Healthy Opportunities Pilot: LME/MCO, AMH+, CMA Care Manager Trainings

The Role of Care Management Teams in the Healthy Opportunities Pilot

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Presenters

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Objectives for Today's Session

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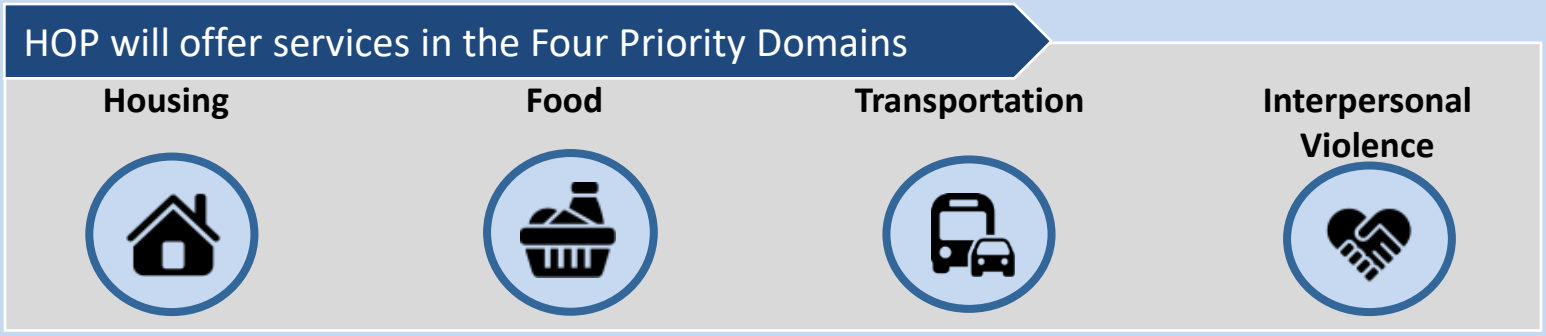
- Kickoff Healthy Opportunities Pilot training series for management teams based at AMH+s, CMAs, and LME/MCO / Tailored Plans
- Review timing for Healthy Opportunities Pilot launch for Tailored Care Management-eligible population
- Provide an overview of Tailored Care Management's role in the Healthy Opportunities Pilot

Healthy Opportunity Pilot Background and Context

What Is the Healthy Opportunities Pilot (HOP)?

The federal government 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 North Carolina Medicaid enrollees.

- HOP funds will be used to cover the cost of federally-approved HOP services in four priority domains and associated administrative costs.



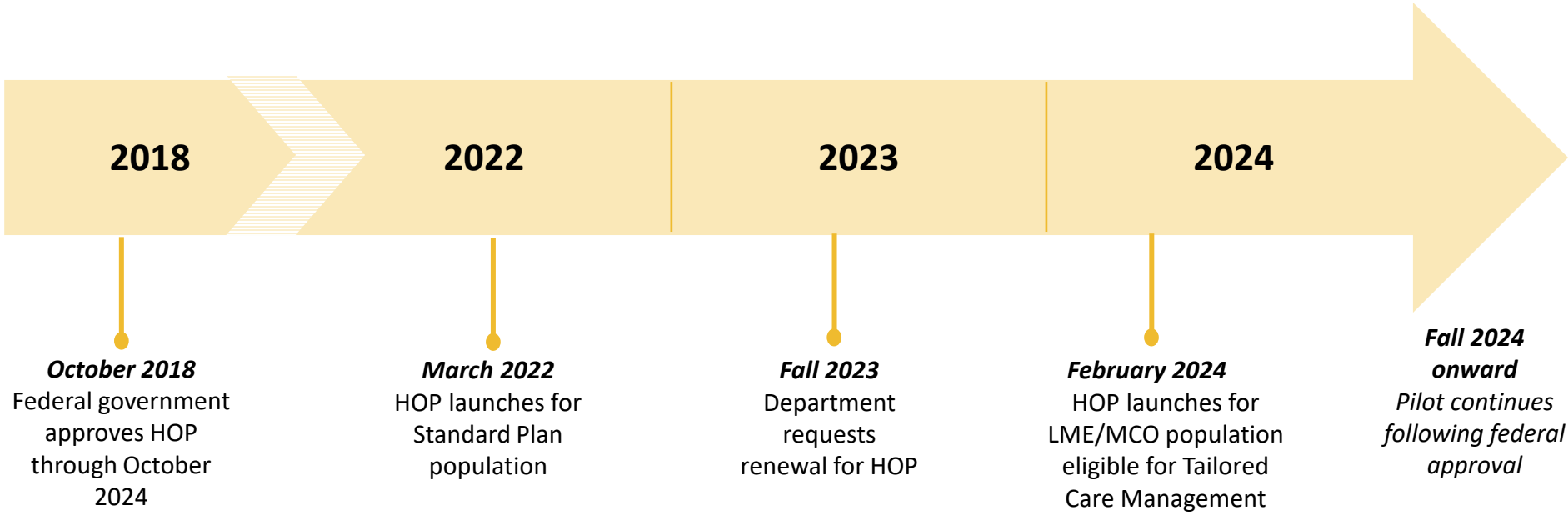
Why Do We Need HOP?

