MEDICAID

Healthy Opportunities Pilot Overview

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Agenda

Overview

- Overview of Healthy Opportunities pilot (HOP)
- Member eligibility
- Phased launch approach

Roles

- Clinically integrated network (CIN)/advanced medical home (AMH) tier 3's roles and responsibilities
- Care management functions

Oversight

- Service level agreements
- Contract requirements
- Training opportunities

Touch points

- HOP CM fees
- Member attribution
- Contract updates

Healthy Opportunities pilot

Healthy Opportunities funding: The Centers for Medicare & Medicaid Services (CMS) approved up to $650 million in Medicaid funding to pilot services.

Pilot will launch in March 2022 with 33 counites in the North Carolina participating.

Pilot focus is to connect PHPs, network leads, and human service organizations (HSOs) in reducing social drivers of health (SDOHs).

Pilot is focused on testing and evaluating the impact of nonmedical interventions related to SDOHs (food insecurities, housing, transportation, and interpersonal violence) to high needs Medicaid beneficiaries.

Healthy Opportunities pilot

Network leads:

- Access East
- CCNC/CCPN
- Community Care of the Lower Cape Fear

North Carolina HOP pilot regions

Healthy Opportunities Network Leads and Regions

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

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Healthy Opportunities phased launch

March 15, 2022	• Launch service delivery in all three pilot regions • Initial launch will focus on food services only • Member enrollment only: Access East, Mission Health Partners, and CCPN
May 1, 2022	• Launch of housing and transportation services • Additional AMH tier 3s or CINs can enroll
June 15, 2022	• Launch delivery of toxic stress and cross-domain services • Blue Cross and Blue Shield of North Carolina begins *care manager* role of assessing eligibility, enrolling and recommending services for Healthy Blue members assigned to tier 1 and 2 AMHs and members assigned to tier 3 AMHs not conducting pilot care management

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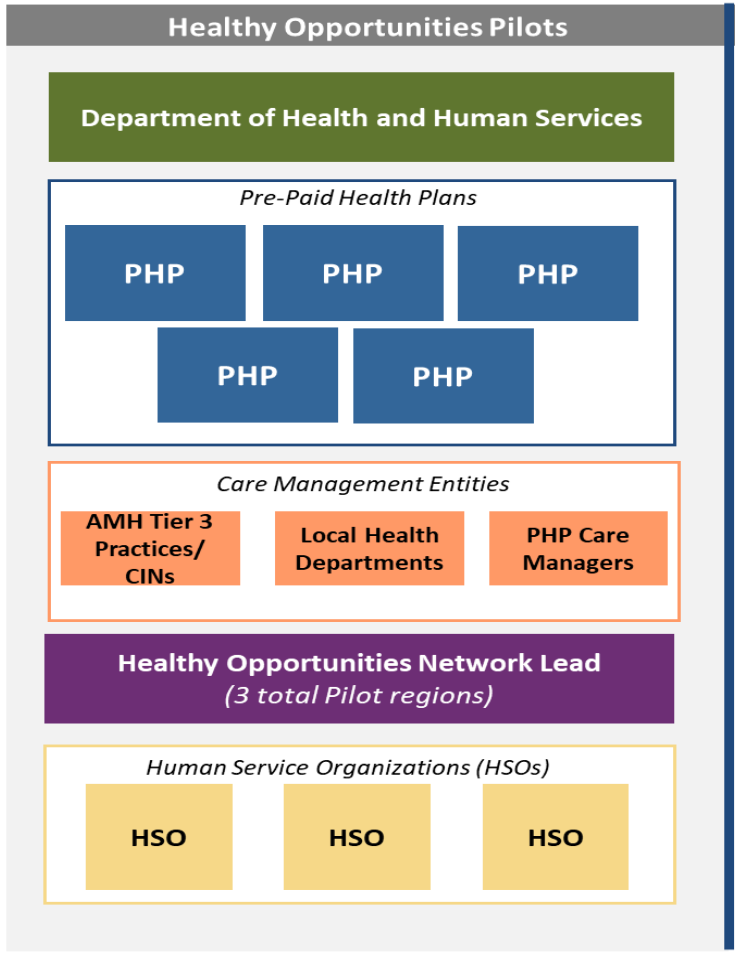
AMH tier 3 practice roles and responsibilities



Pilot Roles & Responsibilities

Department of Health and Human Services (DHHS)
- Oversees Pilot design and implementation, providing program oversight and evaluation

Prepaid Health Plans (PHP)
- Manage a Pilot budget, contract with Healthy Opportunity Network Leads, and pay HSOs for authorized Pilot services
- Maintain ultimate responsibility for determination of Pilot eligibility and service authorization of Pilot services
- Contract with designated care management entities

Care Management Entities *(AMH Tier 3s, LHDs, and PHP Care Managers)*
- Provide care management to Pilot-enrolled patients, assess for Pilot eligibility, and manage coordination of Pilot services
- AMH Tier 3 practices and LHDs enter into contractual relationships with and receive a Pilot care management payment from PHPs
- If a PHP member is not receiving care management from another entity, the PHP must provide it

Healthy Opportunities Network Leads
- Contract with PHPs to develop, oversee, and train a network of HSOs
- Provide training and technical assistance for care management entities on available Pilot services and contracted HSOs based on a patient's circumstances and care needs preferences
- Review HSO invoices, submit them to the PHP for payment, and resolve any payment disputes with the PHP on behalf of HSO

HSOs (e.g., housing agencies, diabetes prevention programs, etc.)
- Deliver authorized Pilot services to Pilot-enrolled patients
- Coordinates with care management entities as needed on Pilot-enrolled patients' progress
- Submit invoices to Healthy Opportunities Network Leads

Health screening questions

	Yes	No
Food		
Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
Within the past 12 months, did the food you bought just not last, and you didn't have money to get more?		
Housing/utilities		
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 (such as couch-surfing)?		
Are you worried about losing your housing?		
Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		

Pilot eligibility assessment: AMH tier 3 would review responses on assessment to determine if patient meets criteria.

Health screening questions (cont.)

	Yes	No
Interpersonal safety		
Do you feel physically or emotionally unsafe where you currently live?		
Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?		
Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate need		
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.		
Would you like help with any of the needs that you have identified?		

Pilot eligibility assessment: AMH tier 3 would review responses on assessment to determine if patient meets criteria.

