Healthy Opportunities Update

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NCCOMeT, NCDHHS Healthy Opportunities Update

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Why Focus on Healthy Opportunities?

"Healthy Opportunities," commonly referred to as the social determinants of health, are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- 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.
- Addressing the factors that directly impact health is a key component of meeting DHHS's mission to improve the health, safety and well-being of all North Carolinians while being good stewards of resources.

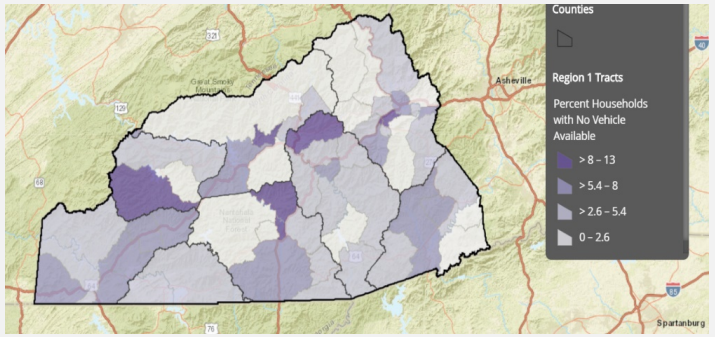
North Carolina's Healthy Opportunities Priority Domains

Unmet Health-Related Needs in North Carolina

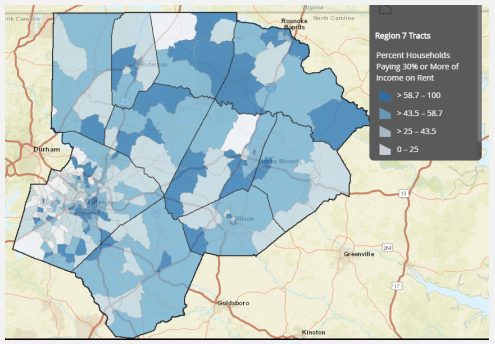
Citizens of North Carolina grapple with the impact of unmet health-related social needs every day.

- Over 1.2 million North Carolinians cannot find **affordable housing**, and one in 28 of the state's children under age six is homeless.
- NC has the 8th highest rate of **food insecurity** in the US, with more than one in five children living in food insecure households.
- 47% of NC women have experienced **intimate partner violence.**
- Nearly 25% of NC children have experienced **adverse childhood experiences** (ACEs),
- On average 7% of the state population do not have access to a vehicle and report that **lack of transportation** causes them to delay their medical care.

Percent of Households Without Access to a Vehicle



Percent of Households Pay >30% Income on Rent



NC DHHS Healthy Opportunities Initiatives

NC DHHS has built shared assets that can be used across populations, as well as targeted initiatives to build the SDOH evidence base.

Shared assets and infrastructure across populations:

- SDOH "Hot Spot" Map
- Standardized SDOH screening questions
- NCCARE360
- Workforce development
- COVID-19 Isolation and Quarantine Supports

