Healthy Opportunities Pilots:
The Role of CIN Care Management Teams in the Healthy Opportunities Pilots

For Discussion: February 11, 2022

Today's Presenters

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Goals for Today's Session

Goals

- Provide CIN care management teams with an overview of the Healthy Opportunities Pilots
- Review the roles and responsibilities of CIN care management teams in the Healthy Opportunities Pilots
- Provide CIN care management teams with 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

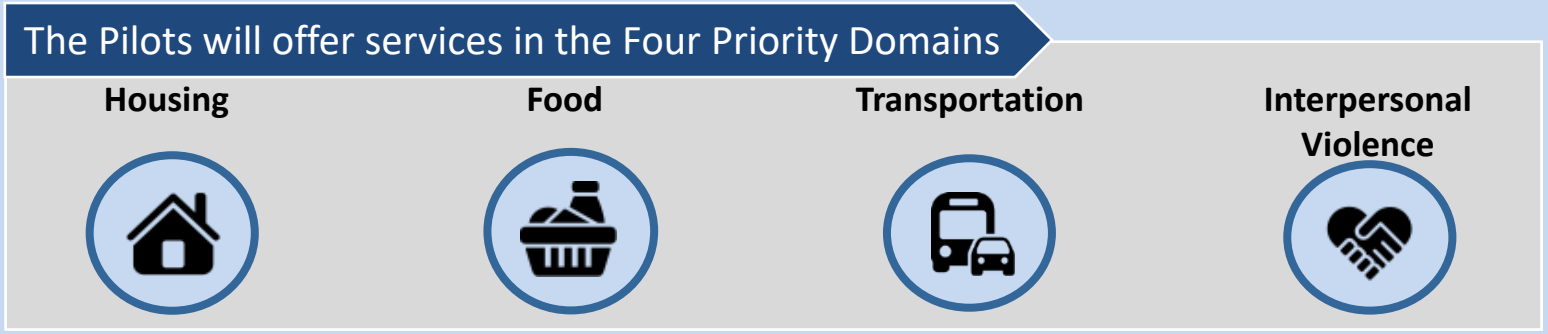
What Are the Healthy Opportunities Pilots?

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 in four priority domains and associated administrative costs



Why Do We Need the 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.

- Social and economic factors have a significant impact on individuals' and communities' health—driving as much as 80% of health outcomes
- The Pilots will facilitate coordination and collaboration between different Pilot entities, including care management teams and HSOs, to provide "whole person care" to Pilot enrollees
- The Pilots will help evaluate the effectiveness of non-medical services on health outcomes and costs, with the ultimate goal of making Pilot services available statewide through the Medicaid managed care program

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

A critical component of implementing the Pilots is how care management entities 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.

- In the Pilots, care management teams will be located in:

Focus for today

  - AMH Tier 3 practices and their affiliated CINs/Other Partners in Pilot regions,

  - LHDs located in Pilot regions, and

  - PHPs, when a local care management entity is not assigned.

- Pilot responsibilities for participating care management teams are integrated into existing care management processes, further supporting the vision of whole-person care.

Why Are Care Management Teams Essential to the Healthy Opportunities Pilots?

Through participation in the Healthy Opportunities Pilot, care management teams will contribute to an innovative and nationally recognized initiative that will shape North Carolina's Medicaid 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!)

Who are the Key Pilot Entities and their Roles?

Care Management Teams

- Frontline care managers interacting with Members
- Assess member eligibility for the Pilots and coordinate Pilot services as part of ongoing care management, in addition to managing physical and behavioral health needs
- Manage members' care plan, inclusive of Pilot services, and track enrollee progress over time

PHPs

- PHPs maintain ultimate responsibility for all Pilot activities
- Approve which members qualify for Pilot services and which services they qualify to receive—based on care manager recommendations
- Pay for Pilot services delivered by HSOs

Network Leads

- Organizations that serve as the essential connection between PHPs and HSOs
- Develop, manage, 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 Network Lead and deliver authorized, Pilot services to Pilot enrollees
- Coordinate with care management teams on the delivery of Pilot service to enrollees

What Services Can Enrollees Receive Through the Pilots?

The federal government has approved 29 services to be offered through the Pilots in five 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

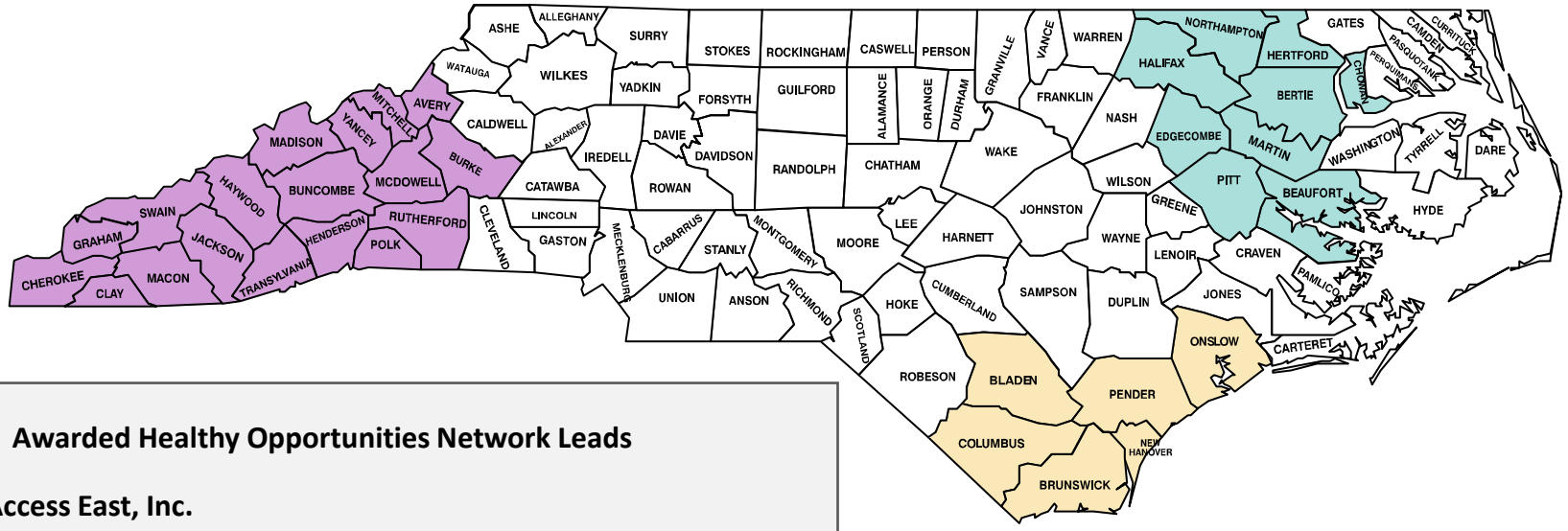
- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

