

Healthy Opportunities Pilots: *Pilot Overview and Care Management Team Roles and Responsibilities*

May 25, 2022

Goals for Today's Session

Goals

- Provide an overview of the Healthy Opportunities Pilots
- Review the roles and responsibilities of care management teams in the Healthy Opportunities Pilots
- Provide information on the process for enrolling members in the Healthy Opportunities Pilots and coordinating services that meet member's health and social needs:
 - Identifying Potentially Pilot Eligible Populations
 - Assessing Pilot Eligibility and Services
 - Eligibility Determination & Service Authorization
 - Referral to Authorized Services
 - Reviewing Service Mix and Reassessing Pilot Eligibility

Overview of the Healthy Opportunities Pilots

What Are the Healthy Opportunities Pilots?

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

➤ **Pilot funds will be used over the demonstration period to:**

- Support capacity building for key entities participating in the Pilots—including providing resources to community-based organizations (referred to as “human services organizations” or “HSOs”) that are providing social services
- Cover the cost of federally-approved Pilot services, Health Plan and Network Lead administration of the Pilots, payments to care management entities for Pilot responsibilities, and value-based payments

The Pilots will offer services in the Four Priority Domains



Why Do We Need the Healthy Opportunities Pilots?

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

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



What is the Role of Care Management Teams in the Pilots?

A critical component of implementing the Pilots is how care management teams will work to identify and assess individuals for Pilot eligibility and needed services, connect those individuals to Pilot services, and provide ongoing whole person care management.

- Care management teams will be central to the success of the Pilots by coordinating Pilot services and providing care management to Pilot enrollees.
- In the Pilots, care management teams can be affiliated with the following care management entities*:



- Practices and their affiliated CINs/Other Partners in Pilot regions (e.g., AMH Tier 3s, AMH+ practices, CMAs)^ or



- Local Health Departments (LHDs) located in Pilot regions that provide Care Management for At-Risk Children (CMARC)/Care Management for High-Risk Pregnancies (CMHRP) or



- Health Plans, when a local care management entity is not assigned (e.g., Standard Plans, Tailored Plans)

*A Pilot care management entity assumes care management responsibilities specifically related to the Healthy Opportunities Pilot

^Refers to Advanced Medical Home (AMH) Tier 3 Practices, AMH+ practices, Care Management Agencies (CMAs)

Key Entities' Roles in the Pilots

Care Management Teams

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

Health Plans

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

Network Leads

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

Human Service Organizations

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

What Services Can Enrollees Receive Through the Pilots?

The federal government has approved 29 services to be offered through the Pilots in the four priority service domains. Examples include:



Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)



Food

- Linkages to community-based food services (e.g., SNAP/WIC application support)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery



