# Promoting Healthy Opportunities Under Medicaid Managed Care and Beyond

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North Carolina Community Health Center Association

# Session Objectives & Agenda

## Objectives

- Describe recent initiatives at state level to address social determinants of health
- Understand how these initiatives may affect safety net providers
- Identify promising practices at safety net providers to address patient resource needs

## Agenda

- Review Statewide Initiatives: Screening Tool, NC Care 360, Healthy Opportunity Pilots
- Review SDOH Framework & Current Efforts at Safety Net Providers
- Discussion: Incorporating SDOH Into Work

# Good Timing!

**MCT 109: Healthy Opportunities in Managed Care**

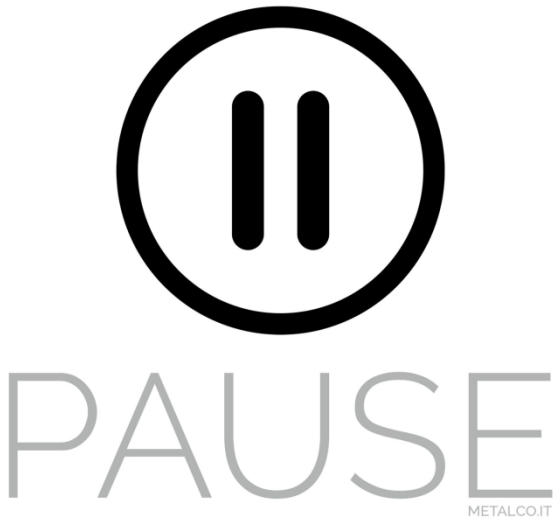
Thursday, June 27 at 12:00 pm

Archive: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses

# In Case You Missed It…

- NC's Medicaid program is transitioning from Fee-for-Service Medicaid to Managed Care
  - November 2019 in 2 of 6 geographic regions
  - February 2020  statewide
- Prepaid Health Plans (PHP) = 4 Commercial Medicaid Managed Care (statewide) + 1 Provider Led Entity (regional- only)
- Will manage care for 1.6 million beneficiaries
- Focus on local care management
- NC DHHS has focused on how the Medicaid program can address social determinants of health & has included several initiatives related to social determinants of health in plans for Medicaid transformation

# Need a definition?



# Opportunities for Health

## NC DHHS and NC Medicaid Terms

**Opportunities for health- "**[DHHS] is committed to providing the *opportunity for health* for North Carolinians, while improving health outcomes and reducing health care costs, and addressing the conditions in which people live that directly impact health."

**Health-related resource needs**
Examples: food, housing, transportation
Needs that are not met are referred to as "un-met health related resource needs"

"We want to build an innovative, whole-person centered, and well-coordinated system of care that addresses both medical and non-medical drivers of health."

Mandy Cohen, Secretary of NC Department of Health and Human Services

80% of a person's health is determined by social & environmental factors

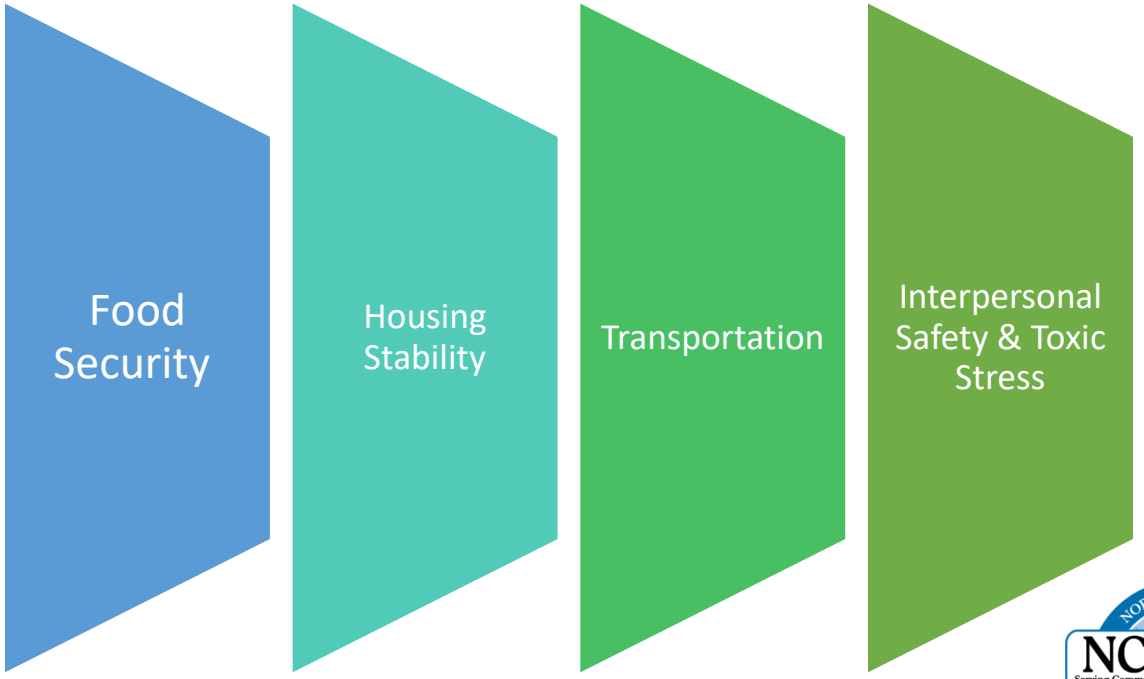
NC Medicaid Healthy Opportunities Pilot Fact Sheet

# NC DHHS Approach to Health Related Resource Needs

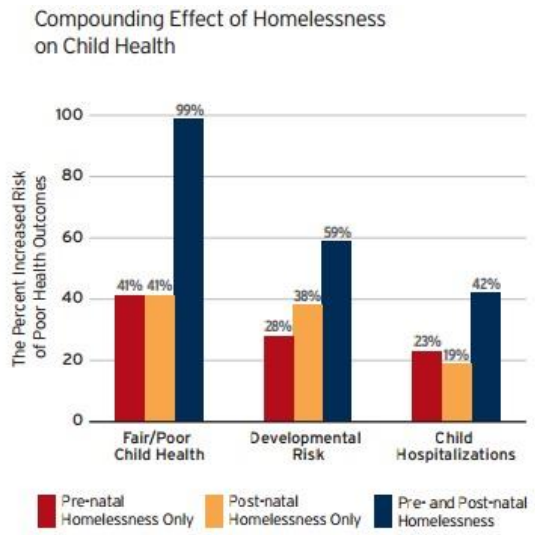
Strategies

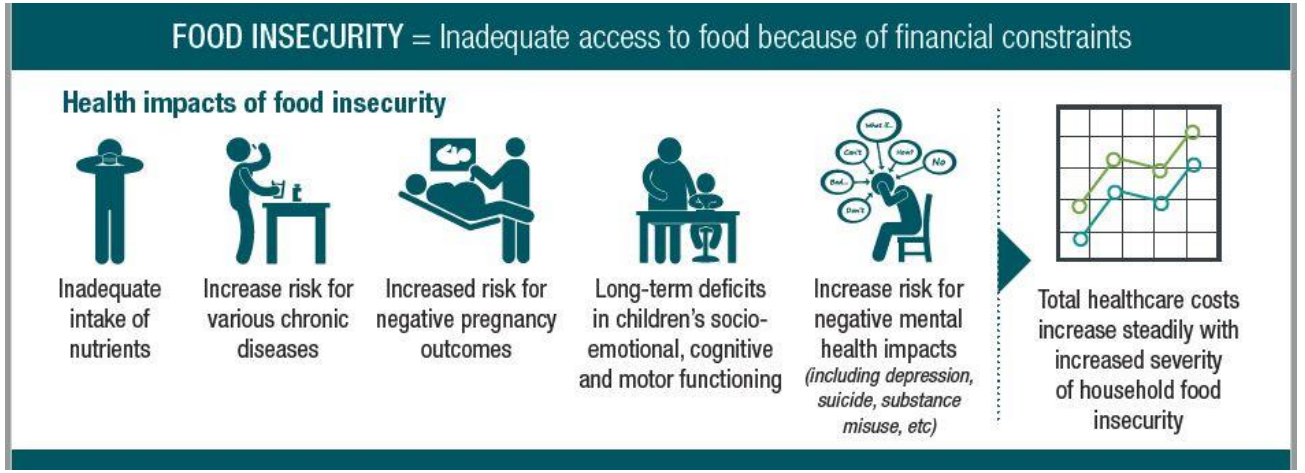

*Medicaid specific

Core Domains



# Unmet Needs and Health Outcomes





# Screening

# Screening for Unmet Health-Related Resource Needs

- DHHS has developed a set of SDOH screening questions to standardize how enrollees will be screened for unmet health-related resource needs affecting social determinants of health, as well as how PHPs will be required to address those needs