Cross-Domain

- Medical respite care
- Linkages to health-related legal supports

Where Will Pilot Services Be Available?

Network Leads (NLs), PHPs, and HSOs will work with communities in three geographic areas of the state to implement the Pilots, as approved by the federal government.



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?

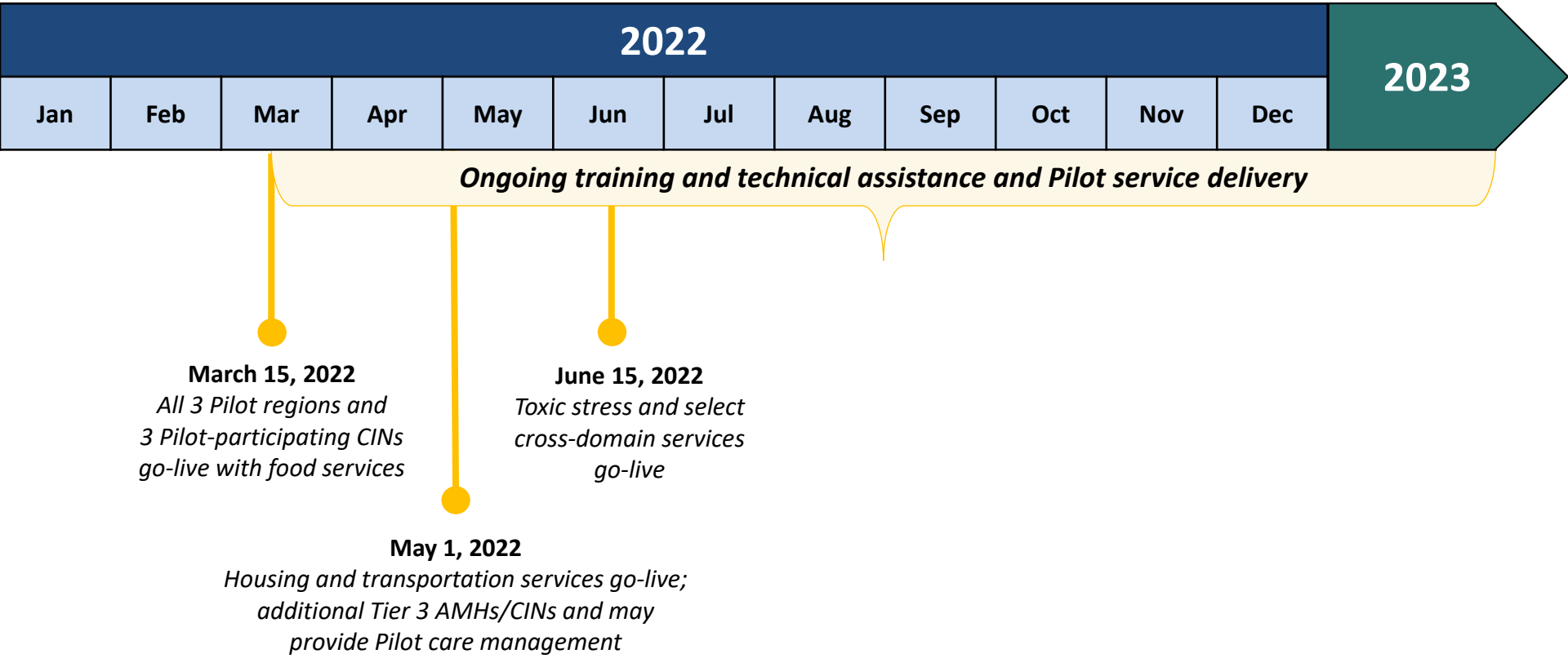
NCCARE360 is a statewide resource and referral platform that allows key stakeholders to connect individuals with needed community resources.

- **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 teams will continue to receive technical assistance and training on NCCARE360 post Pilot launch.

When Will Pilot Services Be Available?

Pilot services will launch in a 'phased approach' beginning March 15, 2022.* The Department will provide training to Pilot entities, including care management teams, to prepare them for successful participation in the Healthy Opportunities Pilots. Training will also extend beyond the start of service delivery.



*Launch date of Pilot IPV and select cross-domain services is TBD

Pilot Care Management Team Responsibilities

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	***PHP Role:*** *The PHP reviews the PESA in NCCARE360 to determine eligibility, authorize services and document Pilot enrollment and notifies AMH Tier 3 practice 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 teams can expedite referral to a limited number and duration of pre-approved Pilot services

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


QUESTIONS?

Information and contact

Recording and slides

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Appendix

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 %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	• 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