Healthy Opportunities Pilots: Standard Plan Roundtable on the Evidence Base

April 6, 2022
Meeting #1

Context & Objectives

Context

- **PHPs are key partners** in the Department's vision for delivering whole person health.

- PHPs will support whole person health for all Medicaid Members but also have a **unique opportunity to leverage Pilot funding** to maximize the impact of non-medical services for Pilot enrollees.

- PHPs must **develop a plan for their investments, due to the Department on May 17, 2022**, that reflects strategic consideration of high priority populations and current evidence regarding which services offer the greatest benefit to specific populations.

- This roundtable will offer a **forum for PHPs, the Department and local and national experts** to discuss the latest findings and share key resources and insights.

Objectives for Today's Meeting

- Describe the importance of PHPs' role in ensuring Healthy Opportunities for Medicaid members.

- Discuss the value of the Healthy Opportunities Pilots to PHPs.

- Describe the purpose of the roundtable meeting series.

- Review the PHPs' "Enrolling High Priority Pilot Populations" report requirements.

Importance of Healthy Opportunities

Importance of Drivers of Health (or "Healthy Opportunities")

- There is broad consensus that social and economic factors have significant impacts on health—**driving as much as 80% of health outcomes.**

- NC was an early adopter of strategies to address drivers of health in Medicaid and since 2018, when NC's waiver was approved, state-, plan- and provider-led efforts have accelerated nationwide.

- COVID-19 has confirmed that addressing historically marginalized populations'* social needs is an integral component to **whole person health, cost containment** and promoting **health equity.**

> *The imperative to build an innovative, whole-person centered, well coordinated system of care that addresses both medical and non-medical needs has never been stronger.*

Maximizing the Pilot's Potential

- Historically, healthcare and social service **silos** and **insufficient funding** and **standardization** have served as barriers to scaling interventions addressing drivers of health

- To bridge these gaps and provide a pathway to sustainable partnerships and the delivery of high-quality, impactful care—ultimately across all of North Carolina—the Healthy Opportunities Pilots seek to create new:

  - **Service delivery infrastructure** (HSO network);

  - **Administrative infrastructure** (standard contracts, Pilot Service Fee Schedule); and

  - **Payment vehicles** (service delivery and capacity building funding, value-based payments).

- SPs are critical partners in North Carolina's efforts to integrate evidence-based, non-medical services into the Medicaid program to:

  - **Improve health outcomes** for Medicaid members

  - **Promote health equity** in the communities served by the Pilots

  - **Reduce costs** in North Carolina's Medicaid program

- To maximize the value of the Pilots, SPs must develop **strategic plans for the deployment of Pilot funds** based on the existing evidence for drivers of health interventions

Opportunity for Plans

The Healthy Opportunities Pilots offer an unparalleled opportunity for Standard Plans to:

Fulfill your mission and contractual directive to support improvements in health.