Pilot eligible population

To qualify for pilot services, individuals must be enrolled in Medicaid managed care, 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

Physical/behavioral health-based criteria

Adults

Two or more chronic conditions:

- 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.
- Repeated incidents of emergency department use (more than four visits of either per year) or hospital admissions.

Pregnant woman

- Multifetal gestation.
- Chronic conditions likely to complicate pregnancy, including hypertension and mental illness.
- Current or recent (month prior to learning) pregnancy use of drugs or heavy alcohol.
- Adolescent less than or equal to 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, and neonatal death.

Physical/behavioral health-based criteria (cont.)

Children

0 to 20:

- 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.
- 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 needs.
- Experiencing three or more adverse childhood experiences (ACEs), or traumatic events that occur to a child before the age of 18.

Pilot social risk factors

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 do not have a steady place to live (for example, temporarily staying with others, or lives in a hotel, shelter, car, or outside), are worried about losing housing in the future, or whose housing has significant issues that affect health and wellbeing (for example, pests, mold, lack of heat, lead paint on pipes, water leaks, etc.) and/or for whom a utilities company has threatened to shut off services or has already shut off services in the home.

Food insecurity

Patients who are experiencing food insecurity, defined as disruption of food intake or eating patterns because of lack of money or other resources:

- **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.

Pilot social risk factors (cont.)

Transportation insecurity

Patients who lack reliable transportation has kept them from attending medical appointments, meetings, work, or getting things needed for daily living.

At risk of witnessing, or experiencing interpersonal violence

Patients who report that anyone, including family and friends, has physically harmed them, insulted or talked down to them, threatened them with harm, or screamed and cursed at them.

AMH Tier 3 and Clinically Integrated Network Care Management Functions

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Service level agreement

Population identification and outreach

- Support the identification of potentially pilot eligible members

Assessing pilot eligibility and recommend services

- Assess physical/behavioral and social needs

Expedited referral for pre-approved pilot services

- Expedite referral to a limited pre-approved pilot services

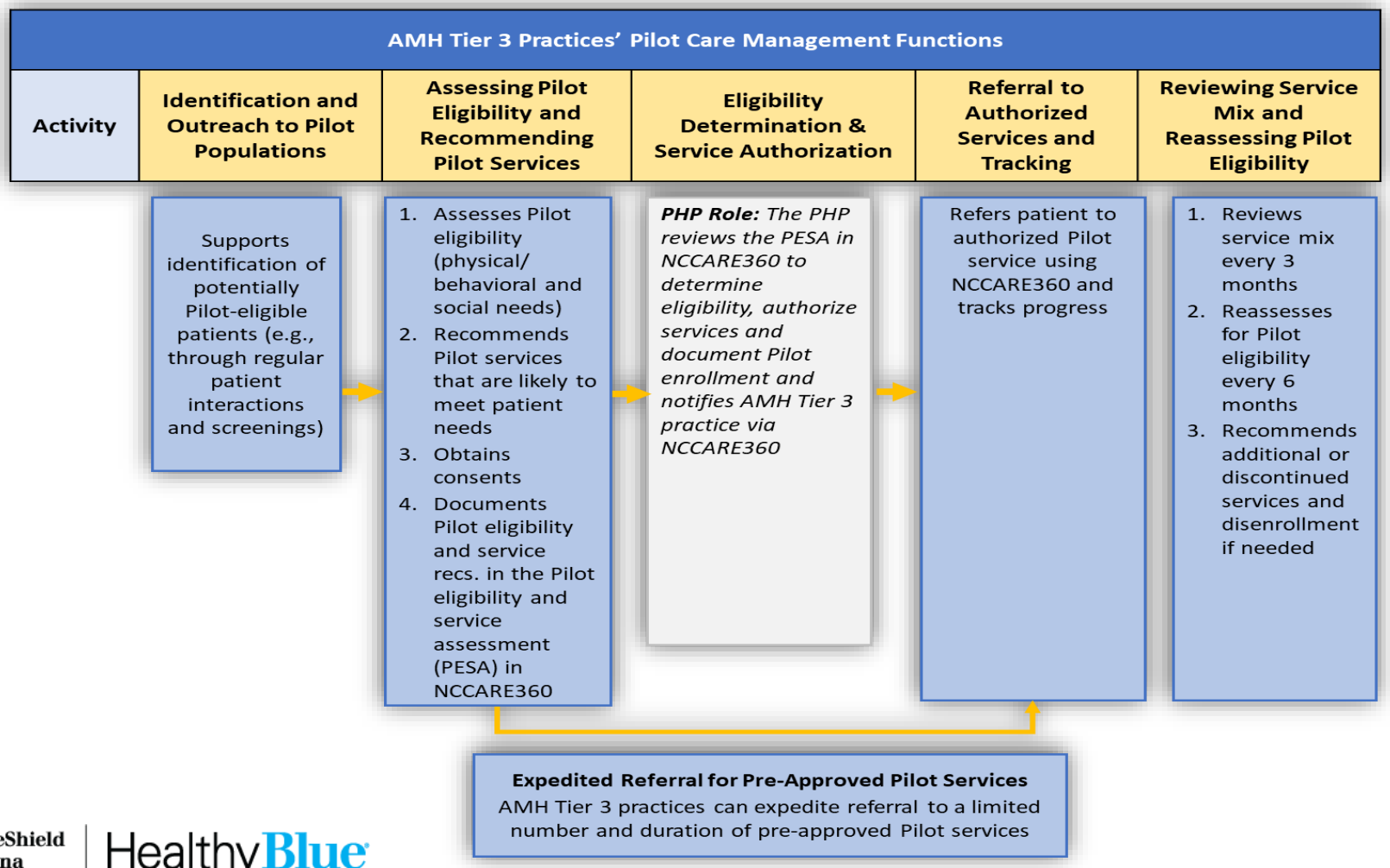
Referral to authorized services and tracking

- Refer members to authorized pilot service using NCCARE360 and track progress

Review service mix and reassess pilot eligibility

- Review service mix every three months, reassess pilot eligibility every six months

