
- **State Psychiatric Hospitals (3)**
- **Alcohol and Drug Abuse Treatment Centers (2)**
- **Community inpatient psychiatric units/hospitals (49)**
- **Adult Facility Based Crisis (9)/Youth Facility Based Crisis (3)**
- **Non-Hospital Detox & Medically Managed Intensive Inpatient & Withdrawal Management (2)**

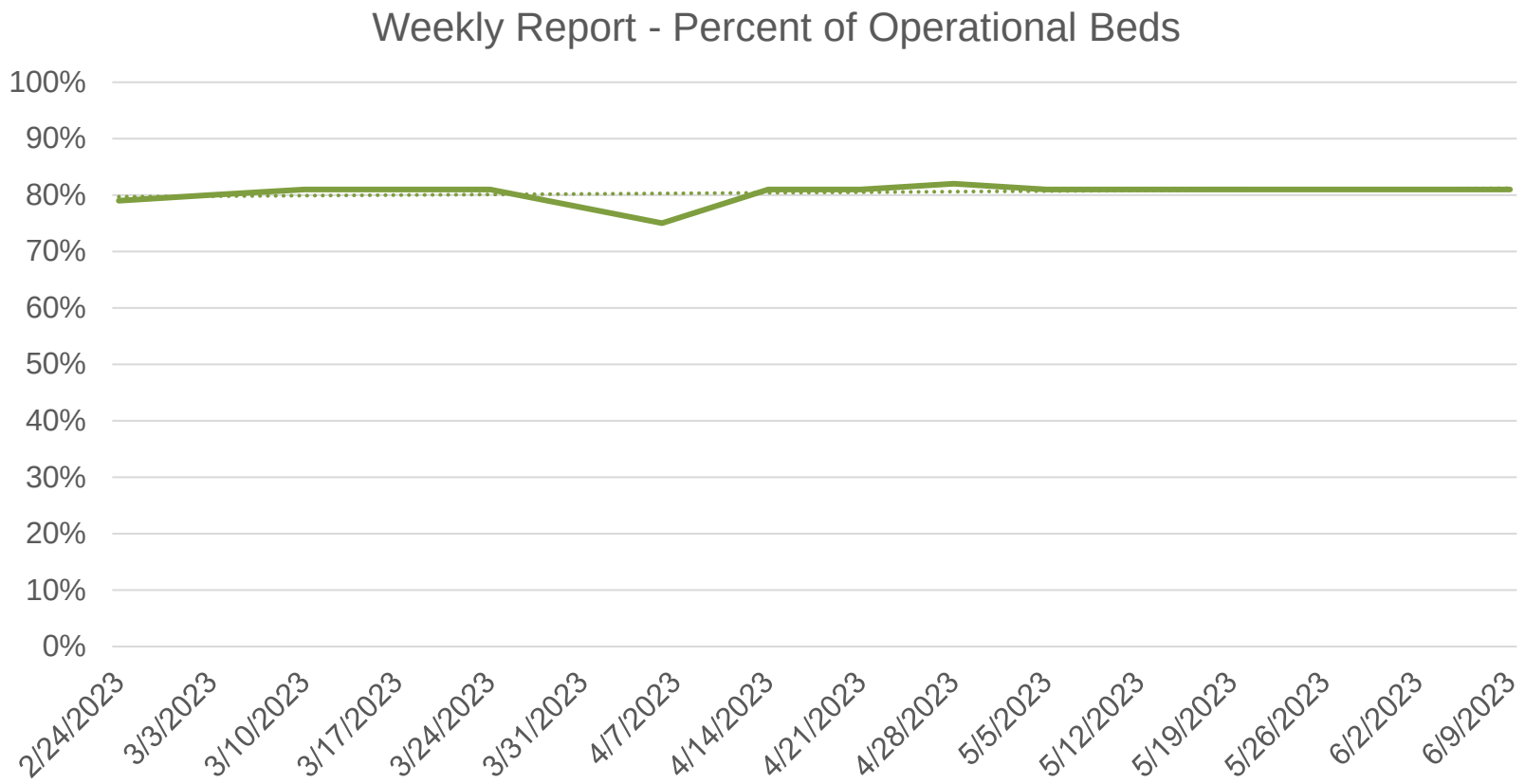
Additional onboarding efforts are continuing with these provider types