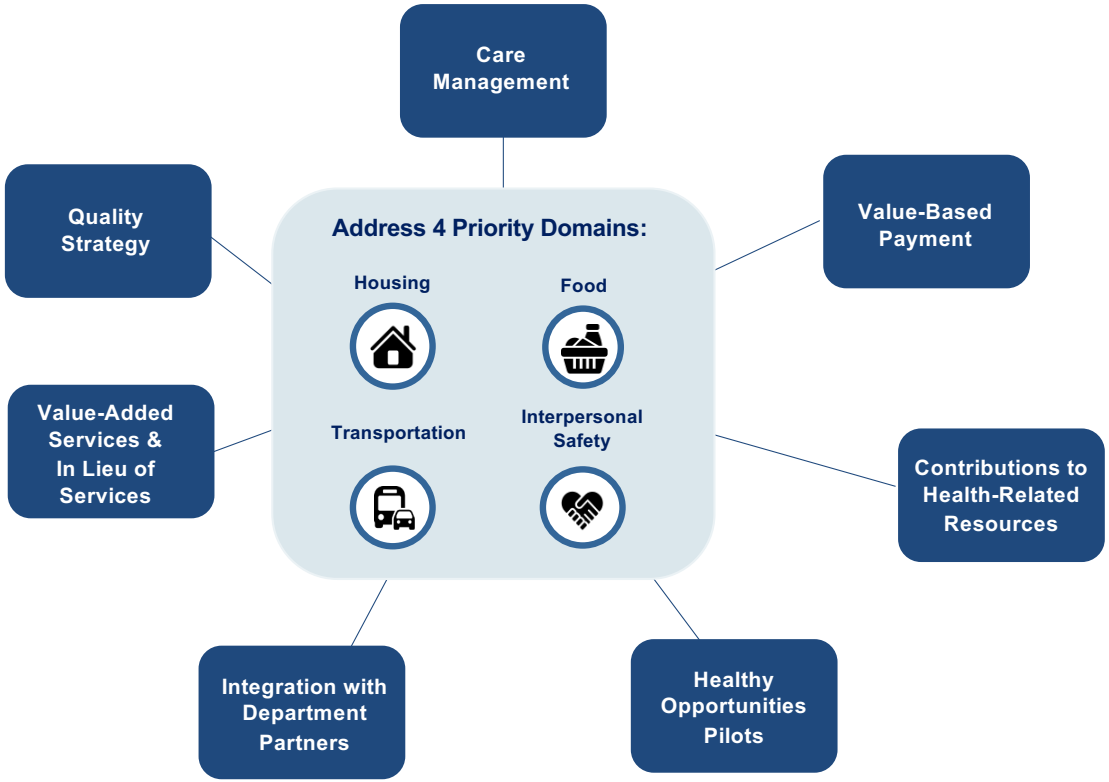
Cross-divisional work within DHHS and work with external health and human service partners

Medicaid Enrollees | Medicare Enrollees | Commercially-Insured | Uninsured

- **Embed assets and infrastructure in Medicaid** as a base for other payers and initiatives to build on
- **Targeted initiatives to develop evidence base:** Healthy Opportunities Pilots

Today's Focus

Healthy Opportunities Embedded into Medicaid Managed Care



Healthy Opportunities in Managed Care: Key Updates

- **Standard Plan Launch:**
  - **Screening:** PHPs will conduct Care Needs Screenings on new members within 90 days of enrollment; Care Needs Screenings include the Department's standardized Healthy Opportunities screening questions.
  - **Referral*:***
    - PHPs are expected to begin using NCCARE360 to refer members to organizations that can address their social needs beginning at managed care launch.
    - Using NCCARE360 will be encouraged but optional for delegated care management entities (e.g. Tier 3 AMHs, CINs, LHDs) at managed launch. DHHS and Unite Us will be working with CINs, Tier 3 AMHs, and LHDs to onboard them to NCCARE360 throughout CY 2021.
  - **Value-Added Services and In-Lieu-of Services:** All PHPs incorporating Healthy Opportunities into Value-Added Services and some incorporating them into In-Lieu-of Services.
  - **Community Investment:** PHPs will be incentivized to voluntarily contribute to health-related resources in the community.

- **Healthy Opportunities Screening and Referral Payment:**
  - Carolina Access II providers may temporarily receive reimbursement for positive Healthy Opportunities screenings conducted using the DHHS standard screening questions or an equivalent instrument. Use of NCCARE360 and z-codes encouraged but not required.
  - Reimbursement is time-limited and effective January 1, 2021 through June 30, 2021. Coverage of this code after managed care launch will be at the discretion of the health plans.