Transportation

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

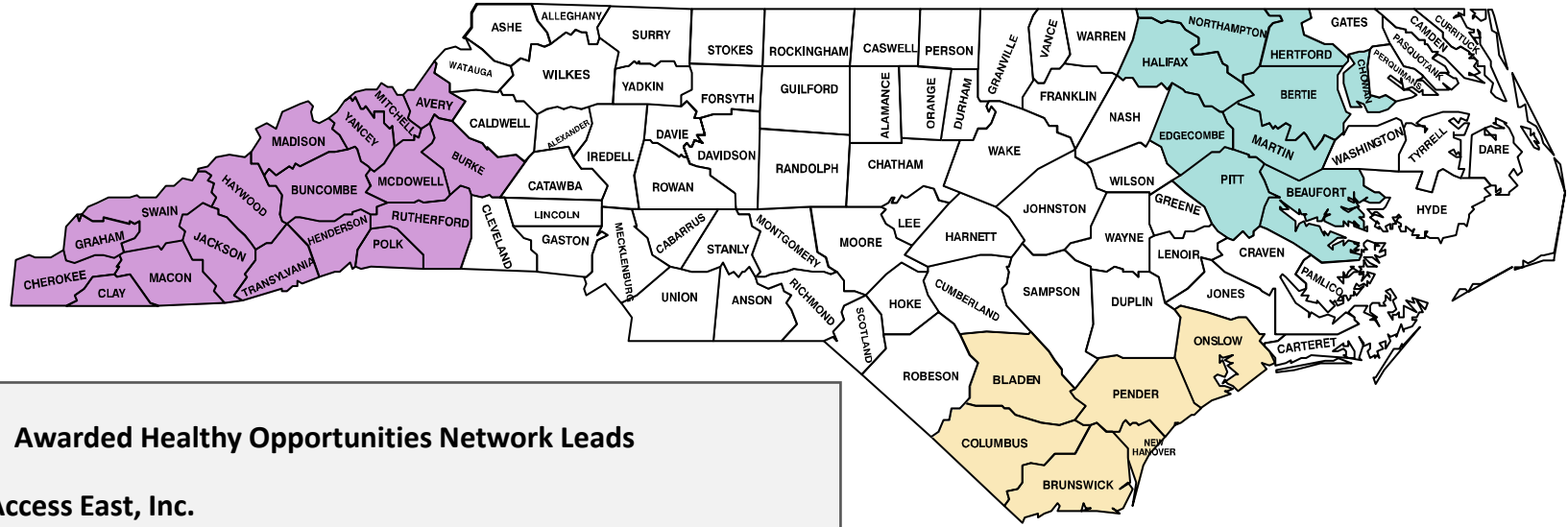


Interpersonal Violence

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

Where Will Pilot Services Be Available?

Network Leads (NLs), Health Plans, care management entities and HSOs will work with communities in three geographic areas of the state to implement the Pilots.



Awarded Healthy Opportunities Network Leads

- Access East, Inc.**
Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
- Community Care of the Lower Cape Fear**
Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
- Impact Health**
Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

What is NCCARE360?

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

- **NCCARE360 is a telephonic, online and interfaced IT platform, providing:**
 - A robust **statewide resource database** of community-based organizations and social service agencies
 - 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
 - **Additional features** to support eligibility, enrollment and invoicing processes specific to the Pilots
- Care management teams will use NCCARE360 to generate referrals for Pilot services, and track enrollee progress over time



Care Management Responsibilities for Care Management Entities

| Activity | Identification and Outreach to Pilot Populations | Assessing Pilot Eligibility and Recommending Pilot Services | Eligibility Determination & Service Authorization | Referral to Authorized Services and Tracking | Reviewing Service Mix and Reassessing Pilot Eligibility |
|----------|--|---|---|--|---|
|----------|--|---|---|--|---|

Support identification of potentially Pilot-eligible patients (e.g., through regular patient interactions and screenings)

1. Assess Pilot eligibility (physical/behavioral and social needs)
2. Recommend Pilot services that are likely to meet patient needs
3. Obtain consents
4. Document Pilot eligibility and service recs. in the Pilot eligibility and service assessment (PESA) in NCCARE360

Health Plan Role:
The Health Plan reviews the PESA in NCCARE360 to determine eligibility, authorize services and document Pilot enrollment and notifies care management entity via NCCARE360

Refer patient to authorized Pilot service using NCCARE360 and tracks progress

1. Review service mix every 3 months
2. Reassess for Pilot eligibility every 6 months
3. Recommend additional or discontinued services and disenrollment if needed

Expedited Referral for Pre-Approved Pilot Services
 Care management entities can expedite referral to a limited number and duration of pre-approved Pilot services

Care management entities will also support transitions of care if a member switches health plans

Roles and Responsibilities of Care Management Teams in The Healthy Opportunities Pilots

Identifying Potentially Pilot Eligible Populations

No Wrong Door—Entry Points into the Pilots

The Pilots will have a “no wrong door” approach to identifying and enrolling individuals in the Pilots, ensuring that individuals who first show up at various “entry points” can be efficiently identified and assessed for Pilot eligibility and needed services.

Provider Referral



Referral from Pilot Participating HSO



Referral from Non-Pilot Participating HSO



Self/Family Referral



Health Plan Identification



Care Management Entity Assessment



Identifying Potential Pilot-Eligible Members

Through ongoing care management with Medicaid members living in Pilot regions, care management entities will have responsibilities to identify potentially Pilot-eligible members. Care management entities may also receive referrals from providers, HSOs, Health Plans or member/family self-referral to assess members for Pilot eligibility.