- Pre-paid health plans will be required to use these screening questions as part of fulfilling their overall care management requirements

# Development of Questions

- Technical Advisory Group (TAG) made up of diverse subject matter experts and stakeholders from across the state
- Health Center Representation on TAG: Sharon Brown-Singleton (NCCHCA), Kim Schwartz (Roanoke Chowan Community Health Center), Howard Eisenson (Lincoln Community Health Center)
- April 2018: Questions released for public comment
- August 2018–Jan 2019: Validating of screening questions.

## Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

| | Yes | No |
|---|---|---|
| **Food** | | |
| 1. Within the past 12 months, did you worry that your food would run out before you got money to buy more? | | |
| 2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more? | | |
| **Housing/ Utilities** | | |
| 3. 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 (i.e. couch-surfing)? | | |
| 4. Are you worried about losing your housing? | | |
| 5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? | | |
| **Transportation** | | |
| 6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living? | | |
| **Interpersonal Safety** | | |
| 7. Do you feel physically or emotionally unsafe where you currently live? | | |
| 8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone? | | |
| 9. Within the past 12 months, have you been humiliated or emotionally abused by anyone? | | |
| **Optional: Immediate Need** | | |
| 10. 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. | | |
| 11. Would you like help with any of the needs that you have identified? | | |

## Evaluación de salud

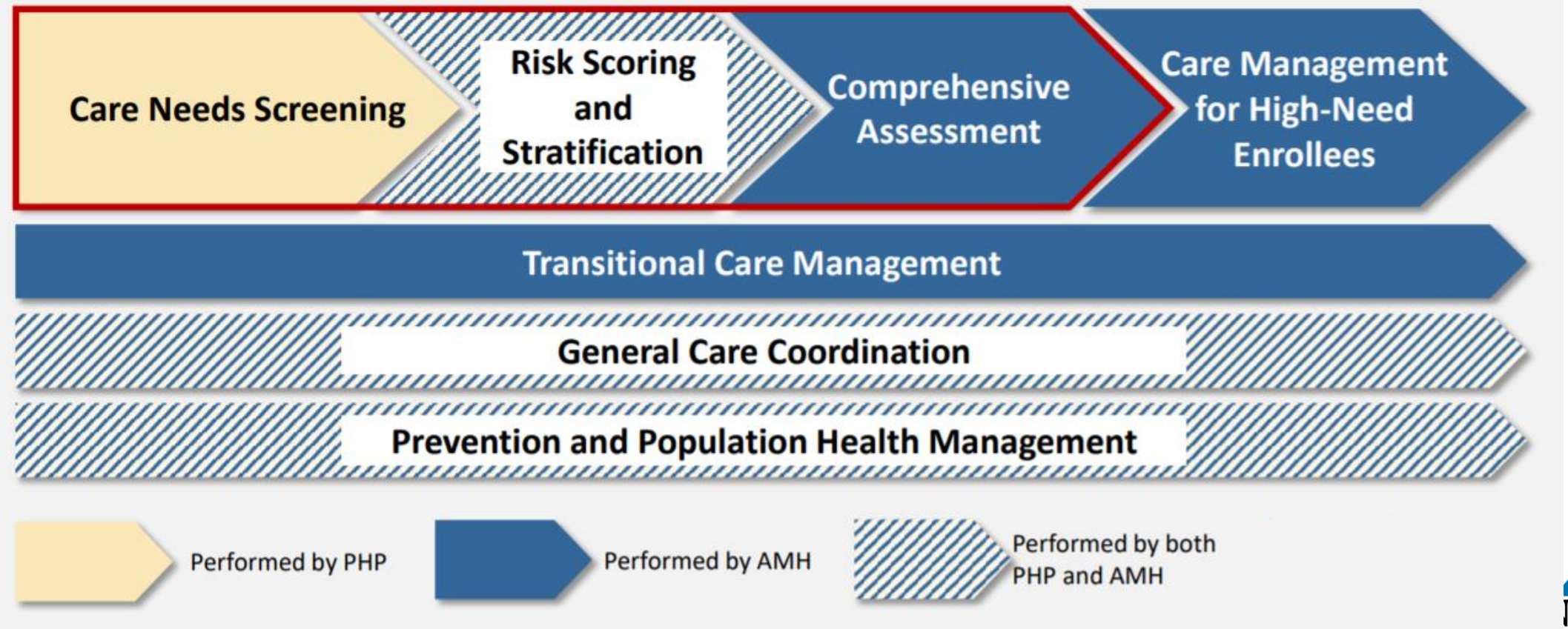
Nosotros creemos que todas las personas deberían tener la oportunidad de estar sanas. Algunas cosas como no tener suficiente alimento, transporte confiable o un lugar seguro dónde vivir, pueden hacer difícil que se encuentre sano. Por favor responda las siguientes preguntas para ayudarnos a entender mejor su situación actual. Quizá no podamos encontrar recursos para todas sus necesidades, pero intentaremos ayudarle en todo lo posible.

| | Sí | No |
|---|---|---|
| **Alimentos** | | |
| 1. En los últimos 12 meses, ¿tuvo la preocupación de que se le iba a acabar el alimento antes de tener dinero para comprar más? | | |
| 2. En los últimos 12 meses, ¿el alimento que compró no le rindió y no tuvo dinero para comprar más? | | |
| **Vivienda/Servicios públicos** | | |
| 3. En los últimos 12 meses, ¿ha tenido que quedarse a la intemperie, en un auto, tienda de campaña, refugio público o temporalmente en casa de alguien -quedándose en el sofá-? | | |
| 4. ¿Le preocupa la posibilidad de perder su casa? | | |
| 5. En los últimos 12 meses, ¿no le fue posible tener servicios públicos - calefacción, electricidad- cuando tenía gran necesidad de ellos? | | |
| **Transporte** | | |
| 6. En los últimos 12 meses, ¿la falta de transporte le ha impedido llegar a citas médicas o realizar actividades de la vida diaria? | | |
| **Seguridad interpersonal** | | |
| 7. ¿Se siente usted inseguro física o emocionalmente en donde vive actualmente? | | |
| 8. En los últimos 12 meses, ¿alguien le ha golpeado, cacheteado, pateado o lastimado físicamente? | | |
| 9. En los últimos 12 meses, ¿alguien le ha humillado o ha abusado emocionalmente de usted? | | |
| **Optional: Necesidad inmediata** | | |
| 10. ¿Son urgentes sus necesidades? Por ejemplo: usted no tiene comida para esta noche, usted no tiene un lugar para dormir esta noche, o si usted tiene miedo de ir a su casa porque puede confrontar problemas. | | |
| 11. ¿Le gustaría tener ayuda en cualquiera de las necesidades que usted ha identificado? | | |