Current Performance Goal: >75% of Facilities Reporting Daily



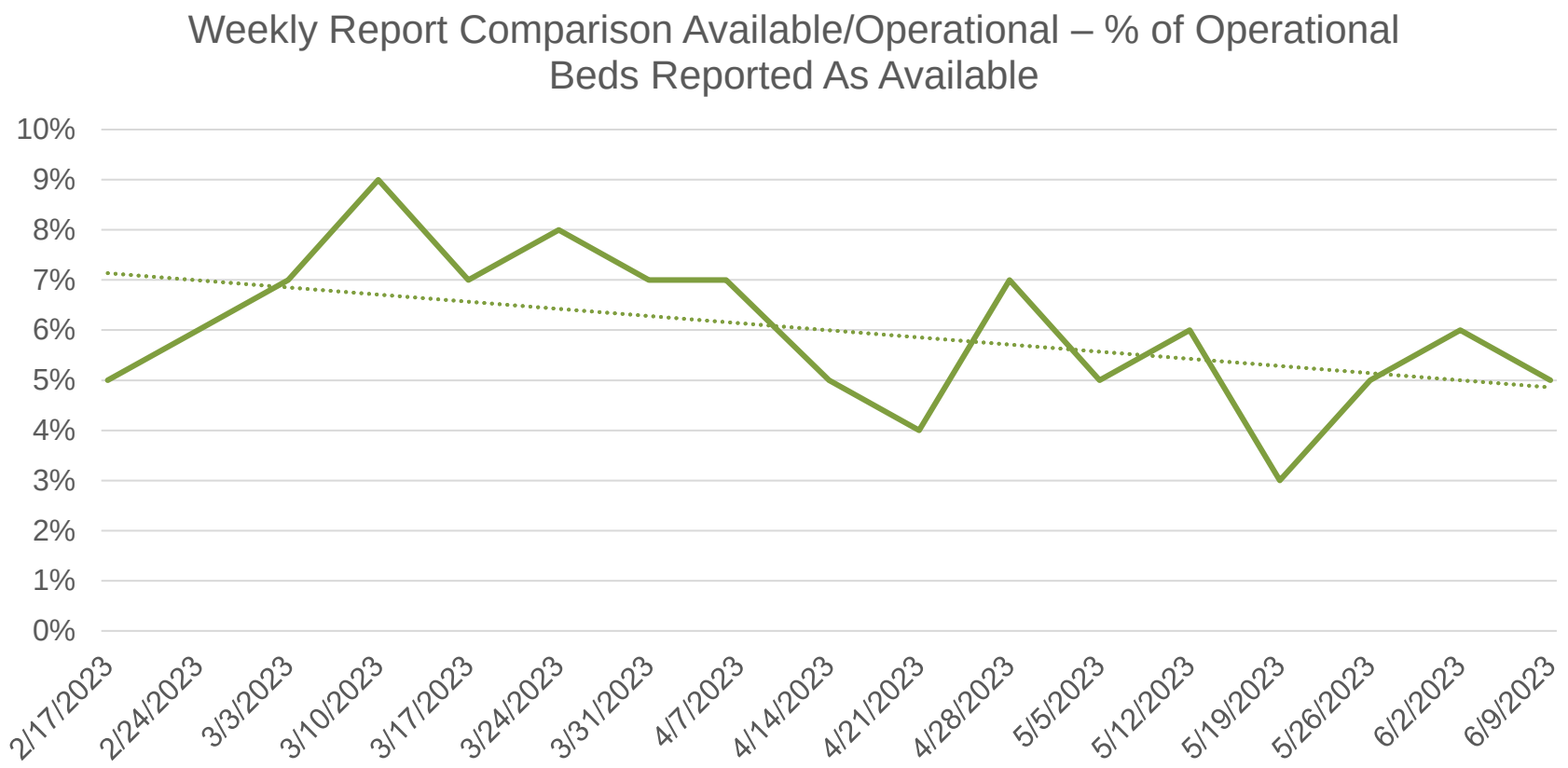
- **Average since Go Live is 80%, 5% above target goal!**
- **All 68 receiving service units are updating bed availability regularly**