HOP presents a unique opportunity to provide selected evidence-based, non-medical interventions to Medicaid enrollees to address social needs. Tailored Care Management members are likely to meaningfully benefit from HOP services.

- **Social and economic factors have a significant impact** on individuals' and communities' health—driving as much as 80% of health outcomes.
- HOP will help evaluate the effectiveness of non-medical services on health outcomes and costs, with the ultimate goal of **making successful HOP services available statewide** through Medicaid.
- **Tailored Care Management members have among the most substantial healthcare needs** in the Medicaid program and, on average, their care needs are more expensive.
- Tailored Care Management members are also **more likely to struggle with social needs such as homelessness and food insecurity**.

What is the Timeline Rollout for HOP?

The Department has received federal approval to operate HOP through October 2024 and is currently requesting approval to continue operating the Pilot for an additional 5 years.



What Are Some Examples of HOP Successes To Date?

HOP has had a positive impact on thousands of Medicaid members, including the success stories below. Additional success stories are available here on the Healthy Opportunities Pilots at Work site.

Keeping the Family Together

A single mother had been staying at a local shelter with her children but needed life-saving surgery. Her children couldn't remain in the shelter without her, which left her in an impossible position. Mom had secured an emergency housing voucher, but it wasn't enough to cover rent in the county where she would be receiving treatment.

Through the Healthy Opportunities Pilots, her care managers were able to help her transfer her housing voucher and secure income-based housing near the hospital. They also helped her access financial support for her security deposit and utility setup fees – all services that are covered for the Healthy Opportunities Pilots participants.

Now, mom is able to focus on her health, schedule needed medical care, and keep her family together under one roof with help from her friends and the Healthy Opportunities Pilots.

Good Food is Good Medicine

A staff member at a local food Human Service Organization (HSO) shared recently that a Healthy Opportunities Pilots enrollee informed them that their blood sugar level, which is used to manage their diabetes, was down from 11 percent to 7 percent. That's down from an emergency to almost normal.

When the enrollee's health care provider asked what they were doing differently, they said it was the healthy food they get through the Healthy Opportunities Pilots. The Healthy Opportunities Pilots staff member shared, *"I am so honored to get to do this work in the community that raised me."*

Key HOP Metrics	
Enrollees Served Through HOP	**13,216 members**
Number of HOP Services Delivered	**123,831 services**
Amount Paid for HOP Service Delivery	**Over $21 million**

As of August 31, 2023

Which Members Can Participate in HOP?

On February 1, 2024, HOP will launch in the three HOP regions for the below groups of Medicaid Direct members.* An AMH+/CMA or LME/MCO care management teams will deliver HOP care management to these individuals. Participation in the Pilot program is optional for AMH+s/CMAs.**

Groups Launching February 1, 2024	Entity Delivering HOP Care Management
• Assigned to an AMH+/CMA for Tailored Care Management	• For AMH+/CMAs that opt into HOP, AMH+/CMA care management teams will deliver HOP care management • For AMH+/CMAs that do not opt into HOP, LME/MCO care management teams will deliver HOP care management
• Assigned to an LME/MCO for Tailored Care Management • Eligible for Tailored Care Management but have opted out • Not participating in Tailored Care Management because receiving ACT/HFW	• LME/MCO based care management teams will deliver HOP care management

Note: Upon Tailored Plan launch, eligible populations in NC Medicaid Direct will transition to a Tailored Plan and continue to have access to both Tailored Care Management and HOP.