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

NORTH CAROLINA NCCHCA Serving Community & Migrant Health Centers Community Health Center Association

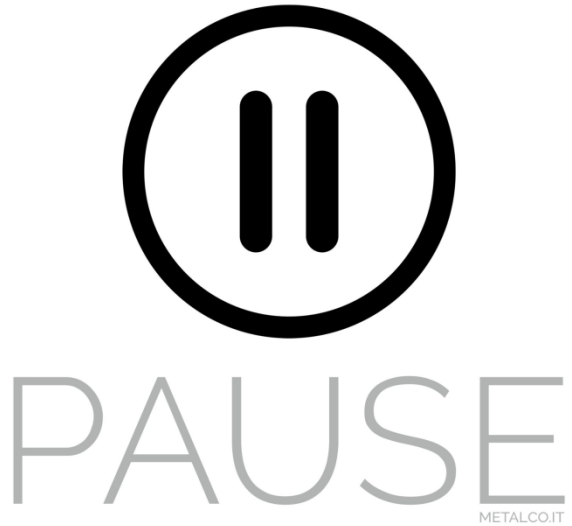
# Screening Process




From: Introduction to Advanced Medical Homes AMH Tier 3: Patient Identification and Assessment Webinar

# PHP=Prepaid Health Plan

- Statewide Standard Plans:
  - **AmeriHealth Caritas**
  - **BlueCrossBlueShield (Healthy Blue)**
  - **UnitedHealthcare**
  - **WellCare**




- Regional Standard Plan (Regions 3 & 5 only)
  - **Carolina Complete Health**

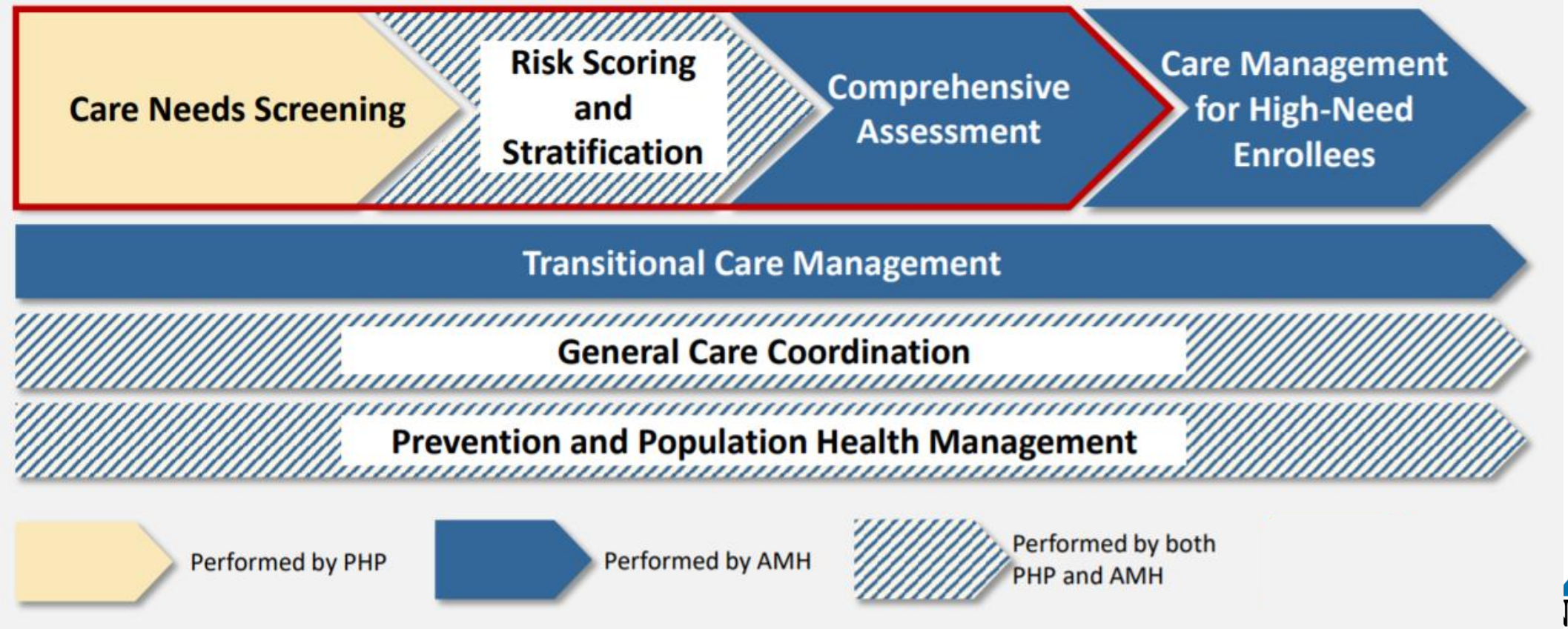
# Advanced Medical Home Program

- DHHS developed the AMH program as the primary vehicle for delivering care management as the state transitions to Medicaid managed care
- Builds on the Carolina ACCESS program
- Requires prepaid health plans (PHPs) to delegate certain care management functions to AMHs at the local level
- AMH program offers practices a range of options for partnering with PHPs in the provision of care management; responsibilities vary by the “Tier” (1,2,3) the practice has attested to

# Care Needs Screening

- The PHP will make their “best effort” to conduct a Care Needs Screening of every Member within 90 days of enrollment
  - PHP must establish evidence based or supported tool to conduct screening
  - Screening must include the standard screening questions for unmet health-related resource needs
  - Will also identify: chronic or acute conditions, chronic pain, behavioral health needs, medications, other
- Can be delegated to designated care management entity
- PHP will share results of screening with assigned AMH/PCP within 7 days of screening
- PHP will report on rates of completed SDOH screening
- Conducted at least annually for individuals not engaged in care management