Care Management Teams

- Care management teams will build in opportunities to assess Pilot eligibility and evaluate healthy-opportunities-related needs through existing checkpoints with members currently receiving care management (e.g., regular care management check-ins).



HSOs

- HSOs will refer members they identify as potentially Pilot-eligible to their care management entity (e.g., LHD, AMH Tier 3/CIN) or to their Health Plan to conduct a Pilot eligibility assessment. HSOs will not assess members for Pilot eligibility.



Health Plans

- Health Plans will proactively work to identify potential Pilot-eligible members as part of their population health management capabilities and must conduct outreach to members to educate them about the Pilots and Pilot services (e.g., through direct mail).

Assessing Pilot Eligibility and Recommending Needed Services

Who Qualifies for Pilot Services?

To qualify for Pilot services, Medicaid managed care enrollees must live in a Pilot Region and have:



At least one Physical/Behavioral Health Criteria:

(varies by population)

- **Adults** (e.g., having two or more qualifying chronic conditions)
- **Pregnant Women** (e.g., history of poor birth outcomes such as low birth weight, condition likely to complicate pregnancy such as hypertension)
- **Children, ages 0-3** (e.g., neonatal intensive care unit graduate)
- **Children 0-20** (e.g., experiencing three or more categories of adverse childhood experiences such as history of abuse and household substance use)



At least one Social Risk Factor:

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

Meet service specific eligibility criteria, as needed.

Pilot Eligibility and Service Assessment (PESA)

Care management teams will use the standardized tool (PESA) to document a member's assessment of Pilot eligibility, service recommendations, and service-specific eligibility criteria. The PESA is not an additional screening tool, but a documentation tool to facilitate the eligibility determination and service authorization process.

- In Pilot regions, care management teams will be responsible for assessing individuals for their Pilot eligibility and recommending Pilot services that will meet their need.
- The PESA will pre-populate a list of all eligibility criteria for Pilot enrollment and selected service(s) allowing care management teams to check off applicable eligibility criteria for a member.
- All Pilot enrollees receiving services must have a completed and up-to-date PESA. A member's PESA will be available to and editable by their care management team and Health Plan.

The PESA will be a standardized across all care management entities and will be a dynamic tool for care management teams to assess and document essential information related to Pilot eligibility and recommended services, including:

- Member contact and identifying information;
- Physical and social risk factors supporting Pilot program eligibility;
- Recommended Pilot service(s);
- Service-specific eligibility for recommended services, and necessary documentation;
- Member consent to participate in the Pilots
- Required documentation for specific services (as needed).

Key Takeaways: Assessing Pilot Eligibility and Recommending Services

Care Management Teams will:

- Assess whether a patient meets the qualifying criteria to be eligible for the Pilots
- Recommend specific Pilot service(s) that can best address the patient's needs (including any minimum eligibility criteria for specific services)
- Obtain verbal or written Pilot-related consent
 - If a member does not give consent, care management teams will explain that the member will not be able to receive Pilot services and provide ongoing care management and identify other services to meet their needs
- Use the PESA in NCCARE360 to document information and transmit to the appropriate service authorization team at the Health Plan



Eligibility Determination & Service Authorization

Eligibility Determination & Service Authorization

Health Plan administrative/service authorization staff will have the ultimate responsibility for determining eligibility and authorizing Pilot services for members. Care management teams must wait for approval from the Health Plan before connecting members to recommended services.



Eligibility Determination

- Health Plans will review a member's PESA to ensure they meet the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots
- Health Plans are expected to rely on the recommendation of the care management team regarding assessment of Pilot qualifying social criteria



Service Authorization

- Health Plans will also review and authorize Pilot services recommended by care management teams
- Health Plans will follow DHHS standardized timeframes for authorization of all Pilot services

Health Plans will document eligibility determination and service authorization information in the member's PESA and communicate approval/denial to the member's care management team. A member will be considered "enrolled" in the Pilots if they have been authorized for at least one Pilot service.

Expedited Referral to Passthrough Pilot Services

To expedite service delivery and reduce touchpoints with members, care management teams are permitted to refer patients to a select number of high-value, low-cost “passthrough” Pilot services for a 30-days without prior Health Plan approval.