Identification and outreach to pilot populations



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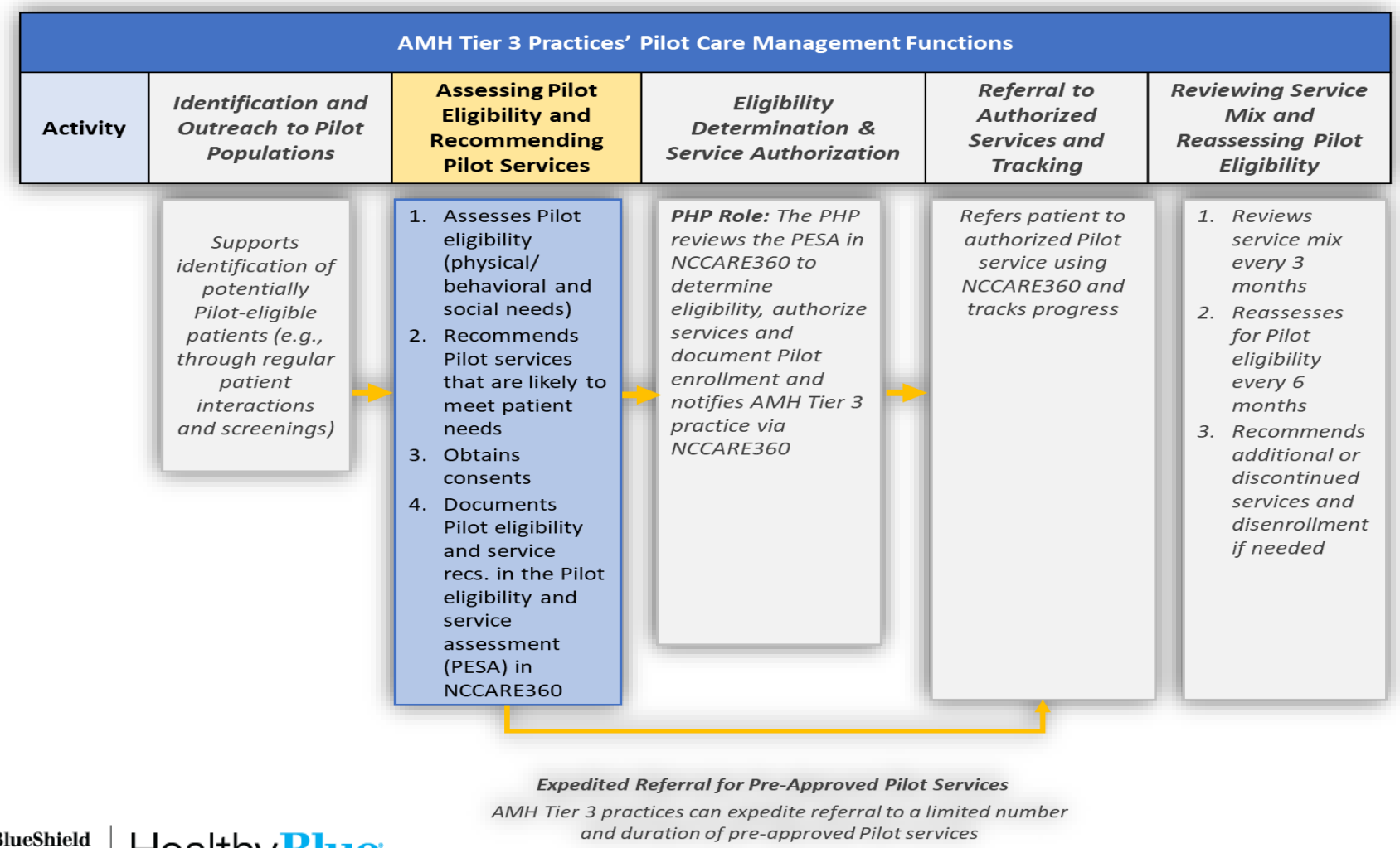
Assessing pilot eligibility and recommending pilot services



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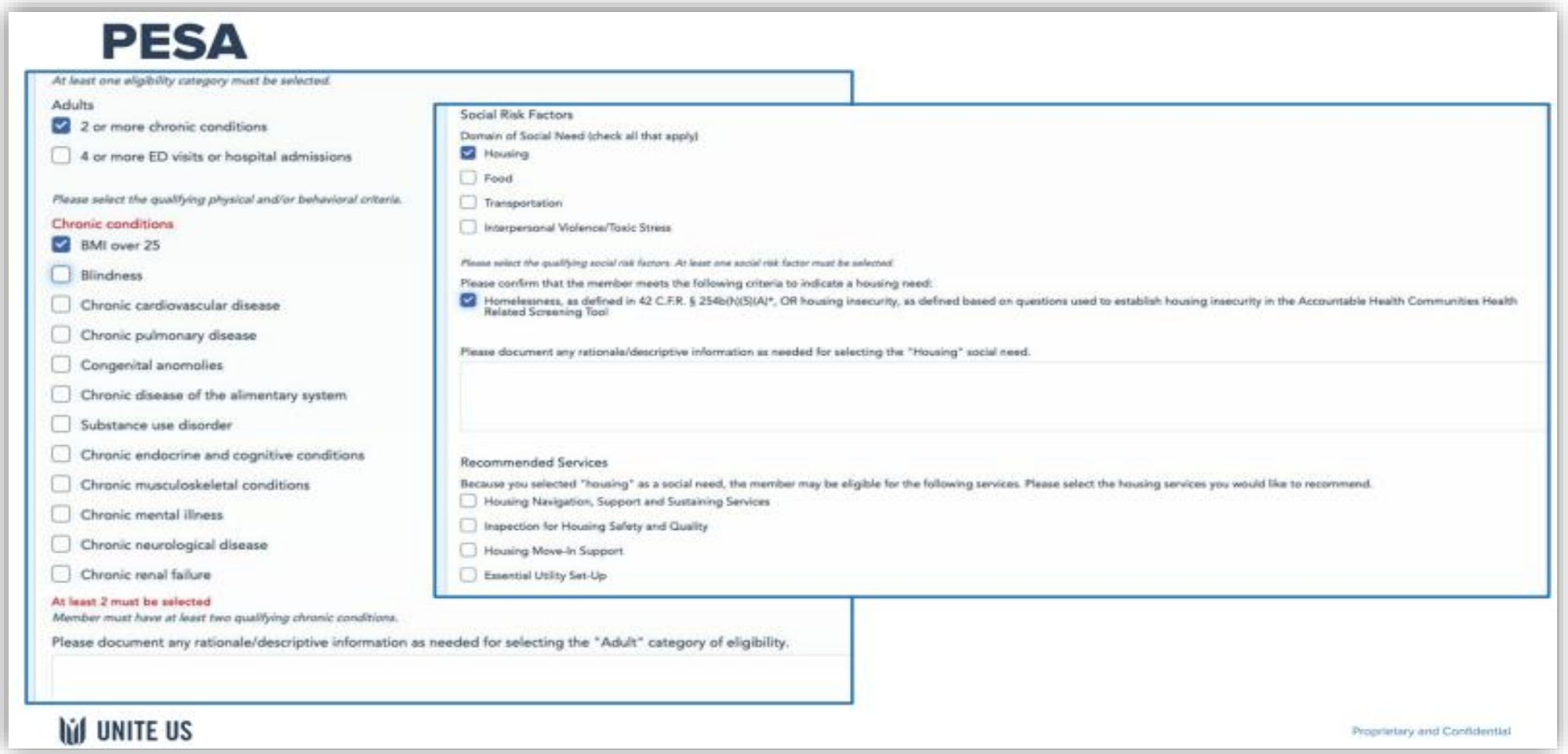
Pilot eligibility and service assessment



