Fact Sheet
Healthy Opportunities Pilot Program

County Playbook: NC Medicaid Managed Care

As part of NC Medicaid Managed Care, the Centers for Medicare & Medicaid Services (CMS) authorized state and federal Medicaid funding for the North Carolina Department of Health and Human Services (NCDHHS) to test the impact of providing select non-medical, evidence-based interventions that address needs in housing, food, transportation and interpersonal safety for high-risk members. This is known as the **Healthy Opportunities Pilot** program.

The Healthy Opportunities Pilot program will allow NCDHHS to leverage findings to integrate interventions that improve health outcomes into the Medicaid program statewide. Healthy Opportunities Pilot program launch will follow a phased approach.

PILOT SERVICES

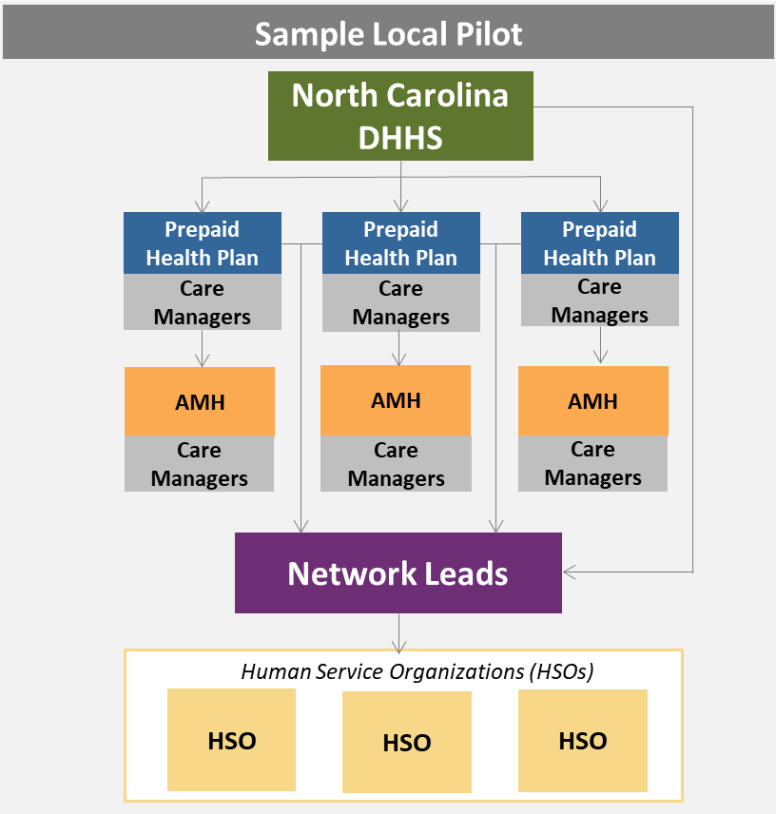
The Healthy Opportunities Pilot program will cover a select set of services that address housing, food, transportation and interpersonal safety for NC Medicaid Managed Care members who meet specific criteria. Please refer to the Pilot Service Fee Schedule for a full list of services. Services will launch as follows:

- **March 15: 2022:** Food services
- **May 1, 2022:** Housing and transportation services
- **June 15, 2022:** Interpersonal safety and cross-domain services*. Delivery of some interpersonal safety, toxic stress and cross-domain services may begin after June 15, 2022, as the Department continues to evaluate potential program modifications to account for legal and data privacy issues related to sensitive services.

Food	Housing	Transportation	Interpersonal Safety	Cross-Domain
• Linkages to community-based food resources • Nutrition and cooking education • Fruit and vegetable prescriptions • Healthy food boxes/meals	• Housing navigation and support • Housing quality and safety inspections and improvements • One-time payment for security deposit	• Linkages to existing transportation resources • Payment for non-medical transportation, such as trips to grocery stores and job interviews	• Case management and advocacy for victims of violence • Evidence-based parenting support programs • Evidence-based home visiting services	• Holistic high-intensity enhanced case management • Medical respite • Linkages to health-related legal supports

*Cross-domain services cut across more two or more domains (service categories) to deliver holistic care.

PILOT ORGANIZATION STRUCTURE



AMH: Advanced Medical Home

Prepaid Health Plans (PHPs):

- Approve member eligibility for services and authorize services
- Ensure members receive care management and are enrolled in other federal or state programs if eligible (e.g., WIC)
- Educate members about pilot services

Care Managers:

- Assess beneficiary eligibility for pilot services (approved by PHP)
- Track member progress and evaluate ongoing needs
- Refer members to Human Service Organizations (HSOs)

Network Leads:

- Establish, manage and oversee a network of HSOs, ensuring the delivery of high-quality services to members
- Provide technical assistance and conduct quality improvement activities with HSOs
- Collect and submit data to support NCDHHS' evaluation and oversight of the program