# Risk Scoring and Stratification



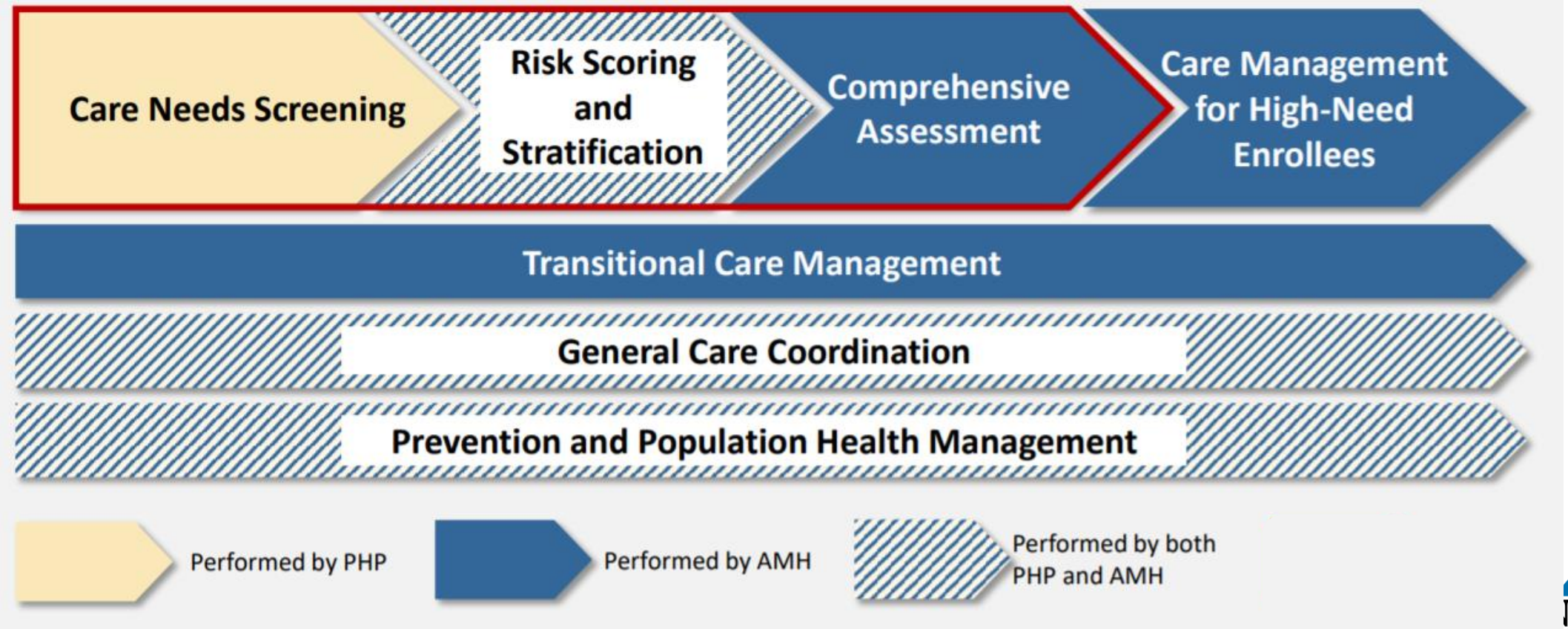

From: Introduction to Advanced Medical Homes AMH Tier 3: Patient Identification and Assessment Webinar

# Priority Populations

- Through risk scoring and stratification, PHP and AMH will identify members who are part of “priority populations” for care management and should receive a Comprehensive Assessment to determine their care management needs

- Among other groups, priority populations must include:
  - **Individuals with High Unmet Health-Related Resource Needs**
    - **Members who are homeless (HUD definition)**
    - **Members experiencing or witnessing domestic violence or lack of personal safety**
    - **Members showing unmet health-related needs in three or more SDOH domains on the Care Needs Screening**

# Comprehensive Assessment




From: Introduction to Advanced Medical Homes AMH Tier 3: Patient Identification and Assessment Webinar

# Comprehensive Assessment & Care Management

- PHPs must ensure that the comprehensive assessment gathers information on the unmet resource needs of beneficiaries across the four priority SDOH domains.
- For individuals identified as having high unmet resource needs and eligible for care management services, PHPs must help address unmet resource needs through various strategies:
  - Understanding of local resources
  - Offering in-person help securing health-related services
  - Providing access to a housing specialist for homeless beneficiaries
  - Providing access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity
- For beneficiaries who do not require intensive care management services, PHPs will be responsible for coordinating services provided by community and social support providers and linking beneficiaries to community resources and social supports.

# Will **Medicaid providers** be required to do SDOH screening for all Medicaid patients?

NO… "The Department is not proposing to require SDOH screening requirements for providers at this time."

BUT… "DHHS strongly encourages practices, providers, social services agencies and community organizations to carry out SDOH screening. Our vision is that the standardized screening questions will be shaped by provider input, become familiar to providers and eventually become part of routine practice workflows statewide."

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

# Will **Medicaid providers** be required to do SDOH screening?

## ALSO…

PHPs may contract with Advanced Medical Homes to conduct the care needs screening (including the SDOH questions)

***and***

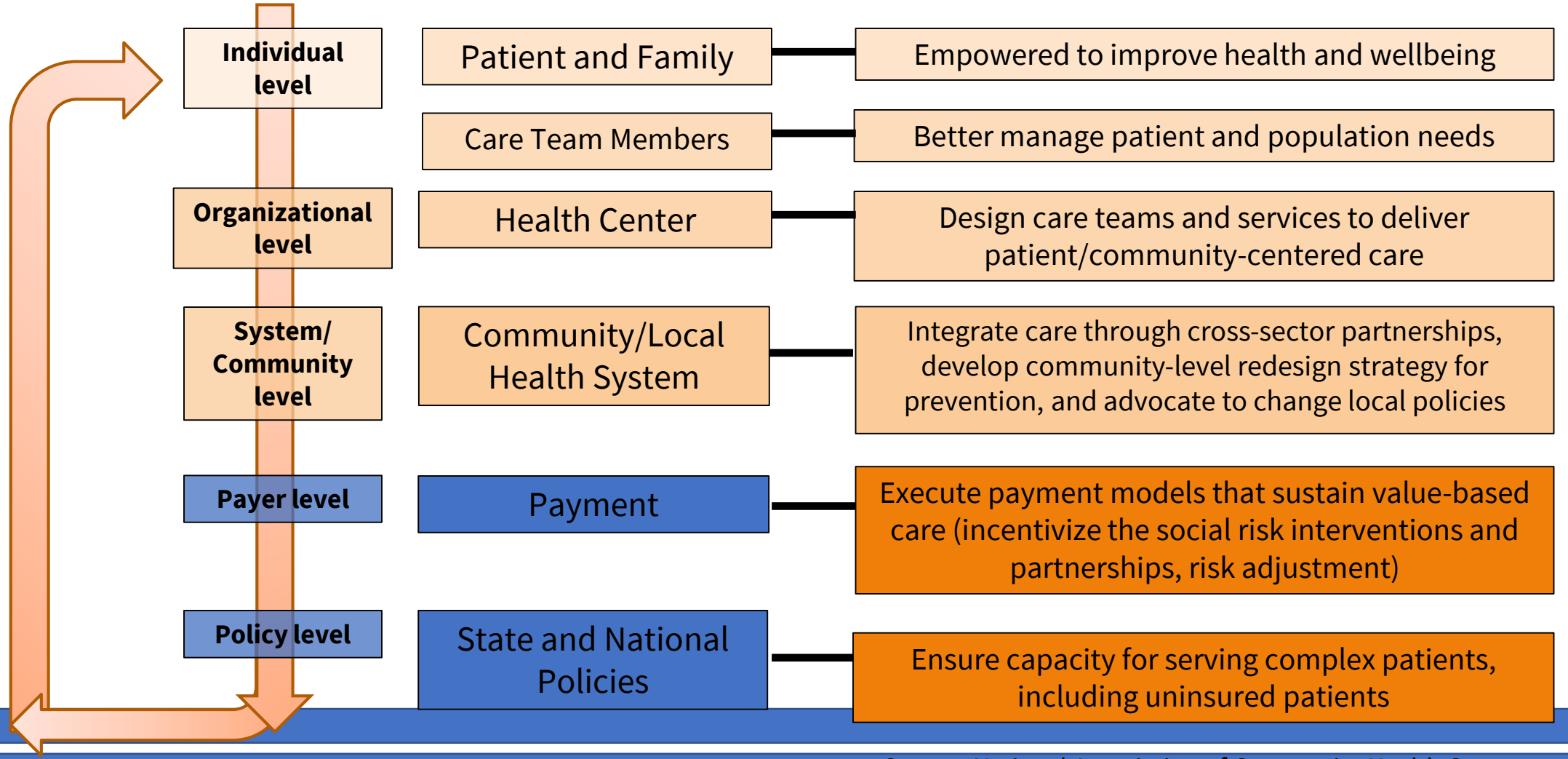
All PCPs should be prepared to review Care Needs Screening & any Care Plan and make sure identified needs have been addressed

AMH Tier 3 Providers must be prepared to incorporate responses to care needs screening (including SDOH questions) into patient stratification

AMH Tier 3 must also perform Comprehensive Assessment that will require information about SDOH

AMH Tier 3 will also need to coordinate resources to address needs for all patients and care management for Medicaid patients with high unmet resource needs

# Beyond Medicaid: Screening for Unmet Health Related Resource Needs




Source: National Association of Community Health Centers

# Should we switch to state's standard screening tool?

If you are already using another screening tool…

- Concentrate on standardizing the "need" not the question
- Cross walk your tool with state tool

If you are not using another screening tool…

- Prioritize using state's tool
- Add or adjust questions as relevant to your patient population