PESA

At least one eligibility category must be selected.

Adults

- [x] 2 or more chronic conditions
- [ ] 4 or more ED visits or hospital admissions

Please select the qualifying physical and/or behavioral criteria.

Chronic conditions

- [x] BMI over 25
- [ ] Blindness
- [ ] Chronic cardiovascular disease
- [ ] Chronic pulmonary disease
- [ ] Congenital anomolies
- [ ] Chronic disease of the alimentary system
- [ ] Substance use disorder
- [ ] Chronic endocrine and cognitive conditions
- [ ] Chronic musculoskeletal conditions
- [ ] Chronic mental illness
- [ ] Chronic neurological disease
- [ ] Chronic renal failure

At least 2 must be selected

Member must have at least two qualifying chronic conditions.

Please document any rationale/descriptive information as needed for selecting the "Adult" category of eligibility.

Social Risk Factors

Domain of Social Need (check all that apply)

- [x] Housing
- [ ] Food
- [ ] Transportation
- [ ] Interpersonal Violence/Toxic Stress

Please select the qualifying social risk factors. At least one social risk factor must be selected.

Please confirm that the member meets the following criteria to indicate a housing need:

- [x] Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A)*, OR housing insecurity, as defined based on questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool

Please document any rationale/descriptive information as needed for selecting the "Housing" social need.

Recommended Services

Because you selected "housing" as a social need, the member may be eligible for the following services. Please select the housing services you would like to recommend.

- [ ] Housing Navigation, Support and Sustaining Services
- [ ] Inspection for Housing Safety and Quality
- [ ] Housing Move-In Support
- [ ] Essential Utility Set-Up