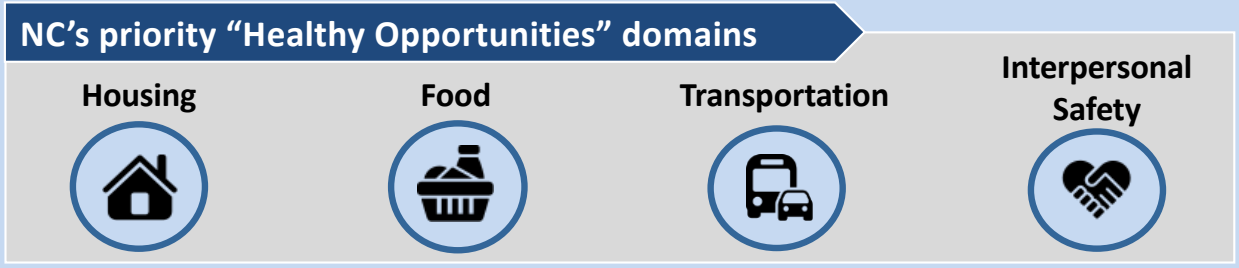
- **NCCARE360 Onboarding Updates:**
  - Statewide rollout of community-based organizations
  - LME-MCOs:
    - Cardinal, Eastpointe, Trillium, and Vaya are live
    - Partners, Sandhills, and Alliance to be live by end of March
  - Continue to onboard PHPs and health systems

Healthy Opportunities Pilots

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

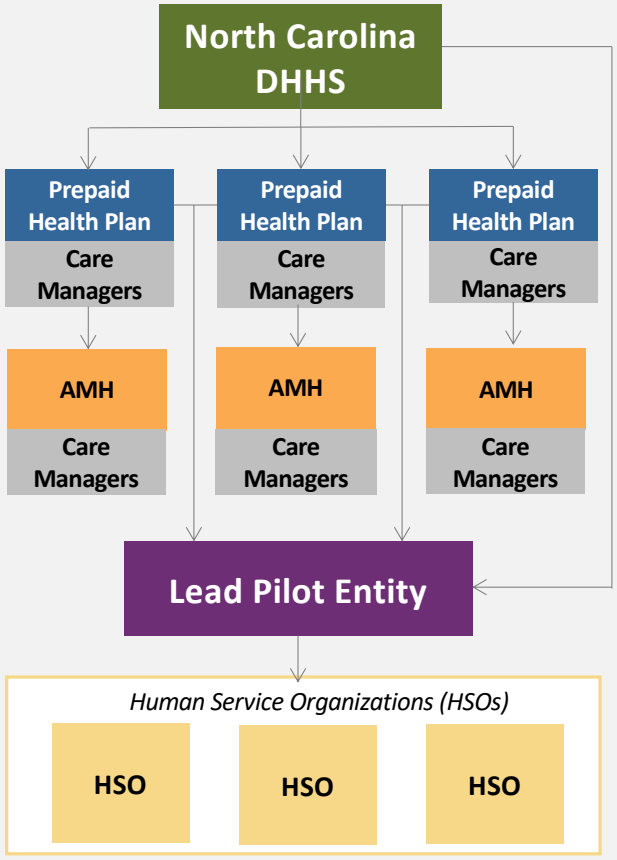
Pilot funds will be used to:

- **Cover the cost of federally-approved Pilot services**
  - *NC DHHS has developed service definitions and a fee schedule to reimburse entities that deliver these non-clinical services*
  - *The fee schedule will promote value and increasingly link payment to outcomes*
- **Support capacity building to establish "Lead Pilot Entities" and strengthen the ability of human service organizations (HSOs) to deliver Pilot services**
  - *NC DHHS will procure up to three Lead Pilot Entities with deep roots in their community that can facilitate collaboration across the healthcare and human service providers through building partnerships.*



How Will the Pilots Work?