Percent of Operational BH Beds in BH SCAN



- **Operational beds are licensed beds that are staffed and functioning**
- **The average has been stable since Go Live around 80%**
- **99% of receiving service units are reporting on operational beds**

% of Operational Beds That Show Availability



- **Less than 7% of the beds in operation have availability**

System Providers Being Considered For Future Onboarding

- **Psychiatric Residential Treatment Facilities**
- **Child Residential Services: Levels I/II – Family Type**
- **Child Residential Services: Levels II-Program/III/IV**
- **IDD residential facilities**

Medicaid Managed Care Update

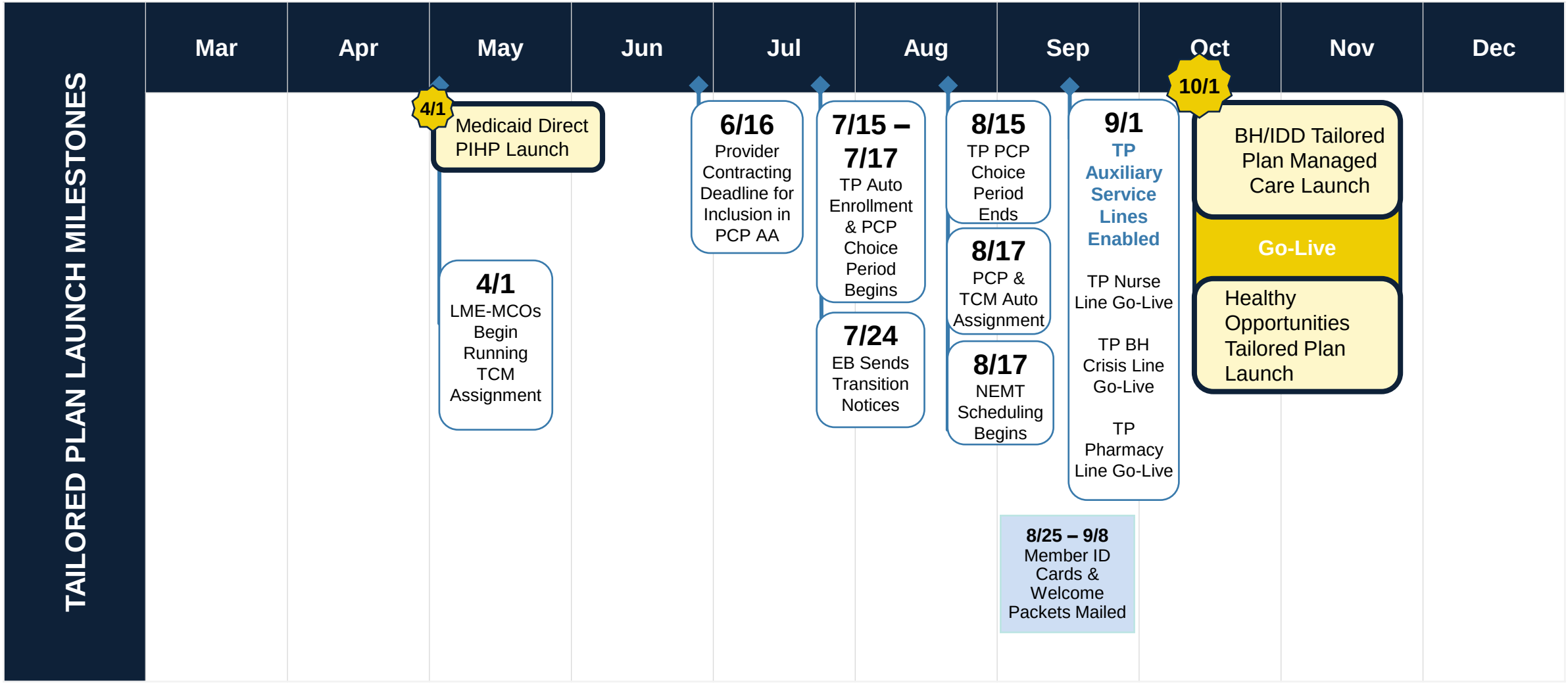
Sarah Gregosky
June 2023

TAILORED PLAN LAUNCH UPDATE

Tailored Plan Launch Update

- Tailored Plans will now go live on October 1, 2023.
  - To make sure that people can seamlessly receive care on day 1, we are delaying the launch of Tailored Plans until October 1. Our highest priority is making sure that the transition to Tailored Plans is as smooth as possible for the beneficiaries they will serve.
  - The delayed start will allow Tailored Plans more time to contract with additional providers to support member choice.
  - Additional populations covered under the LME/MCO began on April. 1, 2023
    - 0-3
    - Legal immigrants
- Nothing changes for members today—except for the new populations that will be served.
  - Beneficiaries eligible for Tailored Plan received Notices about the delay at the end of March.
  - Members are continuing to receive behavioral health services, I/DD and TBI supports through their LME/MCO and physical health and pharmacy services through NC Medicaid, just as they do today.

Tailored Plan Transformation Timeline – Major Milestone Dates



Tailored Plan Readiness

- DHHS continues to focus on working with the Tailored Plans to ensure they are ready for Tailored Plan Launch. Key areas of focus remain:
  - Desktop and onsite reviews
  - Network adequacy
  - End to end testing

Key resources:

- Beneficiary notices: https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/beneficiary-notices
- Provider Playbook and fact sheets: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets
- Medicaid Ombudsman: https://ncmedicaidombudsman.org/

Tailored Care Management and 1915(i) Update

- ***Tailored Care Management***

- Tailored Care Management, which launched on December 1, 2022, is built around the six core Health Home services - comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, and referral to community and social support services.
- Under TCM, the goal is for members to have a single care manager who is equipped to manage all of the needs, spanning physical, BH, I/DD, TBI, pharmacy, LTSS, and unmet health-related resources needs. As of the end of May, more than 30% of members eligible for TCM services are assigned to Care Management Agencies or AMH+ providers, which was the target for community-based delivery of TCM in the first year.
- Early provider feedback on TCM includes that more outreach needed to engage each member, in some cases fewer members are engaged in a given month than anticipated, and there are some challenges with billing for services provided in a month
- DHHS is exploring a number of methods to continue to support providers through the launch of the program to fund start up and outreach costs.

- ***1915(i)***

- DHHS continues to work with CMS on 1915(i) approval and still are asking for a 7/1/2023 implementation date. Individuals transitioning to the Tailored Plan who are getting (b)(3) services now will be the priority for transitioning to the (i) services.
- (b)(3) services will continue until 6/30/24 to allow folks in Medicaid Direct to transition to the (i) services on a birth month schedule.