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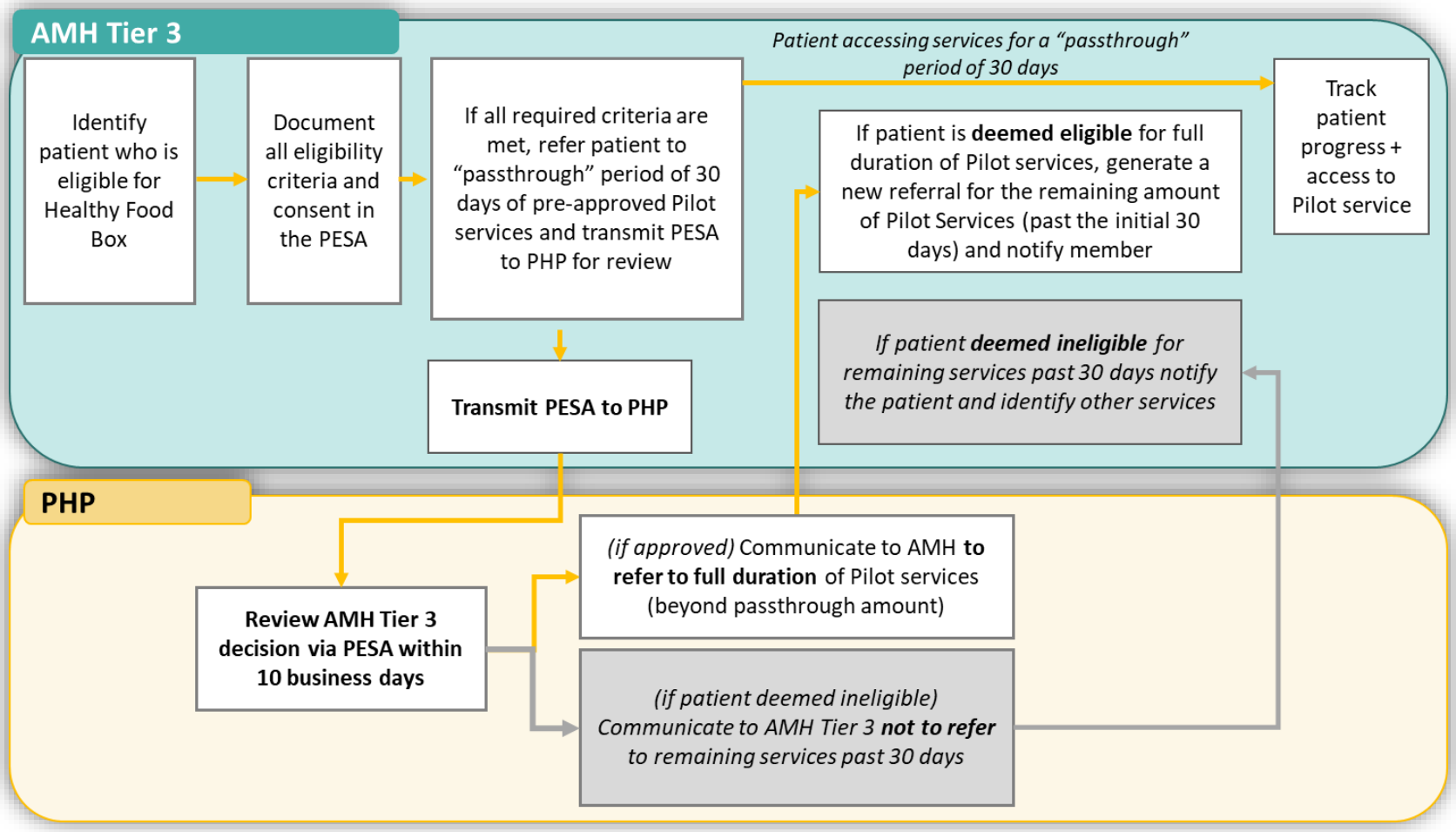
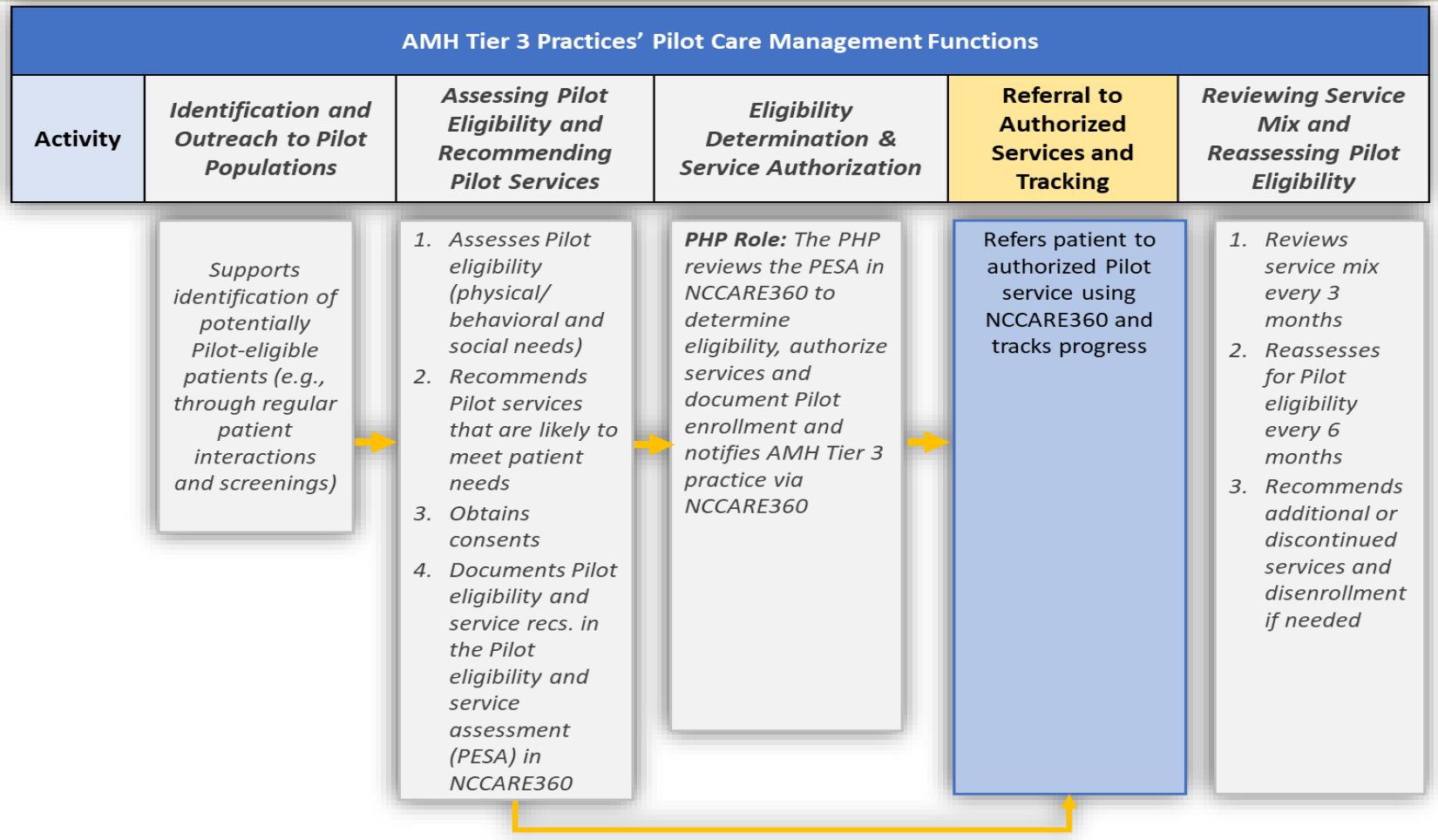
Proprietary and Confidential

Expedited referrals for pre-approved pilot services



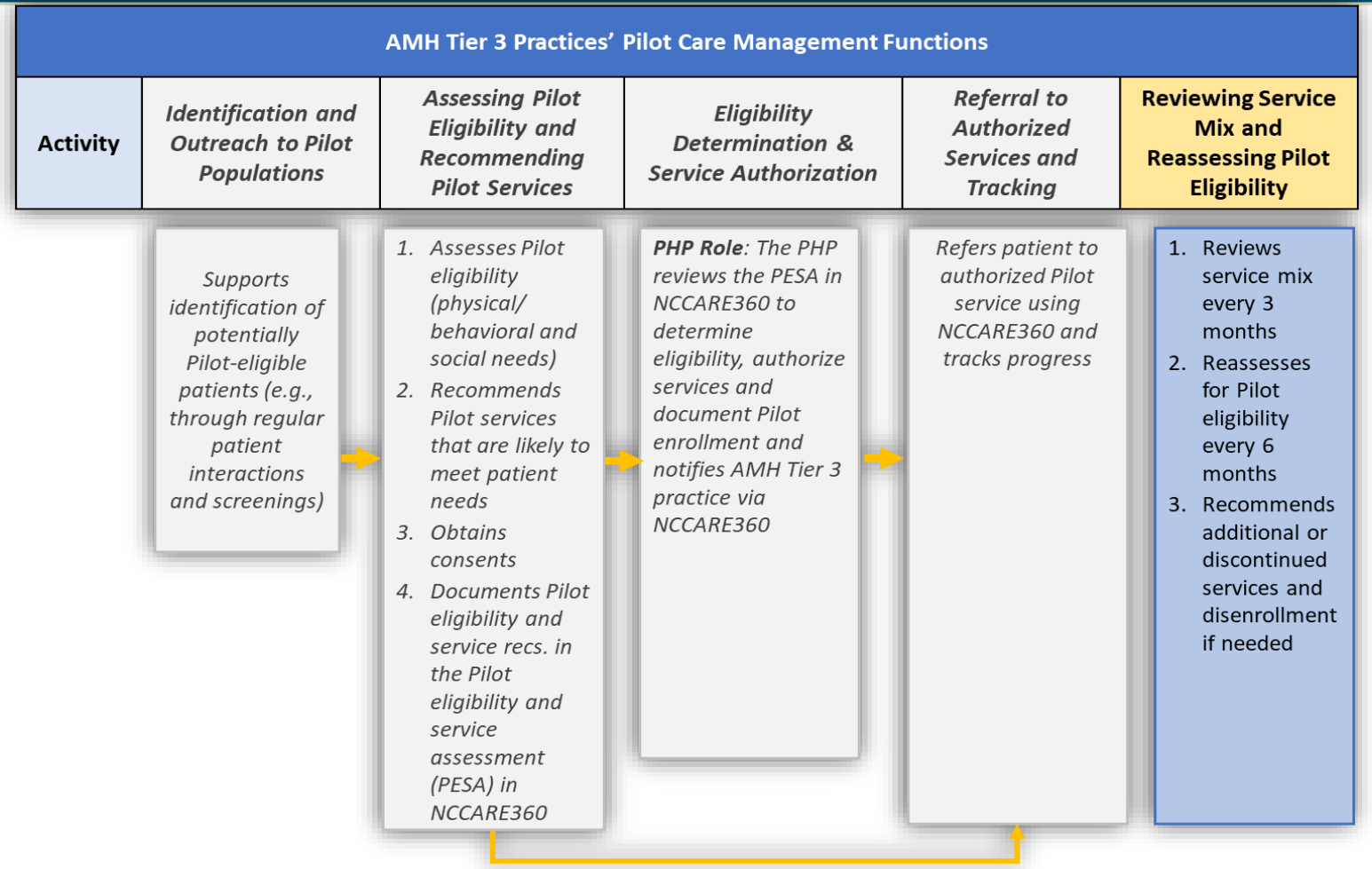
Referral to authorized services and tracking