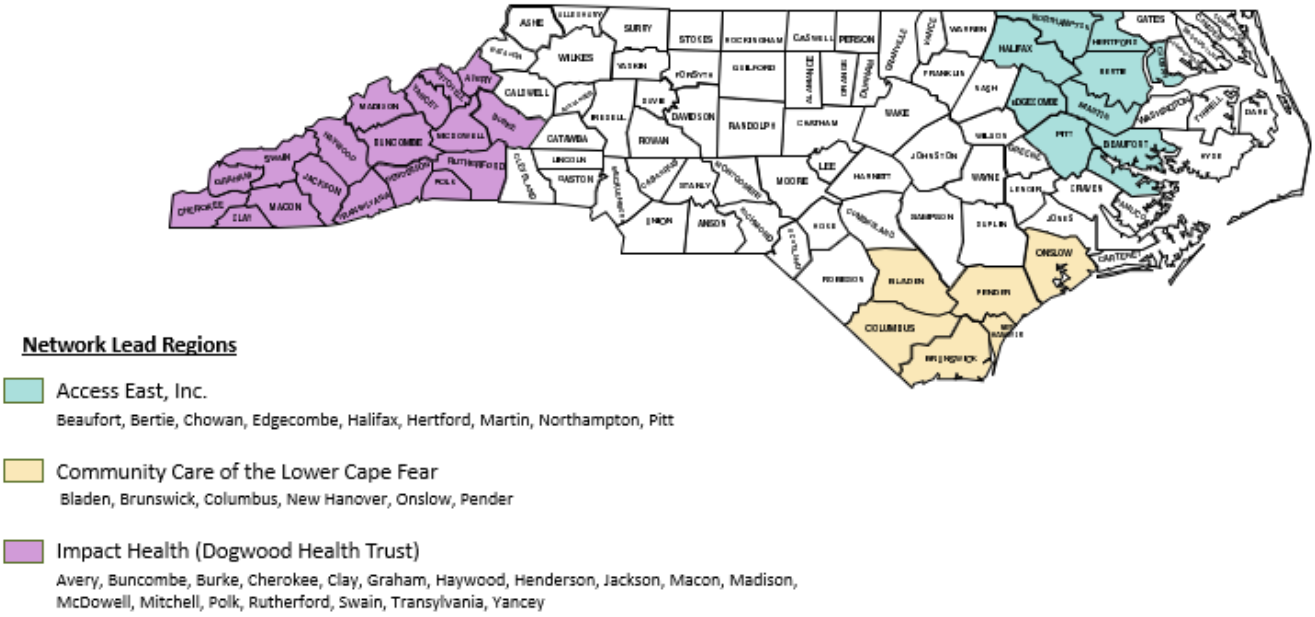
Human Service Organizations (HSOs):

- Social service providers who contract with Network Leads to deliver services to members
- Submit invoices and receive reimbursement for services delivered

PILOT REGIONS

The following organizations will operate as Network Leads and serve three regions, two in eastern North Carolina and one in western North Carolina.

- **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 (Dogwood Health Trust):** Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey



NETWORK LEAD HSO NETWORKS

Access East HSO Network

Community Care of the Lower Cape Fear HSO Network

Impact Health HSO Network

PILOT ENROLLMENT CRITERIA

PHPs are responsible for managing and maintaining Healthy Opportunities Pilot enrollment criteria. To qualify for and receive pilot services, members must:

- be enrolled in a PHP (Standard Plan)

- live in a pilot region (served by one of three Network Leads)

Members must also have:

- at least one qualifying physical or behavioral health condition AND
- at least one qualifying social risk factor

Please refer to the Appendix for a full list of qualifying physical/behavioral health criteria and social risk factors.

DEPARTMENT OF SOCIAL SERVICES (DSS) ROLE: SCENARIO

You receive a call from a beneficiary, Sue Jones, who is worried about having enough food to feed her family. She asks you if there are any community-based food resources available to her. Sue lives in Avery County and is enrolled in WellCare. What do you do?

- Determine whether the beneficiary receives Food and Nutrition Services (FNS) or refer the beneficiary to apply for FNS.
- Let Sue know that she may also qualify for food services through her health plan. Refer Sue to WellCare's Member Services Line or website.
- Ask Sue if she needs assistance with any other questions.

Note: If the beneficiary has an immediate need, DSS staff should follow their normal referral processes (e.g., applying for FNS, emergency food pantry) and then refer the beneficiary to their health plan.

DSS does **not** determine whether the beneficiary qualifies for Healthy Opportunities Pilot services.

APPENDIX

Pilot-Qualifying Physical/Behavioral Criteria

Population	Age	Physical/Behavioral Health Criteria
Adults	**21+**	• Two or more chronic conditions. Chronic conditions 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. • 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 (NICU) 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
	0-20	• One or more significant uncontrolled chronic condition(s) or one or more controlled chronic condition(s) that have a high risk of becoming uncontrolled due to unmet social need. These include 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) • Enrolled in North Carolina's foster care or kinship placement system

Pilot-Qualifying Social Risk Factors

Risk Factor	Definition
Homelessness and Housing Insecurity	• Homelessness defined in U.S. Department of Health and Human Services 42 CFR § 254(h)(5)(A) • Housing insecurity: based on questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool
Food Insecurity	• 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	• 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	• Based on questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool

Fact Sheets will be updated periodically with new information. Created Jan. 10, 2022.
For more information, please visit https://www.medicaid.ncdhhs.gov/transformation.