MEDICAID CONTINUOUS COVERAGE UNWINDING AND MEDICAID EXPANSION UPDATE

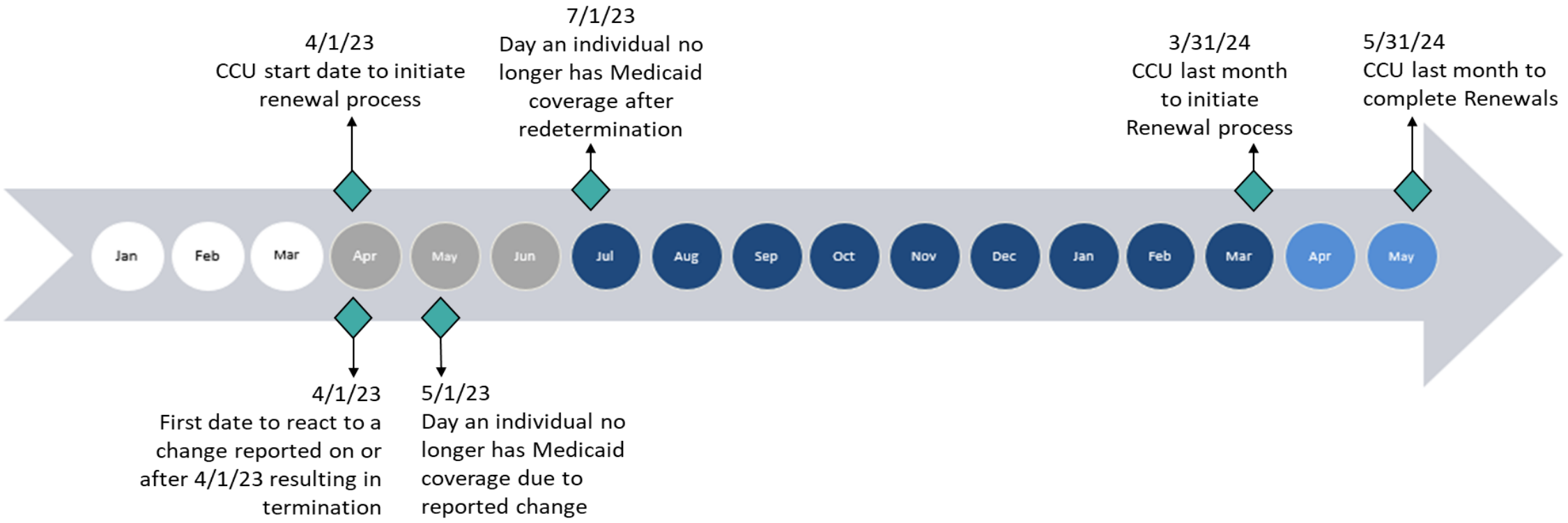
NC Medicaid's Continuous Coverage Unwinding

NC Medicaid began the renewal (recertification) process for Medicaid beneficiaries April 1, 2023. (The unwinding)

- Recertifications will be completed over the next 12 months, as beneficiaries are up for renewal
  - During renewal, the beneficiary's local Department of Social Services (DSS) will use information they have on file to decide if they or their family member(s) still qualify for NC Medicaid
  - If the local DSS needs more information from a beneficiary to decide on coverage, they will send the beneficiary a renewal letter in the mail
- If a beneficiary is found ineligible for Medicaid, they will receive a letter with the following information:
  - The program being terminated or reduced
  - The decision made by DSS
  - Deadlines for responding
  - How to appeal the decision

Continuous Coverage Unwinding Timeline

Local Departments of Social Services have been completing recertifications throughout the PHE, however, coverage has not been terminated or reduced. North Carolina is using an age-based approach for recertifications during the unwinding period.



If a Beneficiary is Redetermined Ineligible

If a beneficiary loses their NC Medicaid eligibility during recertification their Medicaid coverage will end.

- Beneficiaries have the right to:
  - Appeal the decision. Beneficiaries have 60 days from the date of the termination letter to appeal.
  - Continue to receive benefits pending the fair hearing decision.*
- If a beneficiary no longer qualifies for Medicaid:
  - They may be able to buy a health plan through the federal Healthcare Marketplace and get help paying for it. healthcare.gov
  - Four out of five enrollees can find plans that cost less than $10 a month
  - Plans cover things like prescription drugs, doctor visits, urgent care, hospital visits and more

* If the resolution upholds the beneficiary's termination; the beneficiary may be required to pay for medical services received while the appeal was pending.