Expedited Referral for Pre-Approved Pilot Services

AMH Tier 3 practices can expedite referral to a limited number and duration of pre-approved Pilot services

Reviewing service mix and reassessing pilot eligibility



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Expedited Referral for Pre-Approved Pilot Services

AMH Tier 3 practices can expedite referral to a limited number and duration of pre-approved Pilot services

Disenrollment, discontinuation, and transitioning PHPs

Disenrollment

- Instances where a patient is no longer eligible to participate and should no longer receive pilot services

Discontinuation

- Refers to instances when an authorized pilot service should be stopped.
- Does not necessarily mean the individual is ineligible to receive other or modified amounts/intensity of existing pilot services.

Disenrollment, discontinuation, and transitioning PHPs (cont.)

Transitioning

- Coordinate timely warm hand off or transfer between AMH3 and PHP.
- Promote proactive communication.
- Establish a follow up protocol.
- Work with HSO and former PHP.
- Use NCCARE360 functionality.
- Ensure members are reassessed.
- In the case that referral was accepted by HSO:
  - AMH Tier 3 must close the case.
- For services accepted but not started:
  - AMH Tier 3 must contact HSO to close case for pilot service.

NCCARE360

NCCARE360* is the first statewide coordinated care network to electronically connect those with identified needs to community resources and allows for a feedback loop on the outcome of the connection.

Directory	A robust statewide resource directory that will include a call center with dedicated navigators, a data team verifying resources and text and chat capabilities.
Data repository	A data repository to integrate resource directories across the state to share resource data.
Shared technology	A shared technology platform that enables healthcare and human service providers to send and receive secure electronic referrals, seamlessly communicate in real-time, securely share client information and track outcomes.
Statewide network	A community engagement team working with community-based organizations, social service agencies, health systems, independent providers and more to create a statewide coordinated care network.
NCCare360 cost	The department will cover the cost of NCCARE360 use for Medicaid members for pilot related functionalities. UniteUs will provide training.

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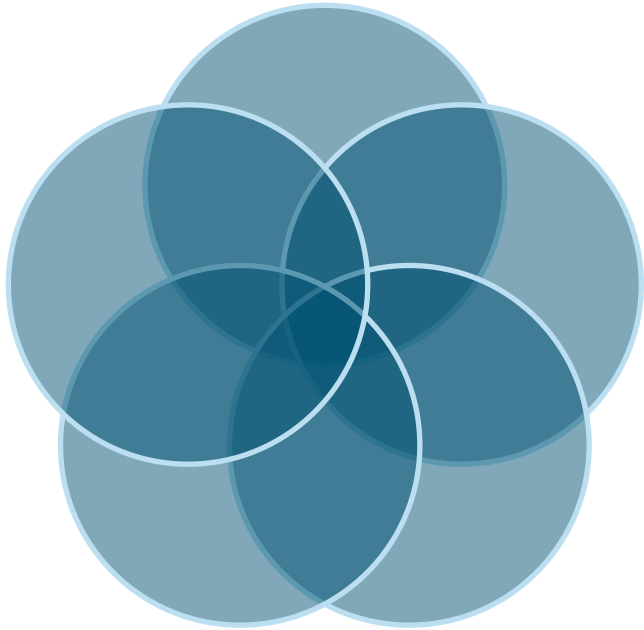
Training and assistance

AMH tier 3s are expected to participate in all pilot-related training and convenings held by:

- **UniteUs**
- **Network leads**
- **The department**

Solicit information about barriers and best practices

Department will hold learning collaboratives designed to share best practices



Identify areas of where training and/or technical assistance may be needed

Strengthen relationships between pilot-participating entities

Review pilot-related policies and procedures

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Training and technical assistance

Network Leads will provide trainings to AMH tier 3s on available pilot services and appropriate contracted HSOs based on a patient's circumstances and care needs preferences.