# Response

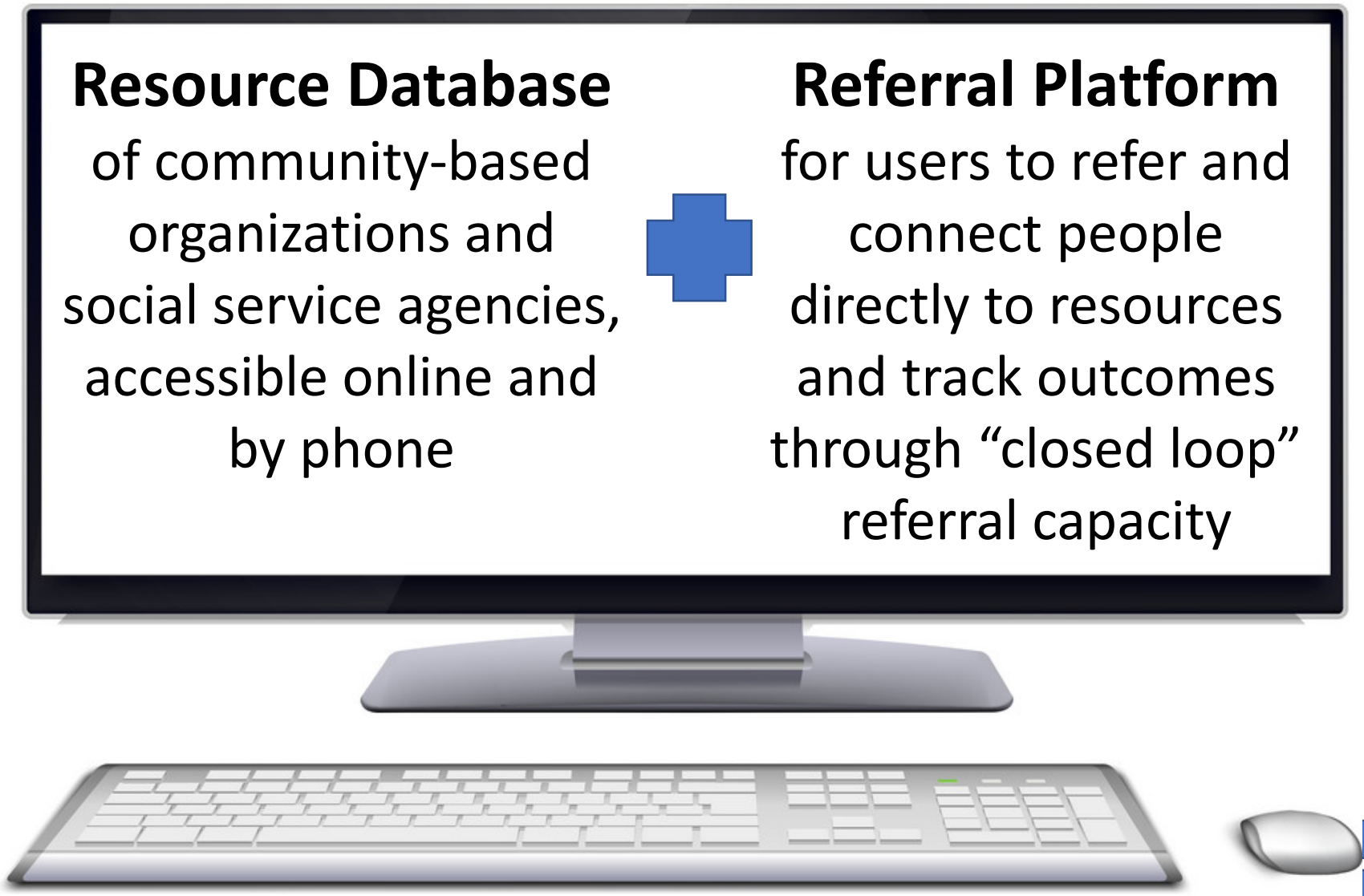
# Responding to Identified Needs

- NC Care 360
- PHP Options to Address SDOH
- Healthy Opportunity Pilots

# Who is responsible for addressing identified needs?

- Entity providing care management to beneficiary responsible for coordinating response. That could be:
  - PHP
  - AMH Tier 3 Practice
  - Care Management Entity contracted with PHP or AMH Tier 3
- Some beneficiaries with identified SDOH needs may not be a “priority population” for high need care management

# NC Care 360


**Resource Database**
of community-based organizations and social service agencies, accessible online and by phone
**Referral Platform**
for users to refer and connect people directly to resources and track outcomes through “closed loop” referral capacity

# NCCare360

- NC 2-1-1: experience connecting individuals and families across NC to free and confidential information on local health and human services resources, through a simple dialing code 2-1-1, and a statewide resource database and call-center.
- Unite Us: provides a care coordination platform that allows healthcare providers, community-based organizations and others to work together securely in real-time.
- Expound Decision Systems: has created a successful data repository model for organizations in Ontario, which will be extended to manage resources specific to the Social Determinants of Health in NC.
- Benefits Data Trust: a national nonprofit that provides streamlined benefits enrollment assistance.

# Functionality Predictions & Connectivity

- Flexible architecture to promote statewide adoption with integration and interface capabilities:
  - Existing local, agency, regional, statewide databases
  - EHRs for referral tracking
  - Health Information Exchange
  - Care Management Platforms
  - Other Resource Platforms
- PHP Requirements:
  - Must use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local resources
  - Must use the NC Resource Platform for referring Members to resources and for tracking closed loop referrals. PHP may use existing platforms for this until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption

# Similar Existing Platforms

Aunt BERTHA™ .COM
CONNECTING PEOPLE AND PROGRAMS

NORTH CAROLINA 2-1-1™

United Way
United Way of North Carolina

NOWPOW

purplebinder

Healthify

NORTH CAROLINA NCCHCA Serving Community & Migrant Health Centers Community Health Center Association

**NCCARE360**
@nccare360

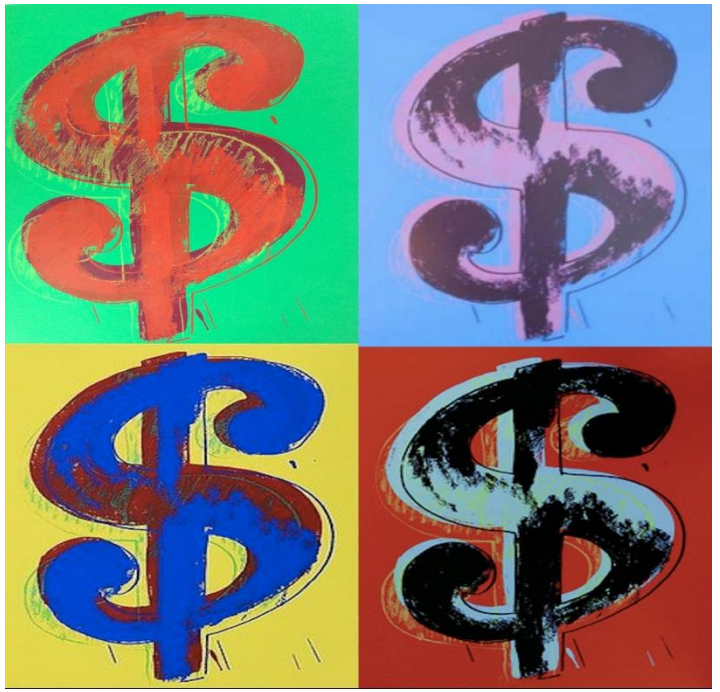
Follow

"We recently received a referral indicating a lady's home was about to be condemned. Through #NCCARE360 we connected the client to another agency and her issue was tracked and resolved within 24 hours"-The Salvation Army of Greensboro. Feedback from our partners means everything.