What Beneficiaries Can Do to Get Ready for Recertification

- Update their contact information
  - Beneficiaries should make sure their local DSS has their current mailing address, phone number, email or other contact information.
  - With an enhanced ePASS account, beneficiaries can update their address and other information for Medicaid online without having to call or visit their local DSS.
- Check their mail

  Local DSS will mail beneficiaries a letter if they need to complete a renewal form to see if they still qualify for Medicaid.
- Complete the renewal form (if they get one)

  If a beneficiary receives a renewal form, they should fill out the form and return it to their local DSS right away to help avoid a gap in their Medicaid coverage.

Omnibus Bill Requirements - Returned Mail Condition

The “returned mail condition” requires states make a “good-faith effort” to contact an individual using “more than one modality” when returned mail is received in response to a request for information to complete a recertification.

Meeting the returned mail condition is a two-part requirement.

- Requirement 1: States must attempt to obtain up-to-date mailing addresses and additional contact information (e.g., phone number, email address) for ALL beneficiaries.
- Requirement 2: During the continuous coverage unwinding period, beneficiaries must be contacted through more than one modality prior to termination if returned mail is received. These modalities include:
  - Forwarding address on returned mail
  - Phone call
  - Email
  - SMS text message

To meet these requirements, Medicaid is conducting a targeted beneficiary outreach campaign during the unwinding period (details in the appendix).

Resources

- Medicaid recertification webpage medicaid.ncdhhs.gov/renew
- Medicaid End of the PHE/CCU website medicaid.ncdhhs.gov/End-of-PHE
- Medicaid recertification video English I Spanish
- Medicaid recertification fact sheet English I Spanish

MEDICAID EXPANSION

What is Medicaid Expansion?

- Governor Cooper signed HB 76 into law on March 27, 2023. This is a historic moment for the health and wellbeing of our state
- Over 600,000 North Carolinians will gain access to health care coverage
- Medicaid Expansion in North Carolina increases eligible population to all adults aged 19-64 who have incomes up to 138% of the Federal Poverty Level
  - Single adults 19-64 who have incomes of approximately $20,000 each year
  - Parents with low incomes – for a family of 3, an annual income below about $34,000 each year
    - Prior to expansion the cutoff for parents is about $8,000 each year
- Same ways of getting care as existing Medicaid
- Same comprehensive benefits and copays as other non-disabled adults in Medicaid
- NCDHHS and other external stakeholders will partner together to drive implementation, outreach and engagement, and support our counties in this work

Who is Covered under Expansion?

Low-income parents
(above current coverage levels and with income less than $34,000 each year for a family of 3)

Low-income childless adults
(with income less than $20,000 per year for a single adult)

Low-wage workers (agriculture, childcare, construction, etc.)

Some veterans and their families

Children who age out of Medicaid

Women who would be covered if they were pregnant

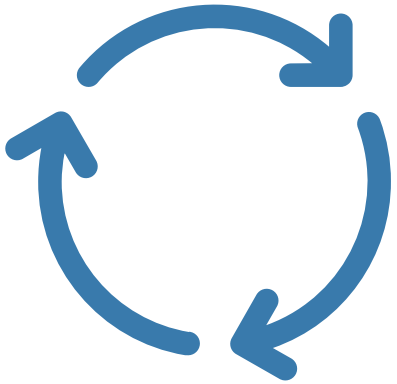
Estimated Eligible Beneficiaries

- More than **600,000 individuals are estimated to be covered under Medicaid Expansion** by the end of the second year. This includes:
  - **300,000** expansion enrollees moved from Family Planning benefit by the end of the first year
  - **100,000** beneficiaries who may have lost full Medicaid coverage during recertification in absence of expansion
  - **200,000** expansion eligible individuals not currently enrolled in Medicaid statewide expected to enroll in the first two years
- Of the estimated 300,000 expansion enrollees moved from the Family Planning benefit by the end of the first year:
  - **92%** of these beneficiaries are estimated to be enrolled in a **Standard Plan**
  - **7-8%** of these beneficiaries are estimated to be enrolled in a **Tailored Plan, or NC Medicaid Direct** prior to the Tailored Plan launch*
  - **Less than 1%** of these beneficiaries are estimated to be enrolled in the **Tribal Option**
  - **Less than 1%** of these beneficiaries are estimated to be enrolled in **NC Medicaid Direct**

*Some of the beneficiaries estimated to be enrolled in a Tailored Plan may stay in NC Medicaid Direct after Tailored Plan launches due to other circumstances.