Sample Local Pilot



Key Entities' Roles in the Pilots

- **PHPs:**
  - Manage a Pilot budget
  - Approve member eligibility for Pilot services
  - Ensure the provision of care management to members
  - Ensure individuals are enrolled in other federal/ state programs if eligible (e.g. SNAP and TANF)
  - Pay HSOs for pilot services delivered
- **Care Managers:**
  - Interface with members to conduct care management at PHPs, Tier 3 AMHs, AMH+s, LHDs, and CMEs/CMAs
  - Assess beneficiary eligibility for Pilot services (approved by PHP); track member progress
- **Lead Pilot Entities:**
  - Competitively procured by NC DHHS (define the geographic region they serve)
  - Develop, manage, and oversee a network of HSOs
  - Provide technical assistance to HSOs; convene Pilot entities to share best practices
  - Collect and report data to NC DHHS to assist in evaluation and oversight
- **Human Service Organizations:**
  - Frontline social service providers that contract with the LPE to deliver Pilot services to Pilot enrollees
  - Submit invoices and receive reimbursement for services delivered

Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must have:

At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children 0-21 (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

What Services Can Members Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot.

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals
- Medically tailored meal delivery

Transportation

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

Interpersonal Safety

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

Pilot Evaluation

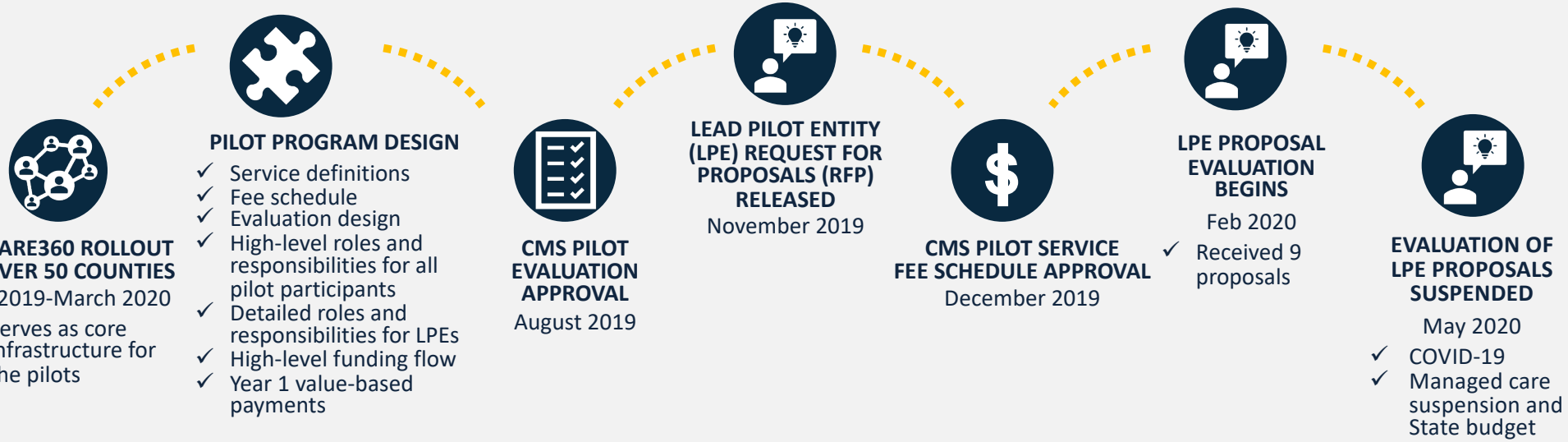
Hypotheses Tested:

- Lead Pilot Entities will enable **effective delivery of Pilot services**
- The Pilot program will increase rates of Medicaid enrollees **screened** for social risk factors and **connected to** services that address these risk factors
- The Pilot program **will improve the qualifying social risk factors, health outcomes, healthcare utilization, and healthcare costs of participants** (overall and by sub-populations)