** Medicaid Standard Plan members can also participate in HOP, as of March 2022.*

*** HOP care management includes identifying members' medical and non-medical needs, recommending appropriate services to address non-medical needs and ensuring that members receive these services, conducting "whole person" care management of medical and non-medical health, and re-assessing member's needs and HOP eligibility every 3-6 months.*

What is the Schedule for HOP Trainings?

In the lead up to HOP launch, the Department will host three live training sessions to review HOP roles and responsibilities for care management teams. Care management teams will subsequently complete virtual self-paced trainings that provide a deep dive into HOP services and how to choose appropriate services for members.

HOP Training Topic	Date
Three live sessions hosted by DHHS staff	
• *The Role of Care Management Teams in the Healthy Opportunities Pilot*	***Today's Focus***
• Deeper Dive on HOP Responsibilities of Frontline Care Managers	**Monday, November 6 11-11:50 AM ET**
• Assessing Member Eligibility for Participation in the Healthy Opportunities Pilot	**Monday, November 20 11-11:50 AM ET**
Self-paced sessions accessed through online AHEC modules*	
• HOP Overview module for Care Managers • Diversity, Equity, and Inclusion (DEI) – Cultural Humility • How Care Managers Can Obtain Pilot Consent • Tracking Enrollee Progress, Reviewing Service Mix, and Reassessing Pilot Eligibility • How Care Managers Can Choose Appropriate Interpersonal Violence Services (Part 1) • How Care Managers Can Choose Appropriate Interpersonal Violence Services (Part 2) • How Care Managers Can Choose Appropriate Transportation Services • How Care Managers Can Choose Appropriate Food Services • How Care Managers Can Choose Appropriate Housing Services • Understanding the Medical Respite Cross Domain Service • How Care Managers Can Choose Appropriate Toxic Stress Services • How Care Managers Can Choose Appropriate Health Related Legal Supports	***Ongoing***

Healthy Opportunities Pilot Overview

What are the Key HOP Entities and their Roles?

Care Management Teams, LME/MCOs, Network Leads, and Human Service Organizations will work to implement HOP.

Care Management Teams

- Frontline care management teams, based at an LME/MCO or AMH+/CMA, interacting with members
- Assess member eligibility for HOP and coordinate HOP services as part of ongoing care management, in addition to managing physical, behavioral health, TBI and I/DD needs
- Coordinate HOP services and track enrollee progress as part of Care Plan/Individual Support Plan (ISP) development and monitoring

LME/MCOs

- Maintain accountability for HOP administration and budget
- Approve which members qualify for HOP services and which services they qualify to receive—based on care management team recommendations
- Pay for HOP services delivered by HSOs

Network Leads (NLs)