Passthrough Pilot Services

- DHHS has designated 7 services as ‘passthrough’ Pilot services. These services and amounts will be standardized across Health Plans:

Food Services

- ✓ Fruit and Vegetable Prescription
- ✓ Healthy Food Box (For Pick-Up)
- ✓ Healthy Food Box (Delivered)
- ✓ Healthy Meal (For Pick-Up)
- ✓ Healthy Meal (Home Delivered)

Transportation Services

- ✓ Reimbursement for Health-Related Public Transportation
- ✓ Reimbursement for Health-Related Private Transportation

- Care management teams must still complete the PESA and transmit it to the Health Plan to confirm authorization decision beyond the first 30 days.

Key Takeaways: Eligibility Determination & Service Authorization

Key Takeaways

- Health Plan administrative/service authorization staff will have the ultimate responsibility for determining eligibility and authorizing Pilot services for members
- Care management teams must wait for authorization before connecting members to recommended services
- Members are only considered enrolled once they have at least one Pilot service authorized
- For select, high-value “passthrough” services, care management teams can refer members directly to an HSO that provides those services

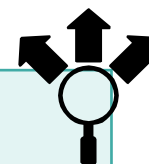
Referral to Authorized Services and Tracking

Key Takeaways: Referral to and Delivery of Pilot Services

Once the care management team receives authorization from the Health Plan administrative staff, they will refer members to an appropriate HSO using NCCARE360 and track their progress.

Care Management Teams will:

- Communicate to the member Pilot services authorized by the Health Plan
- Use NCCARE360 to refer members to authorized Pilot services within two business days of receiving notice from the Health Plan
- Use NCCARE360 to monitor that HSOs accept the referral and initiate the service
- Update the enrollee's care plan with Pilot-related services and goals when an HSO accepts the referral
- Coordinate with HSOs to help assess to what extent Pilot services are meeting their needs



Review Service Mix and Reassess Pilot Eligibility

Overview of Service Mix Review and Eligibility Reassessment

As required by the federal government, care management teams must 1) assess enrollees every 3 months to ensure Pilot services are meeting their needs and 2) reassess enrollees every 6 months for continued Pilot eligibility.

Definitions

- 1. Assessment of Pilot Service Mix (every 3 months):** Assessment of the Pilot services the enrollee is receiving to determine if they are meeting the enrollee's needs. If the current mix of services is not meeting the enrollee's needs, care management teams will recommend modified or new services.
- 2. Reassessment of Pilot Eligibility (every 6 months):** Reassess the enrollee's eligibility for Pilot services based on the qualifying criteria (physical/behavioral health criteria and social risk factor) in addition to service mix.

Care management team check-ins with enrollees at the 3-month and 6-month interval after enrollment are **minimum requirements**. Care management teams are expected to conduct regular check-ins with members at frequencies that best meet their needs.

Discontinuation of Pilot Services and Pilot Disenrollment

Care management teams may identify instances where Pilot services should be discontinued or when members must be disenrolled from the Pilots.

Definitions

Discontinuation: One or more of an enrollee's Pilot services is discontinued because they are no longer required, available or the enrollee is no longer eligible to receive a previously authorized service. Examples include:

- Current Pilot service(s) are not meeting the needs of the patient
- Patient has met their Care Plan goals and no longer requires the Pilot service
- Patient no longer meets the service-specific qualifying criteria

Disenrollment: An enrollee is disenrolled from the Pilots because they are no longer eligible to participate. Examples of potential scenarios for disenrollment from the Pilots include:

- Patient is no longer enrolled in Managed Care
- Patient moved out of a Pilot region
- Patient wishes to opt out of the Pilots

Key Takeaways: Conducting 3- and 6-Month Pilot Reassessments

Care management teams will play an essential role in conducting and documenting the results of 3- and 6-month Pilot reassessments.