Note: These numbers are estimates and can vary from the final numbers at the time of Medicaid Expansion launch.

Intersection of CCU and Medicaid Expansion



- As beneficiaries complete recertifications, they may have incomes above the parent/caretaker income level (~43% FPL) that they did not have during the PHE
- Beneficiaries who may be eligible for Expansion (incomes <138% FPL) will likely qualify for our limited Family Planning Only benefit (incomes <195% FPL)
  - **At Expansion launch date, Family Planning Only beneficiaries will be evaluated for Medicaid Expansion and moved to the Expansion eligibility group on Day 1 of Medicaid Expansion**
  - **Estimate up to 300,000 beneficiaries may be eligible on Day 1**
- Post Expansion launch, individuals will be screened for eligibility for all available programs, including Expansion

APPENDIX

CCU Targeted Outreach Efforts

Requirement 1 — Attempt to obtain up-to-date contact information for ALL beneficiaries.

Contact Modality	Description	Dates	Timing
Mass Text Messages	Update your contact information so you don't miss important updates from Medicaid. Use ePASS or contact your local DSS.	March 2023 – February 2024 Completed in batches based on the beneficiary's renewal due date.	Monthly; based on when the beneficiary is due for Medicaid recertification.
Robo Calls from EB			
Mass Emails			

This is in addition to direct mailings from health plans and the enrollment broker, social media, website, press releases, community presentations and webinars.

CCU Targeted Outreach Efforts

Requirement 2 — Prior to termination of coverage, contact beneficiaries using more than one modality if returned mail is received.

Contact Method	Description	Dates	Timing
Texts, emails, and robo calls in response to a Renewal Form or Request for Information being sent	Your DSS needs information; Check your mail; Link to provide details on how to complete the recertification	April 2023 – March 2024	Weekly (upon generation of the Renewal form or Request for Information)
Mail returned Renewal Notice or Request for Information to Forwarding Address	Resend returned Renewal Notice or Request for Information if a forwarding address is provided	April 2023 – May 2024	As returned mail is received

CCU Flexibilities and Other Efforts to Increase Automation/Save Time

Flexibility / Change	Description	Goal	Implementation Date
Change Reasonable Compatibility threshold from 10% to 20%	Attested income that is within 20% of electronic source income is Reasonably Compatible	Improve STP rates; Increase ex parté rates	January 2023
Straight-through MAGI Recertification Processing Statewide	System processes, approves, and sends renewal notices for some MAGI cases	Reduce caseworker touch on recertifications	January 2023
Update beneficiary address using NCOA or USPS info	Accept updates to beneficiary address from NCOA database and USPS in-state forwarding address without additional confirmation	Change of address from USPS forwarding address label or Enrollment Broker or Health Plan RM reports does not need further confirmation from beneficiary	March 2023
Updates to Case Selection Criteria for Straight-through MAGI Recertification Processing	Some case types that were not being selected for STP are now included	Increase automation	March 2023

CCU Flexibilities and Other Efforts to Increase Automation/Save Time

Flexibility / Change	Description	Goal	Implementation Date
Renewal for individuals based on SNAP income	Auto-renew Medicaid benefits for someone with SNAP benefit started/renewed within the past 5 months	Increase automation during unwinding period	April 2023
Straight-through MAGI Application Processing	System processes, approves, and sends approval notice for some MAGI applications	Reduce caseworker touch on applications	April 2023