Address issues related to pilot services and HSO availability/accessibility

Support AMH tier 3 practices' understanding of and familiarity with contracted HSOs and pilot services

Support AMH tier 3 practices ability to refer patients to contracted HSOs

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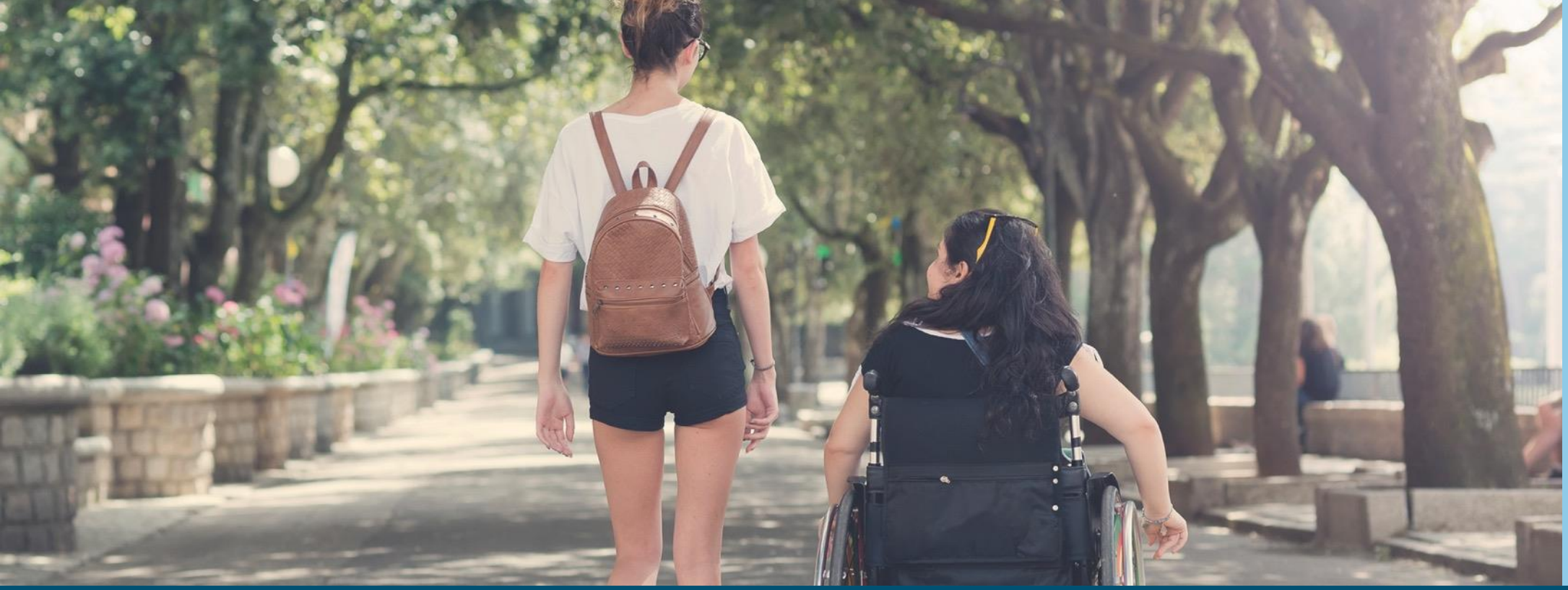
Monitoring and oversight

PHPs will be responsible for oversight and monitoring AMH tier 3 compliance with pilot responsibilities.

Under the existing AMH tier 3 program, PHPs will continue to monitor for compliance of each contracted AMH tier 3.

An individual AMH tier 3 may be discontinued by PHP if found ineligible for pilot or if pilot runs out of funds.



Healthy Opportunities

Payment and member attribution

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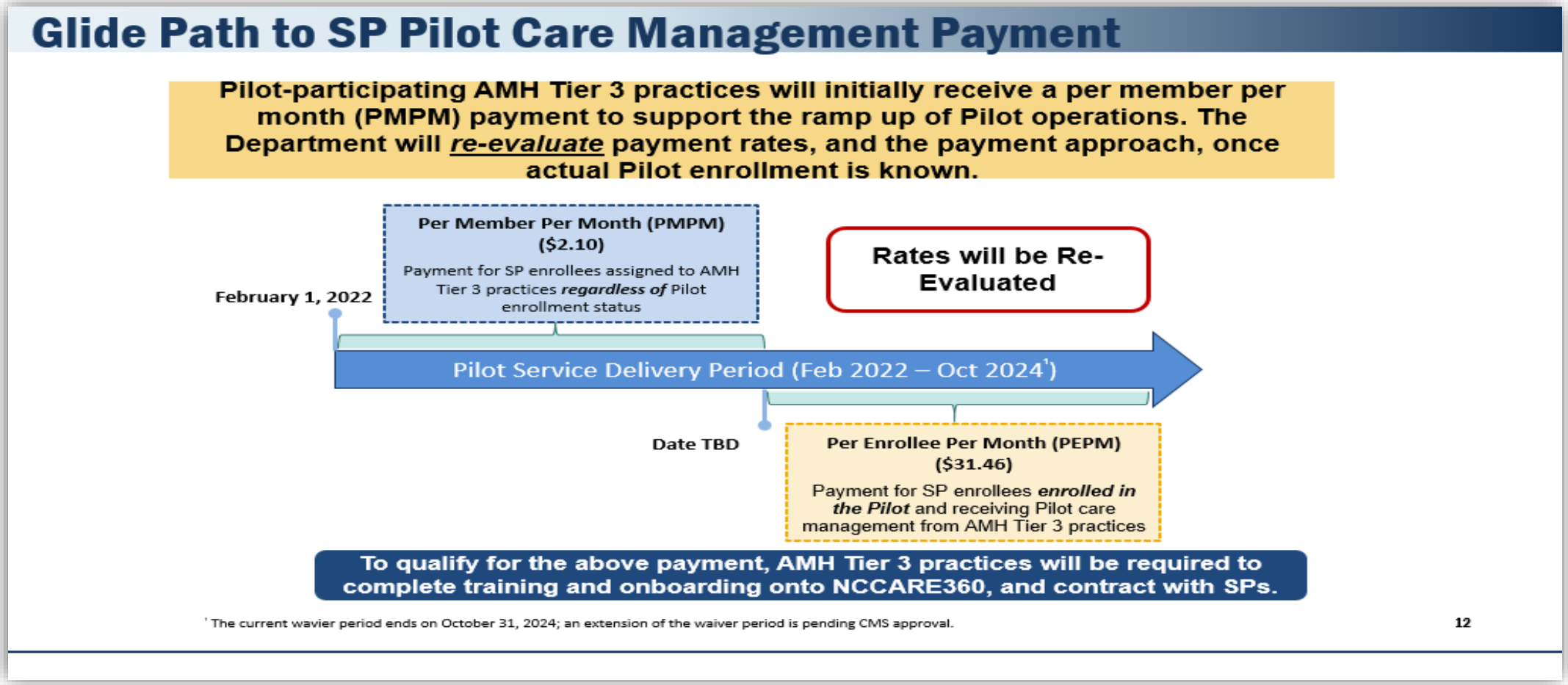
Healthy Opportunities care management payments