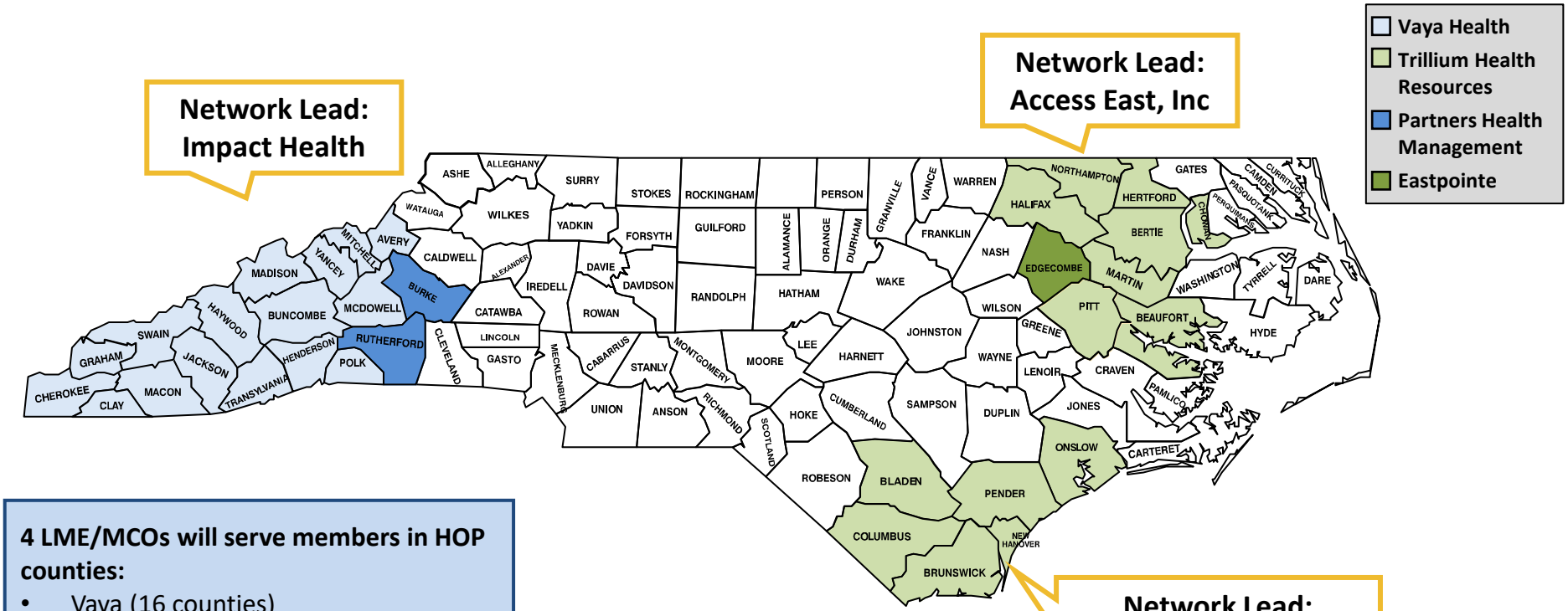
- Organizations that serve as the essential connection between LME/MCOs and HSOs
- Develop, manage, and oversee a network of HSOs
- Provide support and technical assistance for HSO network
- Convene HOP entities to share best practices

Human Service Organizations (HSOs)

- Frontline social service providers that contract with the Network Lead and deliver authorized HOP services to HOP enrollees
- Coordinate with care management teams on the delivery of HOP service to enrollees

Where in North Carolina Does HOP Operate?

HOP operates in three geographic regions of the state led by Network Leads. As of February 1, 2024, HOP regions will be served by four LME/MCOs: Vaya, Trillium, Eastpointe, and Partners.



4 LME/MCOs will serve members in HOP counties:

- Vaya (16 counties)
- Trillium (14 counties)
- Partners (2 counties)
- Eastpointe (1 county)

Who Qualifies for HOP?

Tailored Care Management members are likely eligible to participate in HOP due to their overlap with the health eligibility criteria. To qualify for HOP services, members must live in a HOP region and have:

Physical/Behavioral Health Criteria:

- Individuals eligible for Tailored Care Management meet the HOP health criteria

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.

I/DD = intellectual/developmental disability; TBI = traumatic brain injury

What Services Can Eligible Tailored Care Management Members Receive Through HOP?

HOP will cover the cost of 29 approved services in four priority service domains, plus a cross-domain category. 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 HOP services (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence

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

Cross-Domain

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

See HOP Fee Schedule for full list of HOP services and a summary of service definitions

SNAP/WIC= Supplemental Nutrition Assistance Program / Special Supplemental Nutrition Program for Women, Infants, and Children

What is NCCARE360?

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

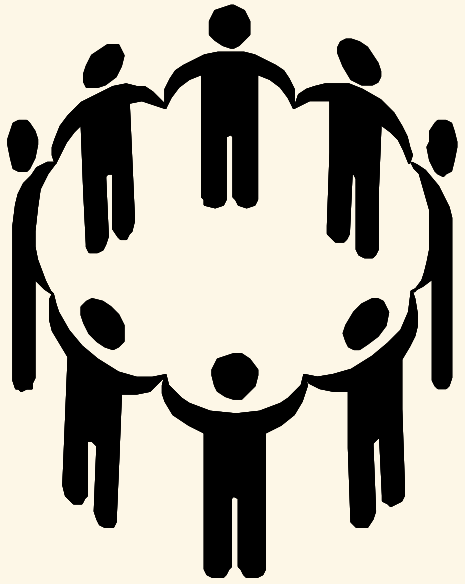
- **NCCARE360 is a telephonic, online and interfaced IT platform, providing:**
  - A robust **statewide resource database** of community-based organizations and social service agencies
  - A **referral platform** that allows health care providers, insurers and human service providers to connect people 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 HOP
- Care management teams will use NCCARE360 to generate referrals for HOP services, and track enrollee progress over time

The Role of Tailored Care Management in the Healthy Opportunities Pilots

How Does HOP Care Management Intersect with Tailored Care Management?