# Who has been involved in NC Care 360 conversations in your local community?

# PHP Opportunities to Address SDOH

1. In Lieu of Services (ILOS)
2. Value Added Services
3. Contributions to Health-Related Resources



# Healthy Opportunity Pilots

- Pilots will provide up to $650 million in Medicaid funding to cover the costs of select services related to housing, food, transportation, interpersonal safety that directly impact the health outcomes & costs of Medicaid enrollees in 2-4 geographic areas
  - More intensive support for navigating human services system
  - Medicaid funds to cover costs of certain services
  - Providing resources to organizations to develop infrastructure needed to work with health care providers and PHPs
- Authorized by CMS for five year period (November 1, 2019-October 31, 2024)

# What are pilot regions & how will they be selected?

- Pilots will operate in 2-4 geographic areas of the state
- DHHS will procure one Lead Pilot Entity for each pilot area
- LPEs will define geographic boundaries based on their assessment of counties they can effectively serve
- Regions must:
  - Consist of at least two contiguous counties that preferably cover both urban and rural areas
  - Not cross over more than one Medicaid PHP region
  - The pilot does not need to fill an entire Medicaid PHP region

# What services will be paid for in the pilots?

| Housing | Food | Transportation | Interpersonal Violence/Toxic Stress |
|---|---|---|---|
| • Targeted tenancy support and sustaining services<br>• Housing quality and safety improvements<br>• One-time payments to secure housing<br>• Short-term post hospitalization housing | • Linkages to community-based food services (e.g. SNAP, WIC app & support, food bank referrals)<br>• Nutrition and cooking coaching/counseling<br>• Healthy food boxes<br>• Medically tailored meal delivery | • Linkages to transportation resources<br>• Payment for transit to support access to Pilot services, including public transit and taxis (in areas with limited public transit infrastructure) | • Linkages to legal services for IPV related issues<br>• Services to help individuals leave a violent environment and connect with behavioral health resources<br>• Evidence-based parenting support programs<br>• Evidence-based home visiting services |

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North Carolina Medicaid

Prepaid Health Plans (PHPs)

*Capacity Building Funds for both LPEs and HSOs*

Tier 3 AMHs, Local Health Departments, Local Care Management Entities

Lead Pilot Entities

Human Service Organizations

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North Carolina Medicaid

Prepaid Health Plans (PHPs)

- Each PHP serving a pilot region will get a capped amount (outside of their MMC capitation payment) from which to finance Pilot services
- Funding will be spent on approved Pilot services based on guidelines
- DHHS will establish guidelines to ensure that funds are spent across eligible populations and guidelines
- PHPs have several tools to make sure they do not go over the cap, including limiting enrollment
- PHPs will approve which enrollee receives which services

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North Carolina Medicaid

Prepaid Health Plans (PHPs)

Tier 3 AMHs, Local Health Departments, Local Care Management Entities

Care management entities will receive payment from PHP for Pilot-related responsibilities (in addition to care management payments they receive)

CME will assess beneficiary eligibility for Pilot, identify recommended pilot services, and manage coordination of pilot services, in addition to managing physical and behavioral health needs

Track enrollee progress over time

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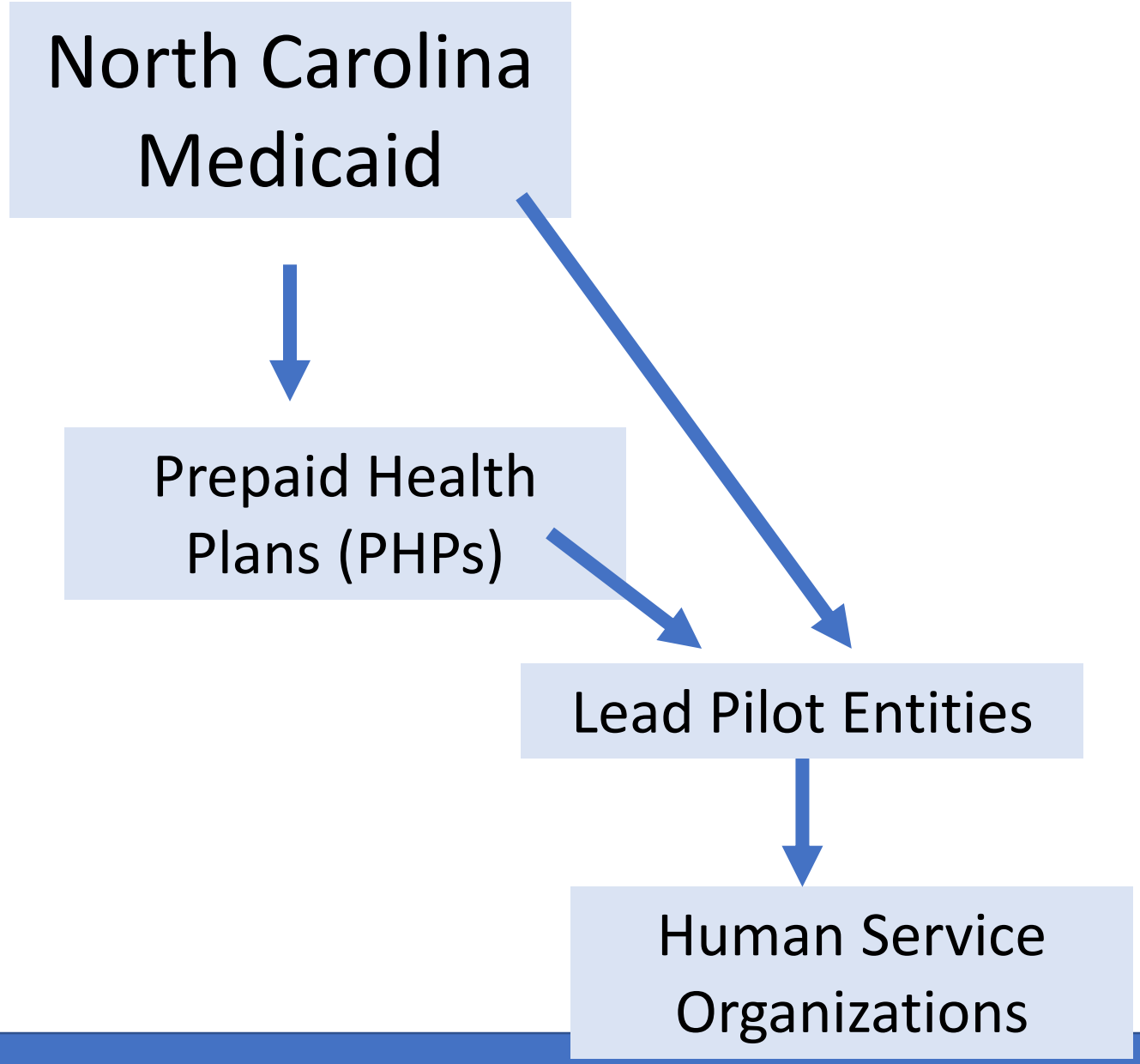
Lead Pilot Entities

- Competitively procured by DHHS
- Develop, manage, pay and oversee a network of HSOs
- Provide support and technical assistance for HSO network
- LPE will get reimbursement from PHP to reimburse HSO for provided pilot services
- LPE & HSO can also get start-up funding support from NC Medicaid