Maximize the value of your investments in care (*the more effective you are at leveraging the Pilots, the lower your costs and better your performance against quality and performance goals*)
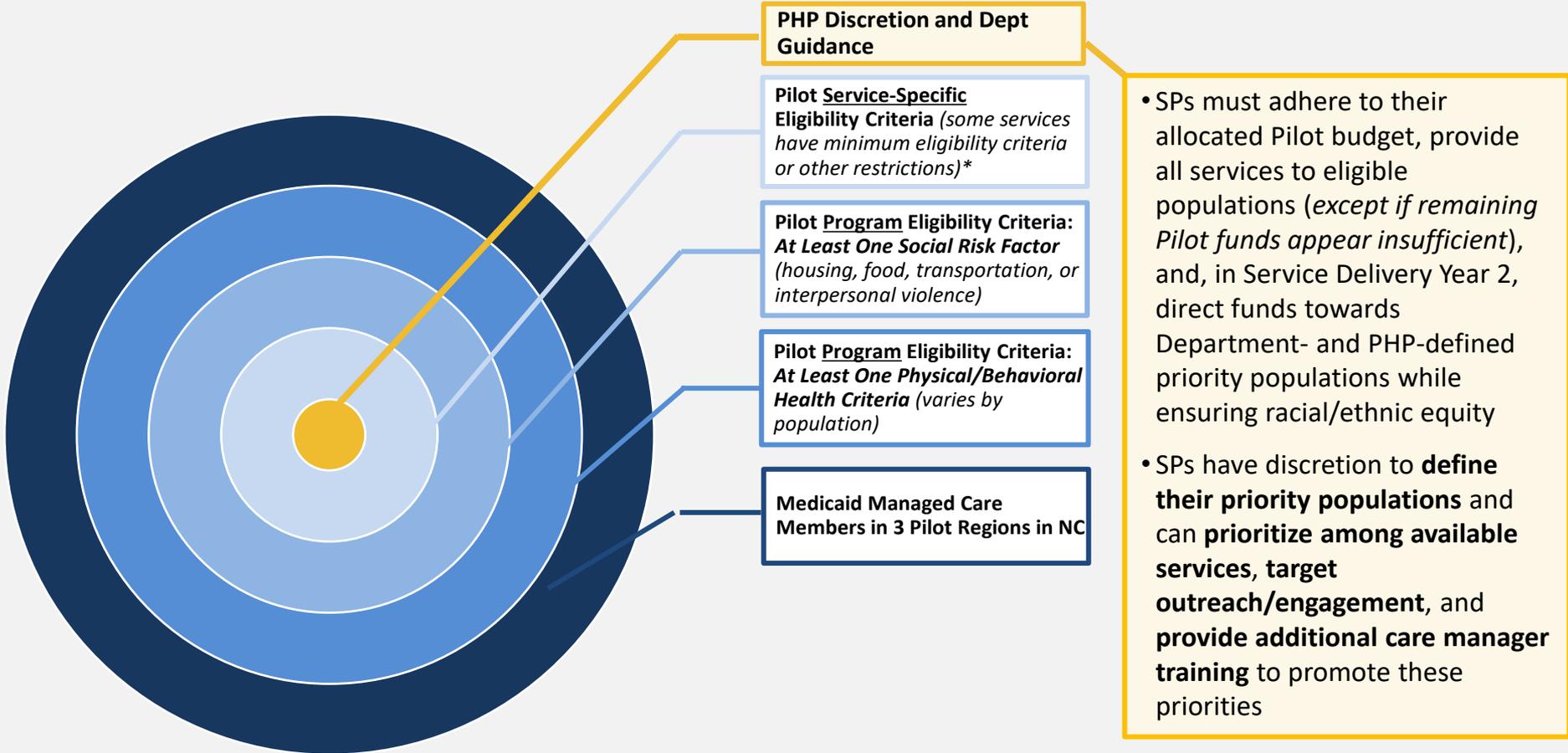
Leverage infrastructure and payment vehicles not available in other states/markets to build partnerships, test system/process modifications, learn about service effectiveness and gain on-the-ground expertise in effectively addressing drivers of health.

Distinguishing Expertise in Markets Nationwide

Strategically Investing Pilot Funds

While the Department has defined Pilot eligibility, SPs have flexibility to leverage expertise and learnings and prioritize Pilot spending to maximize the value of the Pilots (for both members and plans).

PHP Discretion and Dept Guidance

Pilot Service-Specific Eligibility Criteria *(some services have minimum eligibility criteria or other restrictions)**

Pilot Program Eligibility Criteria: *At Least One Social Risk Factor (housing, food, transportation, or interpersonal violence)*

Pilot Program Eligibility Criteria: *At Least One Physical/Behavioral Health Criteria (varies by population)*

Medicaid Managed Care Members in 3 Pilot Regions in NC

- SPs must adhere to their allocated Pilot budget, provide all services to eligible populations (*except if remaining Pilot funds appear insufficient*), and, in Service Delivery Year 2, direct funds towards Department- and PHP-defined priority populations while ensuring racial/ethnic equity

- SPs have discretion to **define their priority populations** and can **prioritize among available services**, **target outreach/engagement**, and **provide additional care manager training** to promote these priorities

More detail on physical/behavioral health criteria and social risk factor definitions are available in the Appendix.

*Including that PHPs make best efforts to validate that no other federal, State or local service, resource or program (e.g., SNAP/WIC) is available and would better meet the Member's needs.