HOP care management will be in addition and complementary to Tailored Care Management.

- Tailored Care Management already includes responsibilities related to addressing unmet health-related resource needs (e.g., referrals to needed social services).
- HOP provides additional structure and resources to support care management teams in addressing the social needs of members.
- HOP care management will be integrated into existing Tailored Care Management workflows.*

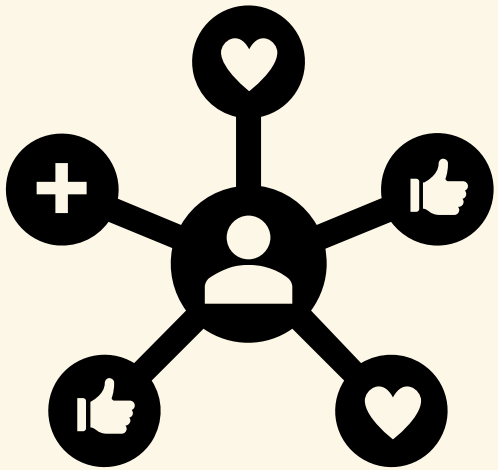


**If a member's AMH+/CMA does not opt into HOP, LME/MCO will deliver HOP care management, coordinating with the AMH+/CMA care manager as needed.*

Why Are Care Management Teams Essential to HOP?

Through participation in HOP, care management teams will contribute to an innovative and nationally recognized initiative that will shape North Carolina's Medicaid program.

- Care management teams will be central to the success of HOP by coordinating HOP services and providing care management to HOP enrollees.
- Given their trusted relationships with members, care management teams play a unique role in identifying individuals who will benefit from HOP services and connecting them to those services.
- HOP does not have any additional staffing or licensure requirements separate from Tailored Care Management requirements.
    - Care management teams may include care manager supervisors, care managers & care manager extenders.

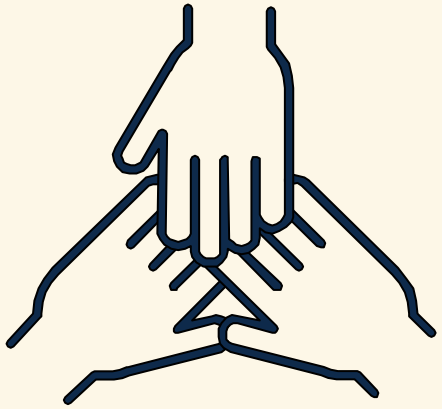


What is the Role of Care Management Teams in the HOP?

A critical component of implementing HOP is providing HOP care management.