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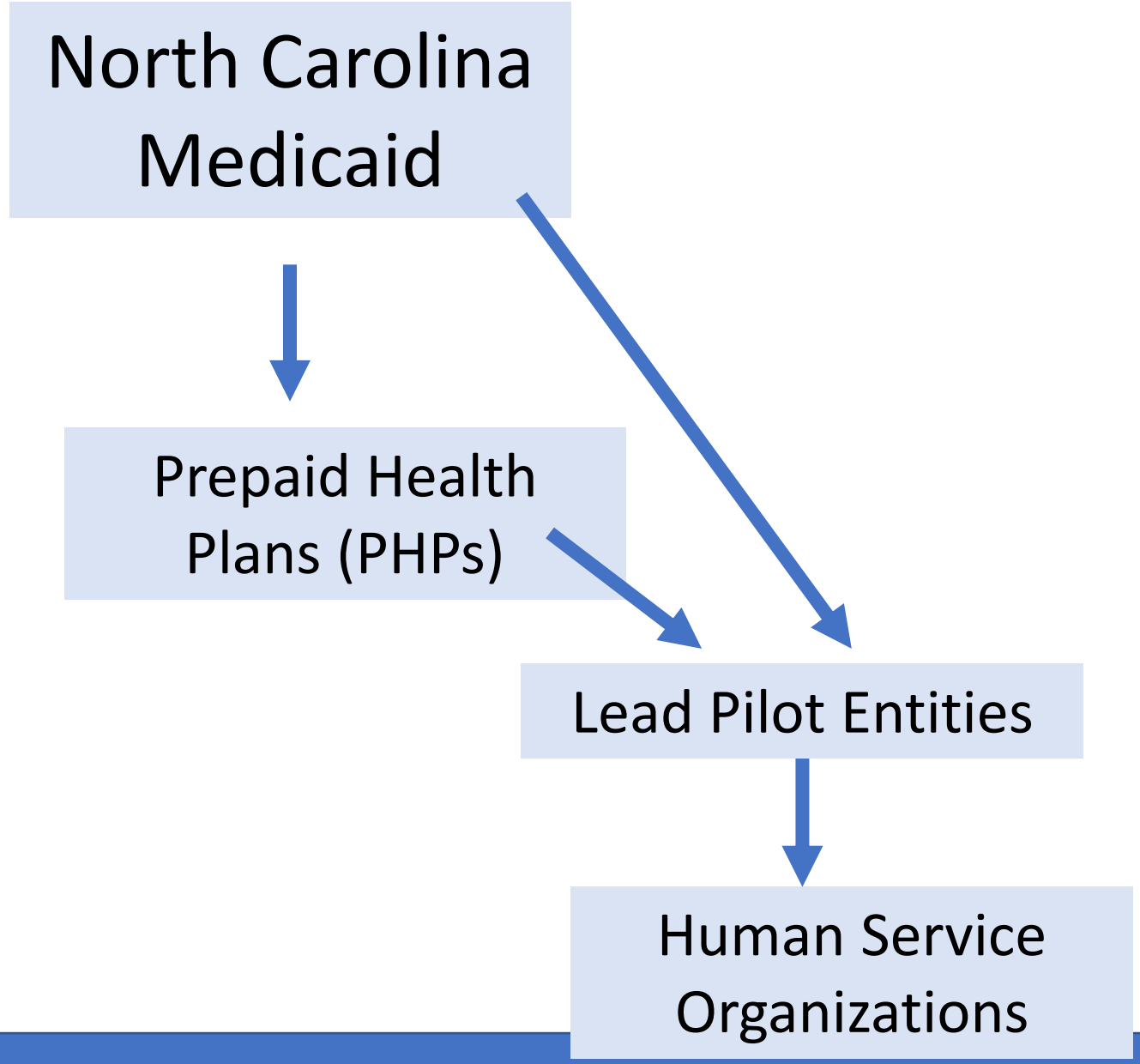
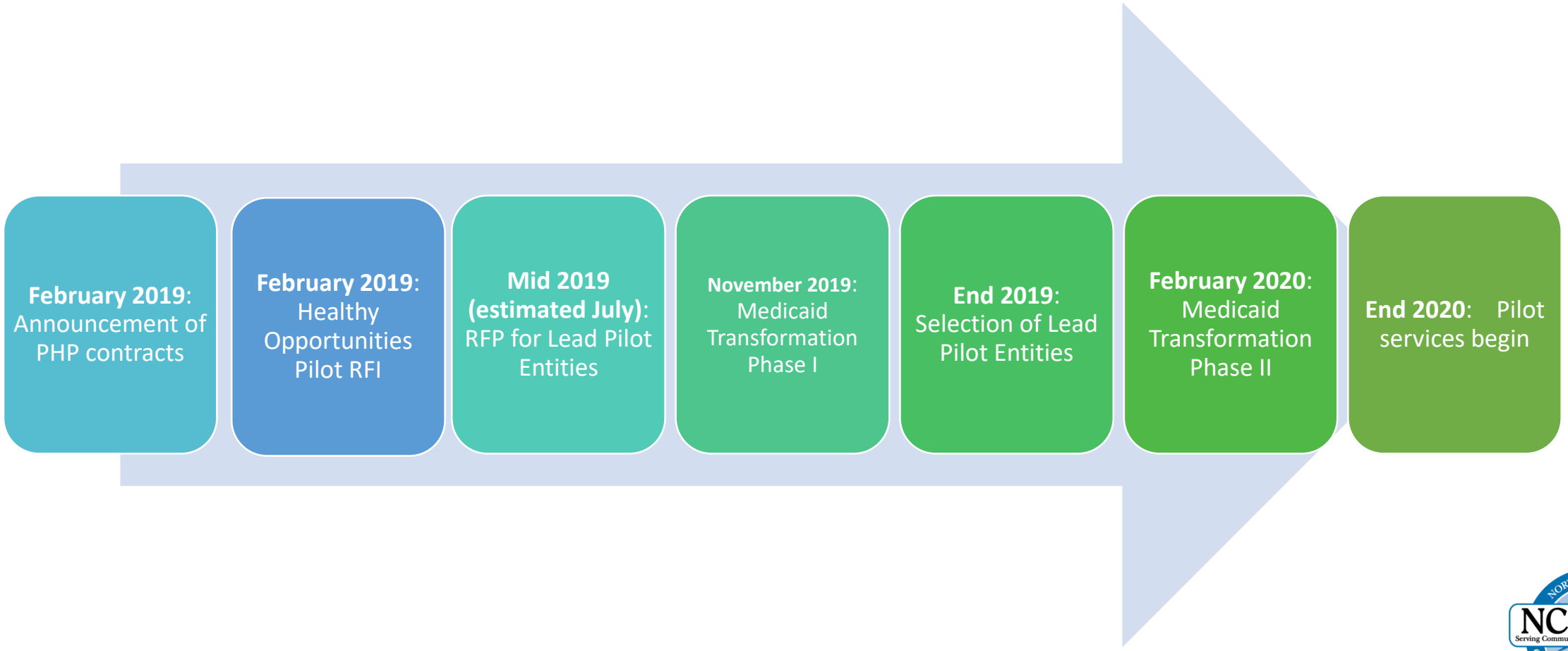
Human Service Organizations

- Frontline social service providers that contract with the LPE to deliver authorized, cost effective, evidence based Pilot services to Pilot enrollees
- Participate in the healthcare delivery system, including submitting invoices and receiving reimbursement for services delivered