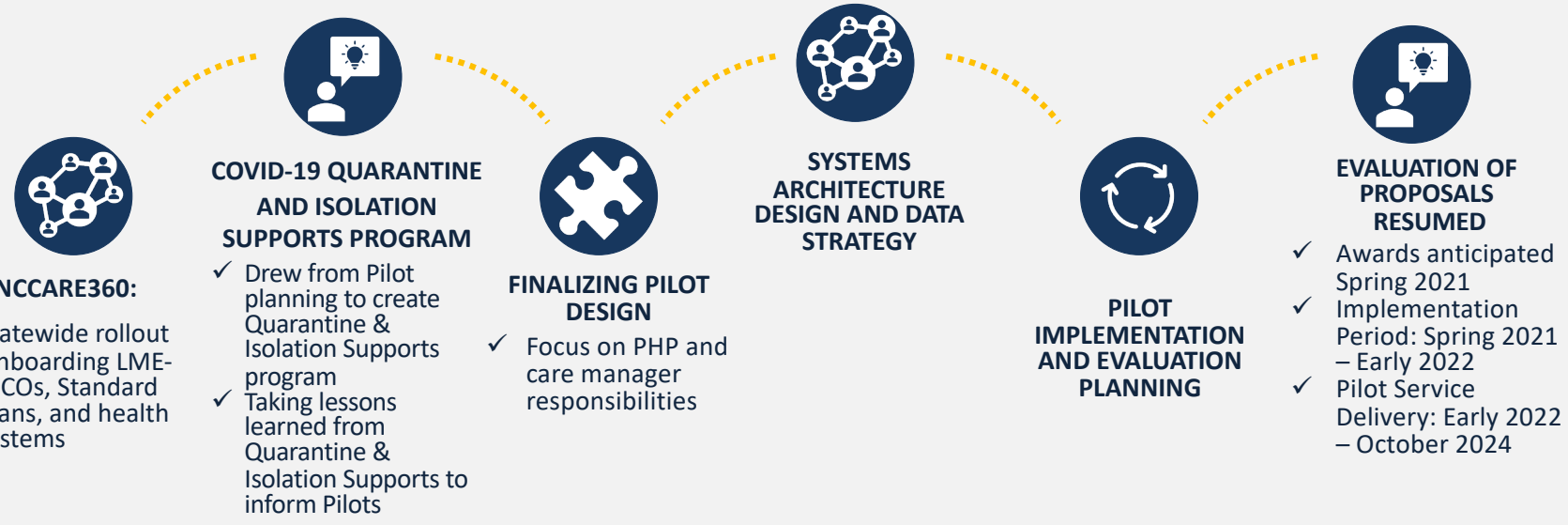
Evaluation Phases:

- **Rapid cycle assessments** culminating in an interim evaluation To enable real-time learning and to adapt pilot interventions based on these learnings
  - Comparisons made within intervention recipients, before and after they receive intervention, using interrupted time series designs
- **Summative Evaluation**
  - To test the effectiveness of the 'final' pilot interventions
  - **Randomization** of higher-intensity services (SMART design)
  - Within-participant comparison (enabled by adaptive randomized design) and comparison of pilot regions to other regions in NC (difference-in-difference analysis)

Context Setting: Key Pilot Accomplishments Prior to COVID-19



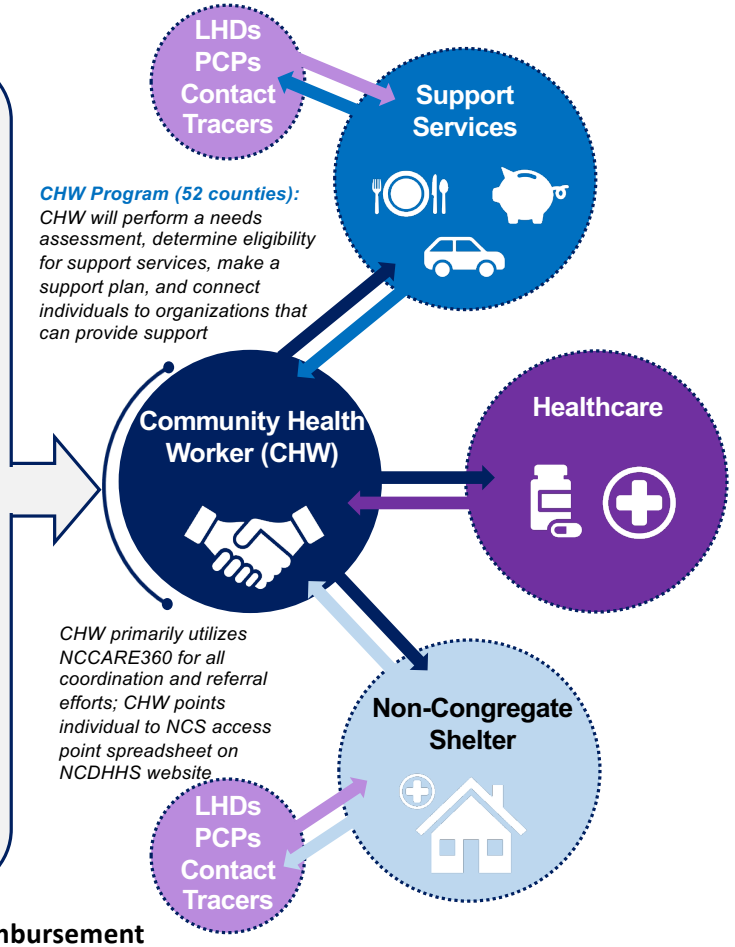
Context Setting: Key Pilot Accomplishments During Suspension and Since Restart