Using the Evidence Base to Support Healthy Opportunities
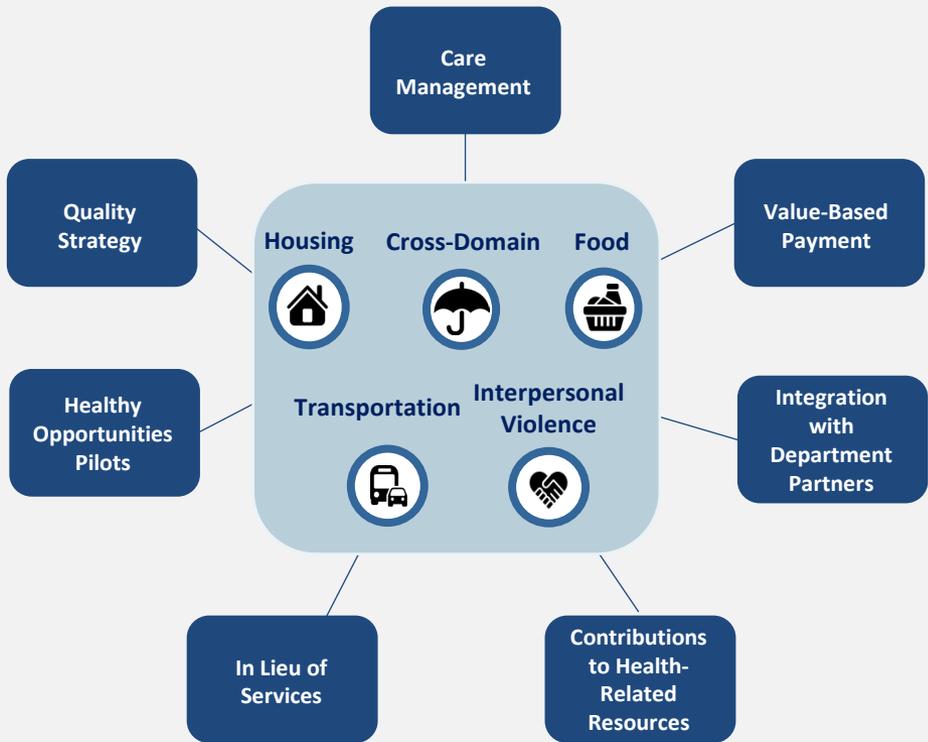
To maximize the value of the Pilot funds, SPs should leverage the existing evidence base to deliver the right Pilot service for the right member at the right time.

- The evidence base supporting use of Pilot services in specific populations is **rapidly evolving**.

- Recognizing that leveraging the evidence base is critical to strategic use of Pilot funds, SPs must be knowledgeable about **reliable sources of information** to guide their investments.

- **Evidence resource libraries** such as SIREN and the Commonwealth Fund Return on Investment (ROI) Calculator "Review of Evidence" can provide critical support to these efforts.

- This forum is a platform for sharing existing efforts, learnings and resources, and discussing the evidence base with subject matter experts.

Healthy Opportunities Evidence Base: Broader Than the Pilots

Evidence-based investments should inform a broader strategy to address HO priority domains.

Understanding the evidence base for services addressing drivers of health can also support PHP investments around Performance Improvement Projects, In Lieu of Services, value-based payment strategies and other population health efforts.

Care Management

Quality Strategy

Value-Based Payment

Housing   Cross-Domain   Food

Healthy Opportunities Pilots

Transportation   Interpersonal Violence

Integration with Department Partners

In Lieu of Services

Contributions to Health-Related Resources

Meeting Series

Roundtable Meeting Series Schedule

Working Session #	Tentative Timing	Topic	Objective
1	Today	Introduction to Meeting Series	Provide context for PHPs' role in maximizing the value of the Pilots; review the "Enrolling High-Priority Pilot Populations Plan" report requirements
2	Week of 4/11	Introduction to SIREN	General orientation to SIREN to describe the database and search option
3	Week of 4/18	Evidence Overview 1 (*tentatively: food and housing*)	Forums to discuss the state of the art and key issues surrounding the evidence base for Pilot service domains with NC and national subject matter experts
4	Week of 4/25	Evidence Overview 2 (*tentatively: IPV/toxic stress and transportation*)	

Each SP is asked to share at least one evidence base resource, relevant initiative or key question during an "Evidence Overview" meeting. SPs should let DHHS know in advance which Healthy Opportunity domain their contribution will address.

For Discussion

Roundtable Series:

–Are there additional discussion topics you are interested in for the Roundtable meeting series?

–How else can the Department support your efforts to maximize the value of Pilot funding?

–How can we best share this learning with Network Leads and Health Services Organizations to strengthen our partnerships and empower them to support our care improvement goals?

Evidence Base Resources

–Are there other evidence resource libraries/databases you leverage already for your efforts to address drivers of health?