Human Service Organizations

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Human service organization delivery services

HSOs will deliver a range of services to address SDOHs such as:

Housing assistance	• Prepare enrollee for stable, long-term housing • Tenancy sustaining services • Home accessibility and safety modifications
Food services	• Healthy food box (pick-up/ home delivery) • Healthy meal (pick-up/home delivery) • Evidence-based group nutrition classes
Transportation	• Transportation for non-medical services (grocery store, job interviews, places of worship) • Reimbursement for health-related private transportation
Interpersonal violence	• Linkages to legal services for interpersonal violence • Services to help leave violent environments, connect with behavioral health resources • Violence intervention services (peer support specialists)

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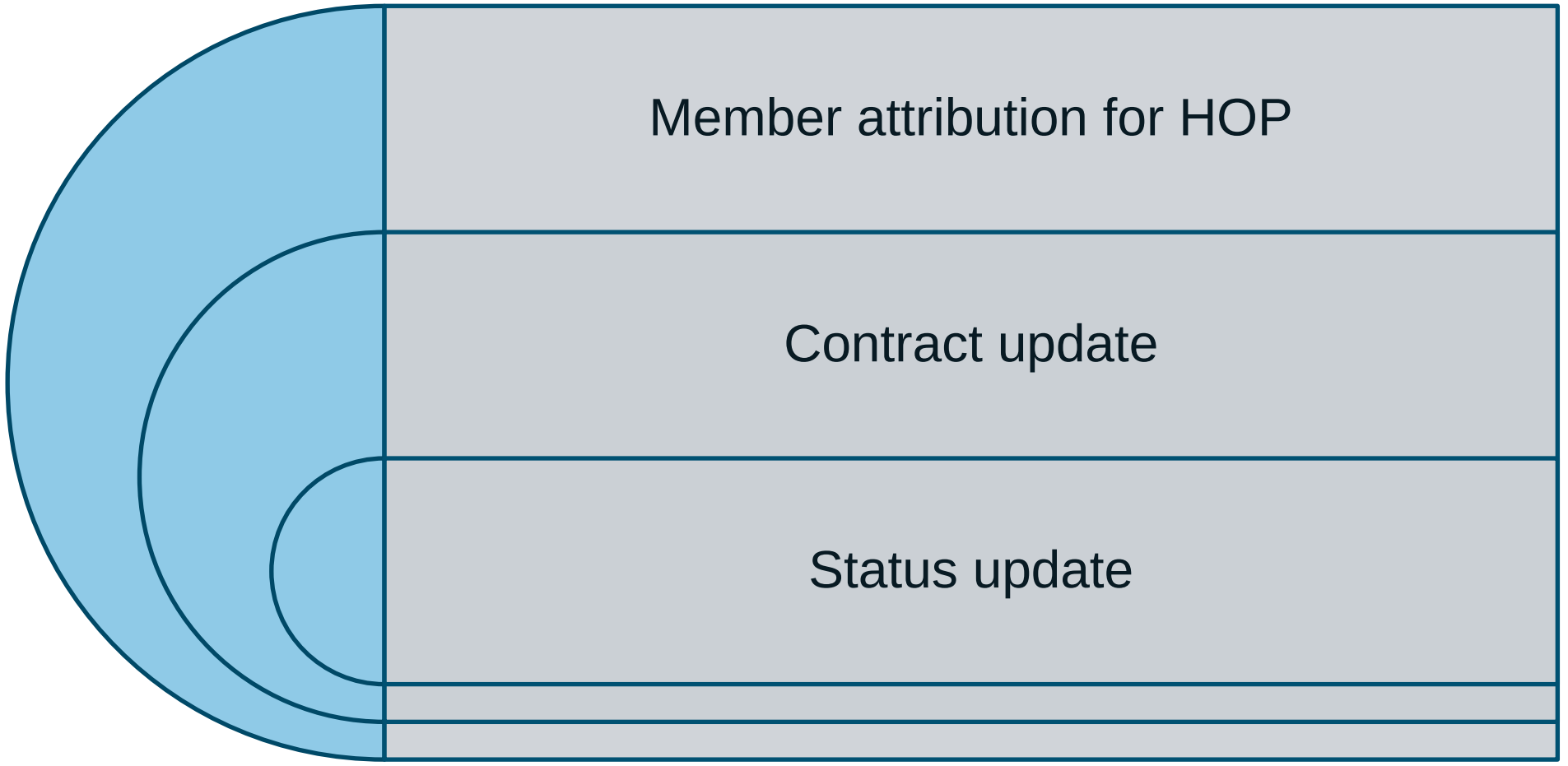
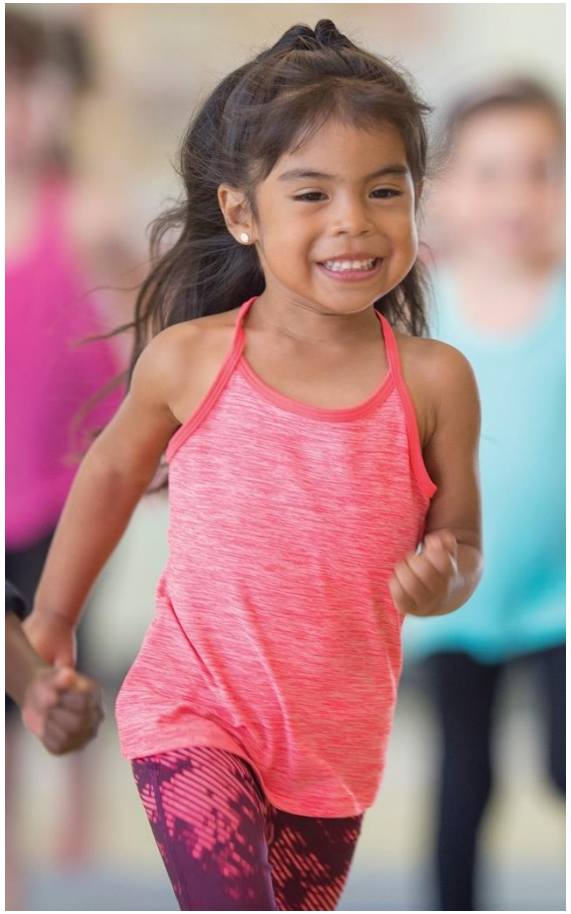
Member attribution



Want to learn more?



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