COVID-19 Quarantine and Isolation Supports

Individual need is identified in a variety of ways ("No Wrong Door"):

- individual tests positive for COVID-19 and receives instructions from the testing center
- individual is contacted by a Contact Tracer about possible COVID-19 exposure/next steps
- individual reaches out to their Local Health Department about COVID-19 needs
- individual is referred to Q&I supports by their doctor/nurse
- individual has recommendation to isolate as a high-risk individual
- individual is a first-responder or frontline healthcare worker
- individual sees information online and believes they might qualify for services
- individual is waiting on test results to come in



Support Services Program (29 counties): Innovative new program to assist individuals in targeted counties who need access to primary medical care and supports such as food or a relief payment to successfully quarantine or isolate due to COVID-19:

1. **Nutrition assistance**, including home-delivered meals and food boxes
2. **A one-time COVID-19 relief payment** to help supplement lost wages or the inability to look for work while in isolation/quarantine and to be used on basic living expenses
3. **Private transportation** provided in a safe manner to/from testing sites, medical visits, and sites to acquire food
4. **Medication delivery**
5. **COVID-related over-the-counter supplies**, such face masks, hand sanitizers, thermometers, and cleaning supplies
6. **Access to primary medical care** to manage COVID recovery will also be provided through telehealth services through Community Health Workers (CHWs).

Non-Congregate Shelter Program (statewide): Collaborative effort between the State, counties and local partners to secure **non-congregate shelter** for individuals with no other safe place to quarantine, isolate, or social distance due to COVID-19.

2 options for reimbursement:
1. Local partners desiring state-centric coverage through NCEM (required MOA)
2. Local partners seeking direct reimbursement from FEMA

Braided CARES Act funding, State dollars, & FEMA reimbursement

Key Lessons Learned from COVID-19 Quarantine & Isolation Supports Program

- **Capacity of vendors is extremely important**
  - Cash reserves and need for up-front funding
  - Staff capacity or partnerships
  - Experience with technology, data monitoring, and reporting

- **Relationships with community members and organizations is key**
  - Trusted members of the community and trusted local organizations were vital in reaching NC residents
  - Existing partnerships enabled the program to launch and scale quickly

- **Need for technical assistance and learning collaboratives**
  - High need for in-depth, one-on-one technical assistance and training as well as collaborative forums for vendors to share experiences, issues, and lessons learned

- **Need for the Department to be nimble, iterative, and collaborative**
  - Focus on speed and simplicity
  - Iterated regularly in response to real-time learnings
  - Cross-divisional effort (Division of Social Services, Medicaid, Office of Rural Health, Office of Healthy Opportunities)
  - Turning design into reality

- **Status**
  - Obtained additional funding to continue the program past December
  - Winding down in February but exploring additional paths to continue a modified program

Contact Information

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