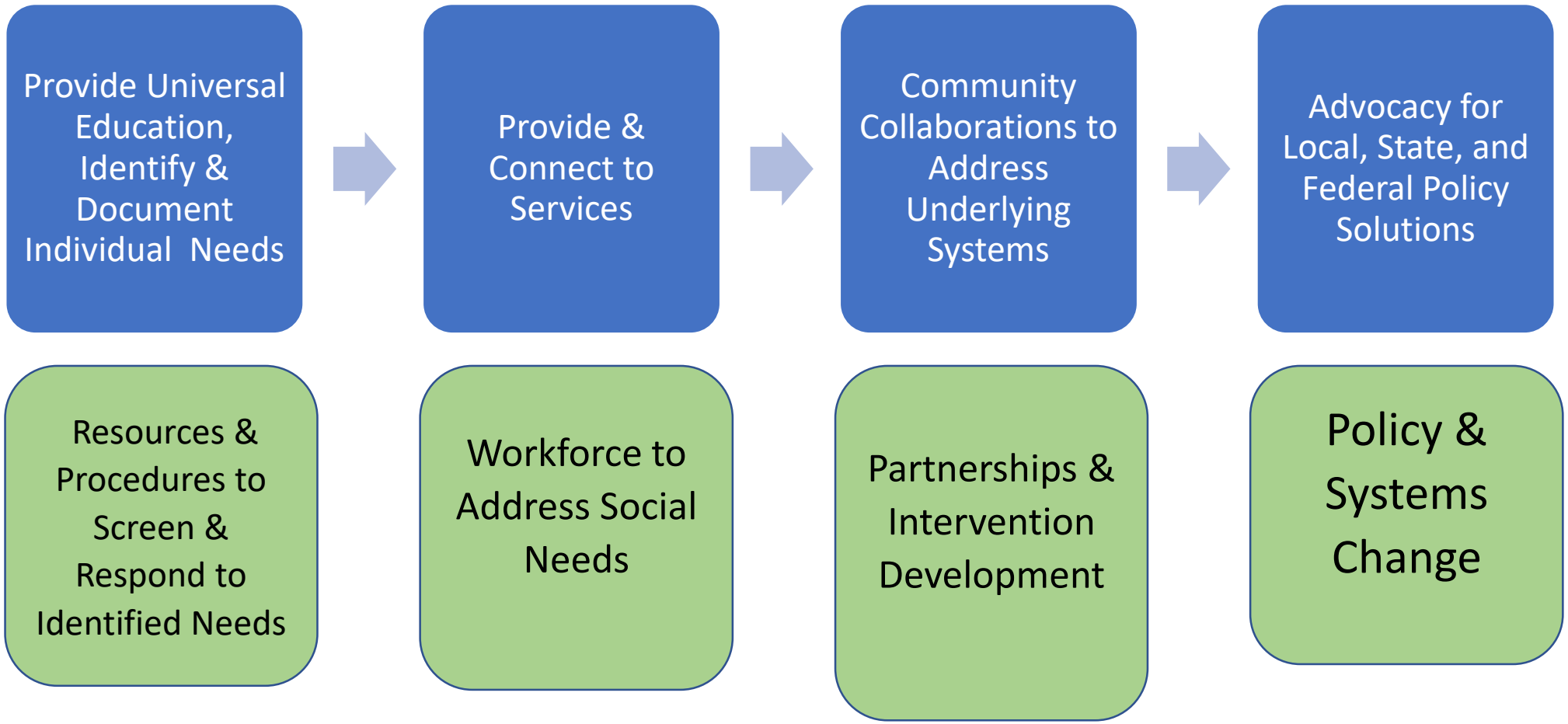


# Pilot timeline



| Strategy | Who Receives/Eligible? | Regions of State | Timeline for Implementation |
|---|---|---|---|
| Care Needs Screening | All Medicaid beneficiaries under Managed Care | All | Upon start of MMC (assignment of beneficiaries to PHP) |
| Comprehensive Assessment | Medicaid beneficiaries identified as priority population | All | Upon start of MMC |
| NC Care 360 | All North Carolinians | All | Regional rollout already begun with all state onboard and fully operational late 2020 |
| Healthy Opportunity Pilots | Medicaid beneficiaries under MMC in areas with pilot | 2-4 areas of state; each area at least 2 counties, cannot cross Medicaid regions, not entire region | Services begin end of 2020 |

# SDOH Framework & Selected Strategies within Safety-Net Providers


Provide Universal Education, Identify & Document Individual Needs
Provide & Connect to Services
Community Collaborations to Address Underlying Systems
Advocacy for Local, State, and Federal Policy Solutions
Resources & Procedures to Screen & Respond to Identified Needs
Workforce to Address Social Needs
Partnerships & Intervention Development
Policy & Systems Change

Health Care Provider Activities

Individual Level

Community, Organizational, Policy Level

| Provide Universal Education, Identify & Document Individual Needs | Provide & Connect to Services | Community Collaborations to Address Underlying Systems | Advocacy for Local, State, and Federal Policy Solutions |
|---|---|---|---|
| Provide universal education on services available at provider level and in community | Provide services & manage interventions to address individual social & economic conditions; “enabling services” | Participate and lead community coalitions to identify and address underlying issues to improve health, social, & economic conditions | Advocate for policy changes to improve health, social, & economic conditions |
| Assess and document individual patient needs | Connect patients to services to address social & economic conditions | Develop partnerships and interventions to address SDOH | |

| Resources & Procedures to Screen & Respond to Identified Needs | Workforce to Address Social Needs | Partnerships & Intervention Development | Policy & Systems Change |
|---|---|---|---|
| **Supporting Activities** | | | |
| Procedures & workflow to support universal education and screening | Enabling services workforce with training & capacity to respond to SDOH | Partnerships with social service providers to strengthen connection of health centers to partners addressing patient social needs | Payment models that support health centers in addressing social issues, including models that support sustainable ES workforce |
| Immediate response to needs identified during clinic | Integration of ES workforce into clinical care team | Processes to support warm handoffs to partner agencies | Policy solutions that support access to care and equity |
| Long term response & follow up to identified needs | Support for staff in understanding and supporting their feelings towards this work | Community coalitions to support community led strategies to fill gaps and address needs | |
| Policies to promote patient and staff safety | | | |

Health Care Provider Activities

# Provide Universal Education, Identify & Document Individual Needs

| | |
|---|---|
| Provide universal education on services available at provider level and in community | Assess and document individual patient needs |

CUES Intervention – Evidence-based, trauma-informed universal education intervention around healthy and unhealthy relationships.

C: Confidentiality

Always see the patient alone for at least part of the visit and disclose your limits of confidentiality before discussing IPV and HT.

UE: Universal Education + Empowerment

Use safety cards to talk with all patients about healthy and unhealthy relationships and the health effects of violence. Always give at least two cards to each patient so that they can share with friends and family.

S: Support

Disclosure is not the goal, but it will happen. Discuss a patient-centered care plan to encourage harm reduction. Make a warm referral to your DV partner and document the disclosure in order to follow up at the next visit.

https://ipvhealthpartners.org/adopt/

Health Care Provider Activities

# Provide & Connect to Services

| Provide services & manage interventions to address individual social & economic conditions; “enabling services” | Connect patients to services to address social & economic conditions |
|---|---|

High Country Community Health Patient Resource Specialists:
Patient Resource Specialists meet with all new patients to complete Barriers to Care form and connect with resources.

Data Informed Outreach Program (CHWs):
CHWS embedded into clinical care teams work with patients at high risk of emergency department use or hospitalization. CHWs use standard tool to assess level of intervention needed.

Health Care Provider Activities

# Community Collaborations to Address Underlying Systems

Participate and lead community coalitions to identify and address underlying issues to improve health, social, & economic conditions

Develop partnerships and interventions to address SDOH

# Discussion: How is your organization prepared?

- Break into small groups.

- Using questionnaire provided, discuss how your organization would respond to each of the questions.

# NCCHCA SDOH Initiatives

- Screening Development Support: Individual consultation with health center
- Project Catalyst (with NC Coalition Against Domestic Violence): Training health centers on CUES intervention
- Community Health Worker Initiative: Data Informed Outreach Program
- Workforce Training & Support: Outreach & Enrollment Workgroup, Special Populations Workgroup, Stand-alone Trainings, Community Health Worker Trainings, Tracks at NCCHCA Clinical Conference (April) & East Coast Migrant Stream Forum (October)
- Health Insurance Outreach & Enrollment Programs: support for O&E programs

# Thank You!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