–Do you rely on specific SMEs in the field to help guide your existing efforts that you'd like us to invite to the series?

PHPs' "Enrolling High Priority Pilot Populations" Report

PHPs' "Enrolling High Priority Pilot Populations" Report (1/2)

PHPs are required to submit the Healthy Opportunities Pilot Enrolling High-Priority Population Plan by May 17, 2022 (45 days prior to Pilot Service Delivery Year 2).

In the Plan, PHPs must:

1. Identify priority populations; and

2. Describe strategies and operational approaches for ensuring equitable distribution of Pilot investments

1. Identifying Priority Populations

PHPs must report on the anticipated proportion of enrollees for the second Pilot service delivery year (July 1, 2022 – June 30, 2023) who will:

- Be pregnant

- Be children ages 0-21

- Have high health care expenditures as determined by the PHP

  o The PHP must define "high-cost populations", describe the methods the PHP will use to identify high-cost Pilot enrollees and any available evidence-base regarding the impact of Pilot-like services on this population.

- Meet any additional priority population designations the PHP intends to focus on for Pilot enrollment (at the PHP's discretion)

  o The PHP must describe how it will identify and define this population and the evidence-based rationale for focusing on the additional priority populations.

PHPs' "Enrolling High Priority Pilot Populations" Report (2/2)

2. Ensuring Equitable Distribution of Pilot Investments

For the second Pilot service delivery year, the PHP must submit a description of its strategies and operational approaches for:

- Identifying and enrolling members residing in Pilot regions to ensure **inclusive representation of priority populations**.

- Ensuring the **racial and ethnic composition of Pilot enrollees and expenditures mirrors Medicaid demographics** in the Pilot region.

- Ensuring that **historically marginalized populations and communities in the Pilot region are proportionally represented** among Pilot enrollees and service expenditures, including at minimum to meet the following goals:

  o Starting in Pilot Service Delivery Period II, the PHP shall direct Pilot services to be distributed to the following groups during each Service Pilot Delivery Period:

    ▪ At least thirty-three percent (33%) of Pilot enrollees are pregnant enrollees or children ages 0-21.

    ▪ At least thirty-three percent (33%) of Pilot enrollees are high-cost populations.

  o The PHP shall ensure that historically marginalized populations and communities in the Pilot region are proportionately represented in the delivery of Pilot services and service expenditures.

Q&A

Appendix

Who are Historically Marginalized Populations?

- Individuals, groups, and communities that have historically and systematically been denied access to services, resources and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression.

- Long standing and well documented structural marginalization has resulted in poor outcomes – health, social, political, economic and overall increased vulnerability to harm.

Historically Marginalized Populations are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status:	
• African American/Black	• Latinx/Hispanic
• American Indian	• Asian American
• Immigrant	• Refugee
• Disability	• Homeless
• LGBTQ+	• Rural
• Veterans	• And others…

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)
- **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)

+

☑ **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.

Healthy Opportunities Pilots:
Qualifying Physical/ Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
Adults	22+	• 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	• 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	• 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	• 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 percentile 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	• Individuals who are **homeless**: defined as an individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. • Individuals who are **housing insecure:** including individuals who, within the past 12 months, have ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch surfing); are worried about losing their housing; or within the past 12 months have been unable to get utilities (heat, electricity) when it was really needed.
Food Insecurity	Patients who are experiencing food insecurity—defined as the disruption of food intake or eating patterns because of lack of money and other resources--including those who: • Report reduced quality, variety, or desirability of diet. There may be little or no indication of reduced food intake. This is considered low food security. • Report multiple indications of disrupted eating patterns and reduced food intake. This is considered very low food security. • Report that within the past 12 months they worried that their food would run out before they got money to buy more. • Report that within the past 12 months the food they bought did just not last and they didn't have money to get more.
Transportation Insecurity	Patients for whom, within the past 12 months, a lack of transportation has kept them from medical appointments or from doing things needed for daily living.
At risk of, witnessing, or experiencing interpersonal violence	Patients who report that they feel physically or emotionally unsafe where they currently live; within the past 12 months have been hit, slapped, kicked or otherwise physically hurt by anyone; or within the past 12 months have been humiliated or emotionally abused by anyone.

NC DHHS Healthy Opportunities Standardized Screening Questions. Available: https://www.ncdhhs.gov/screening-tool-english-providers-final/download