Care Management Teams will:

- Schedule, prepare for, and conduct a 3-month service mix assessment and 6-month eligibility reassessment (in-person, via telephone or via video)
 - **Service Mix Review:** Ask questions to determine if current services are meeting member needs, if new/modified services are required, or if services should be **discontinued**
 - **Eligibility Reassessment:** In addition to service mix review, ask questions to confirm the member's eligibility in the Pilots, or if they should be **disenrolled**
- Document and transmit outcomes of the 3-month and 6-month assessment in the member's PESA and transmit it to the Health Plan
- Communicate any changes to the member, update the member's care plan, and generate new referrals via NCCAREA360, as required

Local Health Department (LHD) Pilot Participation

LHDs Are Essential to the Healthy Opportunities Pilots

Through participation in the Healthy Opportunities Pilot, LHDs will contribute to an innovative and nationally recognized initiative that will provide critical services to North Carolina Medicaid members.

- Eligibility criteria for Pilot services overlaps significantly with eligibility for CMARC and CMHRP*. LHDs will play a unique role in identifying individuals who may be Pilot-eligible, assessing them for Pilot eligibility and connecting them to needed services.
- Pilot responsibilities for care management entities, including LHDs, are integrated into existing care management processes, further supporting the vision of whole-person care.



LHD Pilot Payments

Pilot Care Management Payments for LHDs

LHDs that participate in the Pilots as a care management entity will receive additional Pilot-related care management payments.



➤ LHDs will receive an additional Pilot-related care management **payment for every member enrolled in the Pilots**



➤ A member is considered 'enrolled' in the Pilots once they are found to be **Pilot-eligible** and have been **authorized to receive a Pilot service** by their Health Plan



➤ The Department has developed a 'per enrollee per month' (PEPM) payment rate that considers the **pre-enrollment and ongoing activities*** associated with Pilot care management that are carried out by care management teams

Pilot Care Management Rate

\$31.46 Per Enrollee Per Month

*See additional information in the appendix

Pilot Onboarding for LHDs

Next Steps for LHD Pilot Onboarding

The Department will provide LHDs interested in participating as a Pilot care management entity with additional technical assistance and support in order to onboard onto the Pilots.

Next Steps



➤ Confirm LHDs that are:

- Interested in Pilot participation with the next wave of Pilot care management entities (Phase I)*
- Interested in Pilot participation with subsequent waves of Pilot care management entities at a later date (Phase II)
- Not interested in Pilot participation

➤ Provide interested LHDs with:



- Support onboarding onto NCCARE360 for all Pilot-related functionalities
- Additional training for LHD care management teams on Pilot responsibilities and services

***The Department will follow-up on the timing to begin LHD onboarding for Pilot participation in 2022.**

Thank You

Q&A

Appendix

Healthy Opportunities Pilots: Qualifying Physical/Behavioral Health Criteria

| Population | Age | Physical/Behavioral Health-Based Criteria |
|----------------|------|---|
| Adults | 22+ | <ul style="list-style-type: none"> 2 or more chronic conditions. Chronic conditions that qualify an individual for Pilot program enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease and chronic renal failure, in accordance with Social Security Act section 1945(h)(2). Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions. |
| Pregnant Women | N/A | <ul style="list-style-type: none"> Multifetal gestation Chronic condition likely to complicate pregnancy, including hypertension and mental illness Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol Adolescent ≤ 15 years of age Advanced maternal age, ≥ 40 years of age Less than one year since last delivery History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death |
| Children | 0-3 | <ul style="list-style-type: none"> Neonatal intensive care unit graduate Neonatal Abstinence Syndrome Prematurity, defined by births that occur at or before 36 completed weeks gestation Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth Positive maternal depression screen at an infant well-visit |
| | 0-21 | <ul style="list-style-type: none"> One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of <5th or >85th %ile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention deficit/hyperactivity disorder, and learning disorders Experiencing three or more categories of adverse childhood experiences (e.g. Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) Enrolled in North Carolina's foster care or kinship placement system |

Healthy Opportunities Pilots: Social Risk Factors

| Risk Factor | Definition |
|---|---|
| Homelessness and Housing Insecurity | Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A), and housing insecurity, as defined based on questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool. |
| Food Insecurity | <p>As defined by the US Department of Agriculture commissioned report on Food Insecurity in America:</p> <ul style="list-style-type: none"> • Low Food Security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. • Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake |
| Transportation Insecurity | Defined based on questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool. |
| At risk of, witnessing, or experiencing interpersonal violence | Defined based on questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool. |