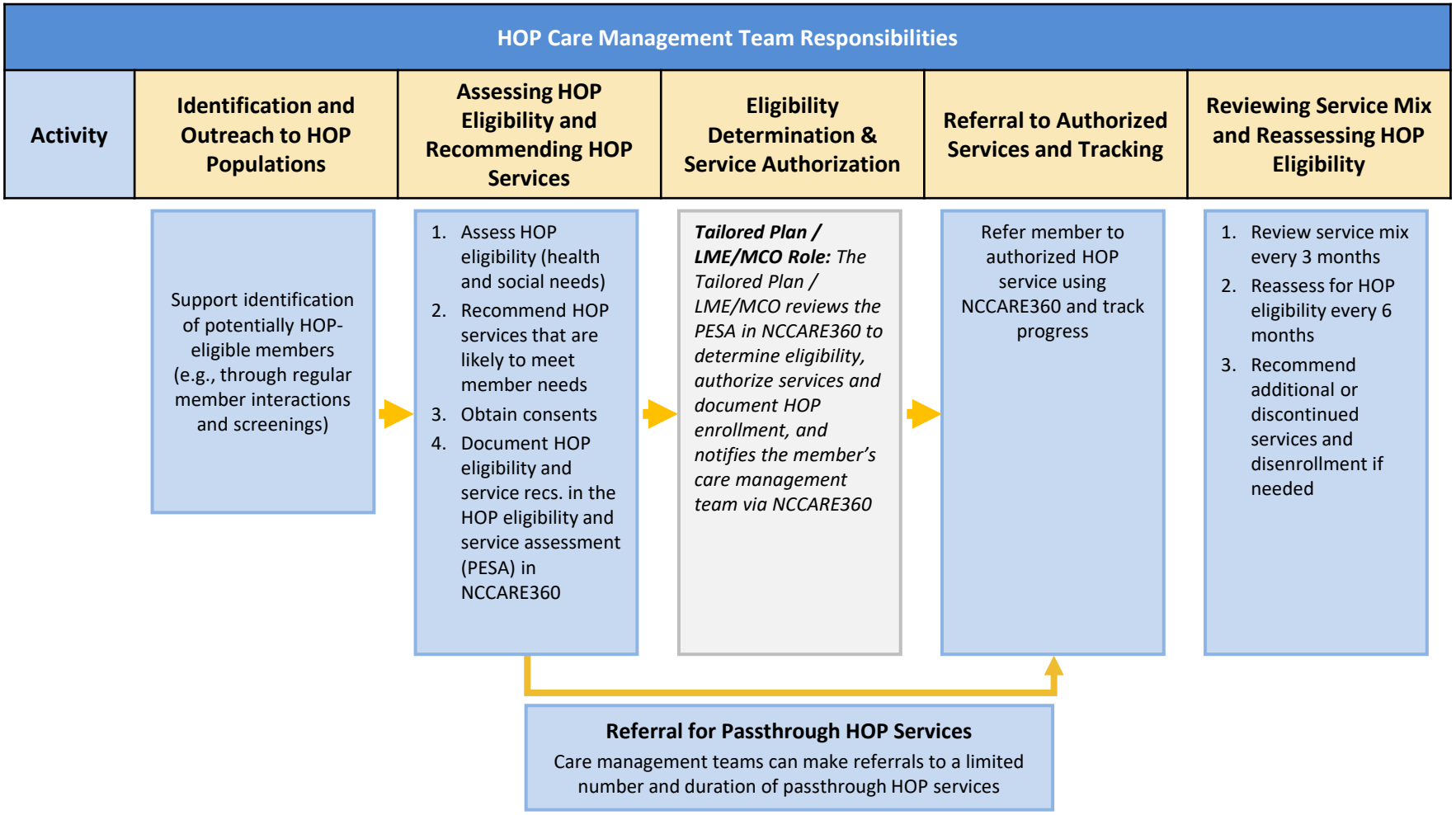
HOP Care Management refers to the activities required to:

- Identify and assess member eligiblity for HOP services
- Connect eligible members with recommend services that meet their needs, and
- Coordinate services, including assessing that members remain HOP eligible and obtain continued/additional HOP services, as needed



Additional details on HOP-related responsibilities and intersection with Tailored Care Management will be reviewed in future trainings

HOP Care Management Team Responsibilities



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

What are the Next Steps for HOP Trainings?

The Department will host the next live training sessions on November 6th and November 20th. Care management teams will subsequently complete virtual self-paced trainings that provide a deep dive into HOP services and how to choose appropriate services for members.

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Questions?

Appendix

Healthy Opportunities Pilot: Qualifying Physical/Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
Adults	21+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for pilot 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, cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease, chronic infectious disease, cancer, autoimmune disorders, chronic liver disease, chronic renal failure, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for Tailored Care Management • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions. • Former placement in North Carolina's foster care or kinship placement system. • Previously experienced three or more categories of adverse childhood experiences (ACEs).
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 • Former or current placement in NC's foster care or kinship placement system • Previously experienced or currently experiencing three or more categories of ACEs • Intellectual or developmental disability (I/DD) • Traumatic brain injury (TBI) • Meets the clinical eligibility criteria for Tailored Care Management
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
	0-20	• 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, cancer, autoimmune diseases, learning disorders, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for Tailored Care Management • Experiencing or previously experienced 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 or formerly enrolled in North Carolina's foster care or kinship placement system