Timelines for Pilot Service Authorization: Housing

| Domain | Pilot Service Name* | Timelines for Pilot Service Authorization | | |
|------------------|--|---|-----------------|-------------------------|
| | | Pre-Approved; Expedited Referral | 3 business days | 7 business days or less |
| Housing Services | Housing Navigation, Support and Sustaining Services | | X | |
| | Inspection for Housing Safety and Quality | | | X |
| | Housing Move-In Support | | | X |
| | Essential Utility Set-Up | | X | |
| | Home Remediation Services | | | X |
| | Home Accessibility and Safety Modifications | | | X |
| | Healthy Home Goods | | | X |
| | One-Time Payment for Security Deposit and First Month's Rent | | | X |
| | Short-Term Post Hospitalization Housing | | X | |

Timelines for Pilot Service Authorization: Food

| Domain | Pilot Service Name | Timelines for Pilot Service Authorization | | |
|---------------|--|---|-----------------|----------------------------|
| | | Pre-Approved; Expedited Referral | 3 business days | 7 business days or less |
| Food Services | Food and Nutrition Access Case Management Services | | | X |
| | Evidence-Based Group Nutrition Classes | | | X |
| | Diabetes Prevention Program | | | X |
| | Fruit and Vegetable Prescription | X | | |
| | Healthy Food Box (For Pick-Up) | X | | |
| | Healthy Food Box (Delivered) | X | | |
| | Healthy Meal (For Pick-Up) | X | | |
| | Healthy Meal (Home Delivered) | X | | |
| | Medically Tailored Home Delivered Meal | | | X |

Timelines for Pilot Service Authorization: IPV, Transportation and Cross-Cutting

| Domain | Pilot Service Name | Timelines for Pilot Service Authorization | | |
|-------------------------|---|---|-----------------|-------------------------|
| | | Pre-Approved; Expedited Referral | 3 business days | 7 business days or less |
| IPV Services | IPV Case Management Services | | | X |
| | Violence Intervention Services | | | X |
| | Evidence-Based Parenting Curriculum | | | X |
| | Home Visiting Services | | | X |
| | Dyadic Therapy | | | X |
| Transportation Services | Reimbursement for Health-Related Public Transportation | X | | |
| | Reimbursement for Health-Related Private Transportation | X | | |
| | Transportation PMPM Add-On for Case Management Services | | | X |
| Cross-Cutting Services | Holistic High Intensity Enhanced Case Management | | | X |
| | Medical Respite | | X | |
| | Linkages to Health-Related Legal Supports | | | X |

Pilot Care Management Incremental Activities

Pilot care management payments are based on estimated costs associated with the below activities.

| Pilot-Related Care Management Incremental Activities | |
|--|--|
| Pre-Enrollment Activities | Conduct outreach and complete assessment of Pilot eligibility with member, including initial filling-out of PESA, recommending Pilot services, obtaining enrollee consent, and document Pilot eligibility and service recommendation in PESA in NCCARE360 platform, including documentation, as necessary. |
| | Coordinate with Health Plan to secure authorization of Pilot services, including submission of Pilot service eligibility and assessment form to Health Plan and additional coordination with Health Plan, as needed (e.g., in case of denial or partial denial of authorization) |
| Ongoing Care Management Activities | Develop a Pilot section of a member’s care plan that documents the member’s Pilot enrollment status and authorized Pilot services and update throughout enrollment. |
| | Identify appropriate HSO(s) and make electronic referral to HSO(s) using NCCARE360. |
| | Track the status of a referral to an HSO to ensure that Pilot service delivery is initiated, Communicate to the member once an HSO accepts a service referral has been accepted; and coordinate with HSO regarding enrollee progress, as needed. |
| | Reassessment of Pilot Service Mix: Review and assess Pilot services the enrollee is receiving to determine if they are meeting the enrollee’s needs, at least every 3 months. |
| | Reassessment of Pilot Eligibility: Review and reassess the enrollee’s eligibility for Pilot services based on the qualifying criteria (physical/behavioral health criteria and social risk factor) in addition to reviewing Pilot service mix, every 6 months. |